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PPACA'S EFFECTS ON MAINTAINING HEALTH COVERAGE AND JOBS: A REVIEW OF THE HEALTH CARE LAW'S REGULATORY BURDEN

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

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PPACA'S EFFECTS ON MAINTAINING HEALTH COVERAGE AND JOBS: A REVIEW OF THE HEALTH CARE LAW'S REGULATORY BURDEN—DAY 1

THURSDAY, JUNE 2, 2011

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

The subcommittee met, pursuant to call, at 12:05 p.m., in room 2322 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Gingrey, Lance, Cassidy, Pallone, Schakowsky, and Waxman (ex officio).

Staff present: Clay Alspach, Counsel, Health; Jim Barnette, General Counsel; Paul Edattel, Professional Staff Member, Health; Debbee Keller, Press Secretary; Ryan Long, Chief Counsel, Health; Katie Novaria, Legislative Clerk; Heidi Stirrup, Health Policy Coordinator; Phil Barnett, Minority Staff Director; Alli Corr, Minority Policy Analyst; Tim Gronniger, Minority Senior Professional Staff Member; Purvee Kempf, Minority Senior Counsel; Karen Lightfoot, Minority Communications Director and Senior Policy Advisor; and Karen Nelson, Minority Deputy Committee Staff Director for Health.

Mr. PITTS. The committee will now come to order. The Chair will recognize himself for 5 minutes with an opening statement.

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

I have here on the desk this giant stack of every regulation, notice and correction that the Obama administration has issued so far related to the recent health care law. By count of subcommittee staff, 370 Obamacare-related items have been issued. Over 3,500 of pages of rules, notices, and corrections have been published, many of which were released as interim final rules, bypassing the traditional public comment period and giving them the force of law.

I would like to focus on just two: grandfathering of existing health plans and the medical loss ratio, MLR.

"If you like what you have, you can keep it," was the promise that President Obama repeatedly made on the campaign trail and in the months leading up to the passage of PPACA in March 2010. "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 is President Obama with remarks at White House on July 21, 2009. "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 in April 2010.

During the 2008 presidential campaign and the months leading up to passage of the health care reform law, President Obama, his administration, and Congressional Democrats made a series of promises to the American people. Whether you supported PPACA when it became law or not, it has become abundantly clear that those promises have been broken.

According to the administration's own estimates of June 17, 2010, its regulations will force half of all employers, and as many as 80 percent of small businesses, to give up their coverage in the next 2 years.

The regulations state, "After some period of time, most plans will relinquish their grandfathered status," meaning American workers will lose the coverage they have now and become subject to PPACA's more costly requirements.

A May 2011 Price Waterhouse Coopers survey of employers reveals companies' responses to the new health care law and how many are contemplating eliminating coverage as a result. It also echoes the administration's warnings. Of note, 51 percent 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. The report also found that "84 percent of companies indicated they would make other changes to their plans, that is, raising premiums and copayments, to offset costs associated with PPACA."

The regulations associated with grandfathering health plans are just one reason Americans will lose the coverage they have, even if they like it. The medical loss ratio is another. Despite the fact that the MLR 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."

Recently, the administration granted waivers to New Hampshire and Nevada regarding the medical loss ratio requirements in the health care law, on top of the waiver already granted to Maine. Nine other States still have their own waiver applications pending before HHS, Kentucky, Florida, Georgia, North Dakota, Iowa, Louisiana, Kansas, Delaware, and Indiana.

In an October 27, 2010, letter to Secretary Sebelius, the National Association of Insurance Commissioners warned: "We continue to have concerns about the potential for unintended consequences arising from the medical loss ratio. As we noted in our letter of October 13, consumers will not benefit from higher medical loss ratios if the outcome is destabilized insurance markets where consumer choice is limited and the solvency of insurers is undermined."

Many companies have also applied for MLR waivers. Perhaps the most publicized was McDonald's, whose 30,000 employees were granted a waiver from the annual limit requirement on their minimed plans and yet were still in danger of losing their coverage because they could not meet the MLR requirements.

The December 1, 2010, MLR regulation exempted mini-med plans from the requirement for 1 year, after which HHS will determine whether or not to extend the waivers for 2012 and 2013, meaning employees could still be in danger of losing their current coverage.

The fact that so many Americans have had to be exempted from the law's protections under waivers, or risk losing their current coverage, should be alarming to every Member of Congress.

And this stack, this giant stack, is just the beginning. More regulations are due out in the near future, including the establishment of the essential minimum benefits package, which will increase premiums and put people's coverage at risk.

[The prepared statement of Mr. Pitts follows:]

Opening Statement for Rep. Joe Pitts
Energy and Commerce Subcommittee on Health
Hearing on "PPACA's Effects on Maintaining Health Coverage and Jobs: A Review of the Health Care Law's Regulatory Burden."
June 2, 2011
(Remarks Prepared for Delivery)

I have here on the desk every regulation, notice, and correction that the Obama Administration has issued so far related to the recent health care law. By the count of subcommittee staff, 370 Obamacare related items have been issued. Over 3,500 of pages of rules, notices, and corrections have been published, many of which were released as interim final rules, bypassing the traditional public comment period, and giving them the force of law.

I'd like to focus on just two: grandfathering of existing health plans and the Medical Loss Ratio (MLR).

"If you like what you have, you can keep it." A promise President Obama repeatedly made on the campaign trail and in the months leading up to the passage of PPACA in March 2010.

"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)

During the 2008 presidential campaign and the months leading up to passage of the health care reform law, President Obama, his administration, and Congressional Democrats made a series of promises to the American people.

Whether you supported PPACA when it became law or not, it has become abundantly clear that those promises have been broken.

According to the administration's own estimates (June 17, 2010), its regulations will force half of all employers – and as many as 80% of small businesses – to give up their coverage in the next two years.

The regulations state: "after some period of time, most plans will relinquish their grandfathered status," meaning American workers will lose the coverage they have now and become subject to PPACA's more costly requirements.

A May 2011 Price Waterhouse Coopers survey of employers reveals companies' responses to the new health care law and how many are contemplating eliminating coverage as a result. It 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.

The report also found that "84% of companies indicated they would make other changes to their plans [e.g., raising premiums and copayments] to offset costs associated with [PPACA]".

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The fact that so many Americans have had to be exempted from the law's "protections" under waivers, or risk losing their current coverage, should be alarming to every Member of Congress.

And this stack is just the beginning. More regulations are due out in the near future, including the establishment of the essential minimum benefits package, which will increase premiums and put people's coverage at risk.

Thank you to our witnesses today. I would especially like to welcome a fellow Pennsylvanian, Dr. Scott Harrington of the Wharton School at the University of Pennsylvania.

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Mr. PITTS. First of all, thank you to our witnesses today. I would especially like to welcome a fellow Pennsylvanian, Dr. Scott Harrington, of the Wharton School at the University of Pennsylvania, and I will yield back my time.

The Chair recognizes the ranking member of the subcommittee, Mr. Pallone, for 5 minutes for an opening statement.

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

Mr. PALLONE. Mr. Chairman, I really have to object today on many levels. You know, this hearing has essentially become a farce. There is nobody here, other than yourself, myself and Dr. Burgess, and as much as I love to go back and forth with you and Dr. Burgess, I think that it is important that other members on both sides of the aisle be able to attend.

Now, I mentioned to you that because of the fact that we had the full committee hearing this morning and then we are going to have votes I understand as early as 12:30, and then were the Democrats and the Republicans yesterday, but the Democrats today are leaving at 1:00 to go over to meet the President at the President's request, that it would be virtually impossible to have a hearing today that members would be able to attend. The fact that only the three of us are here just lends credence to that.

You know, I was only asking you to postpone the hearing, not because I didn't want to have it, although frankly, I wouldn't want to have it because I think that the subject is a little absurd, too. I will get into that. But just the fact that I was concerned that no one would be able to attend, and there isn't anybody here. We are all going to get out of here at 1:00, and I guess then we are going to go back, reconvene after the President, but then there is going to be more votes. So I just think it is terribly disruptive to the witnesses and to the process, and I wanted to postpone it because I wanted to have everybody to be here and hopefully some come, but it doesn't look like they are here.

Now, the second thing is, you know, again, we are talking about repeal or either not the whole of the Affordable Care Act in this case, but provisions of the Affordable Care Act. I don't know how many times, it is now what, June 2, 5 or 6 months of just the same thing over and over again, repeal the Act, the Act is bad, defund the Act, turn it from mandatory to discretionary. I don't know how many times we are going to hear over and over about the same thing. I don't hear really much in the way of any kind of replacement or Republican alternatives that would provide coverage or provide affordable coverage. Again, today our focus is on repealing the provisions that limit what the insurance companies can do, abundantly clear that the Republicans are in the pockets of the insurance companies and will do whatever the insurance companies want them to do, even if it means at the expense of the public.

So anyway, I have 2½ minutes left. Let me get to some of my prepared remarks, but I really am very disappointed in the way this was set up today and the fact that we keep dealing with the same thing to no avail.

The Affordable Care Act was the transformational law that brought protection to patients across the United States' healthcare system. We finally were able to put a stop to the incendiary insurance industry abuses and reform the insurance system. We expanded coverage, reduced healthcare costs and reduced the federal deficit while building on the private insurance system. We sought after and I believe accomplished bringing better value to consumers and insurance plans and promoting more affordable comprehensive healthcare to Americans.

Some of the most important reforms made in the Affordable Care Act that are meant to curb the insurance industry bad practices are the same ones my Republican colleagues will attack today. They include the medical loss ratio requirements and rate reviews. Medical loss ratio requirements foster transparency and accountable in how insurance companies spend patients' premiums. They also force insurers to be more efficient in delivering quality healthcare. I believe that American patients deserve a guarantee they are getting good value for their dollar. When that value is not met, insurance companies should be required to refund consumers. In fact, HHS estimates that up to nine million Americans could be eligible for rebates starting in 2012 worth up to $1.4 billion, a clear indication there is a real need to hold insurers accountable.

Today I expect to hear from some of our witnesses that this requirement will disrupt the marketplace and limit choices for consumers. They will say we need a transitional period in which insurers can bring their products in line with these requirements slowly and methodically. However, contrary to the naysayers, the loss waivers were put in place for potential disruptions, but it is the States who are in the best position to examine their own markets and make these determinations. The waivers are much better suited to be in response to a specific State condition rather than a one-size-fits-all transition policy.

Another important critical reform was the process of rate reviews. Let me be clear. This is not a provision that prohibits or restricts an insurance company from raising their rates, but what it does is ensure that any large proposed increases are based on reasonable cost assumptions and solid-based evidence. And this step is meant to hold insurance companies accountable and provide unprecedented transparency to the healthcare market.

Now, while Congress was drafting and debating the Affordable Care Act, the insurance industry was recording record profits. In fact, this year the Nation's largest insurers are entering their third straight year of huge profits. According to the New York Times, insurance companies have reported first quarter earnings that beat analysts' expectations by an average of 30 percent. And I have got to be honest across the aisle, you simply can't argue that the insurance industry has been hurt by the Federal healthcare law.

Thank you, Mr. Chairman.

Mr. PITTS. Thank you to the ranking member, and I yield to the vice chairman of the subcommittee, Dr. Burgess, for 5 minutes for an opening statement.

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

Mr. BURGESS. I thank the chairman for yielding. I thank you for having this hearing today. Goodness knows we could have had this hearing in the last Congress, and we should have had this hearing in the last Congress. It is well into a year since the signing into law of the Affordable Care Act, so it is high time we look at some of these things. Both sides of the dais will talk about jobs and the economy. We talk about it, we demagogue about it, but the big question is, are we going to do anything about it. Unemployment is at 9 percent, and it begs the question: Why are American employers hesitant to hire new employees. Part of the reason might be, just might be, that in the first year since the passage of the Affordable Care Act, this is what a small business owner confronts when they want to hire a new employee. Is it any wonder that they would stop and look and say I don't think I can do that at this time? We will make do with what we have.

Now, the burdensome regulations delivered by the United States Congress stack up as you can see here to be almost insurmountable by anyone who has ever run a small business that looks at a stack like this, would say I don't think that is for me. But here is the simple truth. You just cannot be anti-employer and claim to be pro jobs. It doesn't equate.

Now, the Affordable Care Act, in my opinion, levies unreasonable demands on employers, manufacturers, doctors, and not only discourages hiring but encourages employers to drop their employee health insurance. We certainly punish physicians, and we tax industry off-shore and out of America.

Shortly after the signing of this Act a year ago, large employers reported that the law would increase costs. In fact, several large employers restated their earnings for the year. That inflamed members of the then-majority, and a hearing was called in the Energy and Commerce Committee, in the Oversight Committee, to call these folks in and make them explain why they were restating their earnings.

Document demands were made of these employers, and they produced the documents. The documents were examined, and it turned out that the employers were simply complying with the Securities and Exchange Commission, but some of the information contained within those documents made the then-majority, the Democrats, to side not to hold the hearing after all because what they found was large employers were looking at the data and wondering how in the world it was going to be cost-effective to continue to provide health insurance. No employer wanted to be the first to drop this benefit, but there were many who would likely be second, third or fourth.

The strict medical loss ratio regulations are another provision that have proved to be overly burdensome, not only on businesses but on the States. Currently three States have been given waivers, another 10 are asking and are pending approval.

Now, a State realizes that their market can't comply with the law. How in the world is the person who runs a lawnmower shot going to be able to comply with these regulations?

The Affordable Care Act really ought to come with a boxed FDA warning that says, Warning: The Affordable Care Act, when used

as directed, may be harmful to your health. It may reduce your healthcare and increase your cost.

The overregulation incites a sense of uncertainty which discourages hiring and hampers economic development. Every day we get another announcement about another rule going into effect. Far too many are coming out, and quite frankly, several are coming out with the notice of final interim rules, completely bypassing public comment. That is, they become, the regulations have the force of law, without the period of public comment.

Now, if my friends on the other side of the dais are serious about getting Americans back to work, one of the first steps should be to loosen the regulatory nightmares that had been imposed by this law.

Again, I thank the chairman for calling the hearing, and I will yield back the balance of my time.

Mr. PITTS. The Chair thanks to the gentleman and now recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Mr. Chairman. I want to thank all the witnesses for joining us to discuss the important insurance reforms in the Affordable Care Act and their implementation. I want to say a special thanks to Steve Larsen who has become a regular fixture at the Energy and Commerce Committee, and we may even have to get him a permanent name plate.

This hearing is intended to cover all of the regulations issued under the Affordable Care Act and those yet to come. It is an ambitious hearing that gives us the chance to review important new consumer protections being implemented by the department, including rate review, the grandfathering rules and the medical loss ratio provision.

Provisions such as rate review and medical loss ratio provide consumers with protections from insurance company rate hikes and help them receive a good value for their premium dollars. Rate review requires transparency so that insurers are required to justify why premiums continue to increase. Premium increases are a hardship for consumers facing a tough job market and a struggling economy, and they are hard to understand given that insurer profits have risen by staggering amounts.

Over the last 10 years, the premium cost of family health insurance has increased 131 percent. This has led to soaring profits. In just the last 3 years, the profits of the Nation's largest insurers have risen over 50 percent. Rate reviews gives consumers protections against this kind of abuse. Contrary to the claims of critics, the law works to review rates based on existing State authorities. Some States have more authorities, including the right to review rates and deny unjustified increases while others merely have transparency requirements.

The Federal Minimum Rate Review provision provides some consistency across the country and offers an easy-to-understand explanation of premium increases and their justification for consumers.

The healthcare reform law's new minimum medical loss ratio requirement is aimed at protecting consumers and ensuring that their hard-earned dollars are spent on benefits and quality improvements and less on insurer profits and CEO salaries.

A number of States have medical loss ratio rules, and the new federal law standardizes the calculations and sets a minimum of value for consumers wherever they live. The calculation allows for quality improvements, innovation and fraud detection to be counted as medical expenses.

Today we will hear from the association that represents brokers and agents, that the medical loss ratio calculations exclude their commissions. Many brokers and agents provide a valuable benefit for their consumers, but exempting their commissions for the medical loss ratio in effect means increasing premiums and overhead expenses for the consumer. It is time to hold insurance companies accountable, particularly in markets such as the individual and small group markets where they—for years, weakening rules that require them to provide better value to the consumers moves us in a closer direction.

The Affordable Care Act provides a series of popular insurers' reforms that have already gone into effect, such as allowing adult children up to the age of 26 to stay on their parents' insurance, eliminating lifetime limits and prohibiting rescissions of insurers when someone gets sick. These apply to all plans 6 months after enactment, overriding the grandfathering rules because of their importance to families. The dependents up to 26 policies have been immensely helpful in responding to the downturn in the economy. The prohibition of rescissions is responsive to the insurance company abuses and has received bipartisan support, and the prohibition on lifetime limits of benefits is necessary protection for a person with cancer or hemophilia who has nowhere left to turn when he or she has exhausted lifetime maximums. In 2014, these benefits will be greatly expanded, truly reforming the insurance marketplace in the United States. The market will no longer reward companies that avoid risk and leave some of our sickest with no options. It will be inclusive, accessible, affordable, built on the notion of individual responsibility.

It is important that we understand the implementation of these rules, but we need to do so in a constructive manner that serves our constituents' needs. We all want a future where the insurance marketplace is healthy, competitive and providing quality care.

I yield back my time.

Mr. PITTS. The Chair thanks the gentleman. That concludes opening statements. We will go to the first panel.

At this time, I would like to thank the witnesses for agreeing to appear before the committee, and we will introduce them.

Randi Reichel is a counsel at Mitchell, Williams, Selig, Gates & Woodyard, PLLC, and is testifying on behalf of America's Health Insurance Plans.

Scott Harrington is the Professor of Health Care Management and Insurance and Risk Management at the Wharton School at the University of Pennsylvania.

Janet Trautwein is the CEO of the National Association of Health Underwriters.

Katherine Hayes is an Associate Research Professor at the George Washington University School of Public Health and Health Services.

Ethan Rome is the Executive Director of Health Care for America Now.

Edward Fensholt is the Senior Vice President for the Lockton Benefit Group.

And Terry Gardiner is Vice President for Policy and Strategy at the Small Business Majority.

Your written testimony will be made a part of the official record. We ask that you please summarize your testimony in 5-minute opening statements, and we will go in the order that our witnesses were introduced.

Ms. Reichel, you are recognized for 5 minutes' opening statement.

STATEMENTS OF RANDI REICHEL, ESQUIRE, COUNSEL, MITCHELL, WILLIAMS, SELIG, GATES AND WOODYARD, PLLC, ON BEHALF OF AMERICA'S HEALTH INSURANCE PLANS; SCOTT E. HARRINGTON, PH.D., PROFESSOR OF HEALTH CARE MANAGEMENT AND INSURANCE AND RISK MANAGEMENT, WHARTON SCHOOL, UNIVERSITY OF PENNSYLVANIA; JANET TRAUTWEIN, CEO, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS; KATHERINE HAYES, ASSOCIATE RESEARCH PROFESSOR, DEPARTMENT OF HEALTH POLICY, GEORGE WASHINGTON UNIVERSITY SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES; ETHAN ROME, EXECUTIVE DIRECTOR, HEALTH CARE FOR AMERICA NOW; EDWARD FENSHOLT, SENIOR VICE PRESIDENT, LOCKTON BENEFIT GROUP; AND TERRY GARDINER, VICE PRESIDENT, POLICY AND STRATEGY, SMALL BUSINESS MAJORITY

STATEMENT OF RANDI REICHEL

Ms. REICHEL. Thank you, Chairman Pitts, Ranking Member Pallone, and members of the subcommittee. My name is Randi Reichel, and I am an attorney with the law firm of Mitchell, Williams, Selig, Gates & Woodyard. I am here today as outside counsel to America's Health Insurance Plans, and I thank you for the opportunity to testify today about the unintended consequences and the regulatory burdens of the medical loss ratio requirement under the ACA.

I think it is really critically important to examine this provision and the Department of Health and Human Services' regulation that implements the MLR provisions. The requirements, the way they have been implemented, impose an unprecedented new federal cap on administrative costs of health plans and strictly micromanages the plans' abilities to invest in initiatives and innovations to benefit their members and enrollees.

There likely will be a number of unintended consequences for individuals, families and employers, and there are a number of reasons for this. The first is a lack of a uniform transition period. Most States today either don't have medical loss ratio requirements in the large group, small group or individual markets or the ones that do have medical loss ratio requirements that are crafted to incor-

porate existing actuarial practices in order specifically to avoid any type of market disruption.

Without the time to make the adjustments and the changes that are needed to comply with the MLR provisions, some of the health plans in the marketplace today have no choice but to exit the market. And you know, we know that we are not crying wolf about this, and the reason that we know that is HHS has already acknowledged in its letters to Nevada, in its letters to New Hampshire, when those two States asked for a waiver of the MLR requirements, they conceded that the MLR standard could, in fact, lead to a destabilization of the individual market in those States.

While the MLR is problematic across the board for all types of health insurance coverage, I think it is important to look specifically at the impact that this may have on access to high-deductible health plans. There is a reason for this. On a per-enrollee kind of basis, fees options are intended to have a much higher deductible and they are lower cost to the individual. So as result, the—ratios are higher because the administration of these plans doesn't cost us any less.

So the premium is lower, the administrative costs are higher, and the MLR, by not taking the kind of differences or special circumstances of these plans into account really provides a significant challenge to the companies that write this business and make it really questionable whether or not the individuals who have this very popular, very affordable option are going to be able to continue to either obtain it or maintain the policies that they have going forward.

Even more than that, one of the things that we are really concerned about right now is that the MLR requirements do in fact turn back the clock on any kind of efforts to prove quality and prevent fraud and abuse, and they do this for two reasons. One is they only permit dollar recoveries from fraud programs to be counted toward the MLR, but they penalize companies for actually preventing fraud in the first place. And they don't recognize as quality the expenses of transitioning into the ICD–10 coding system that is intended for disease eradication and quality.

By having only four categories that qualify as quality categories, the MLR requirements inhibit any kind of—by capping expenses for real quality programs that may fall outside the very guardrails of those four quality categories. The way the regulation is structured, I think it is going to be very problematic moving forward.

And the most telling thing is that while the MLR is intended to put a cap on administrative costs, indeed the MLR itself is going to increase administrative costs. There are a host of new reporting requirements that companies have to undergo in order to comply with the new regulations. The companies are going to have to have new data collection, new accounting, new auditing and the staff and the ramp-up for all of these things.

We have talked to AHIP members, and preliminary estimates from at least some of the larger multi-State plans have put some of their preliminary compliance costs at more than $20 million.

Mr. PITTS. Would you wrap up, please?

Ms. REICHEL. I don't want to repeat what else is in our testimony. We do have some recommendations to mitigate the harmful

impact of the medical loss ratio. With that I will thank you for the opportunity to testify and present our perspective.

[The prepared statement of Ms. Reichel follows:]

Testimony

for

House Energy and Commerce Committee
Subcommittee on Health

The Unintended Consequences and Regulatory Burdens of the New Medical Loss Ratio Requirements

by
Randi Reichel
Mitchell, Williams, Selig, Gates & Woodyard

on behalf of
America's Health Insurance Plans

June 2, 2011

I. Introduction

Chairman Pitts, Ranking Member Pallone, and members of the subcommittee, I am Randi Reichel, an attorney with the law firm of Mitchell, Williams, Selig, Gates & Woodyard. I am testifying today on behalf of America's Health Insurance Plans (AHIP), which is the national association representing health insurance plans that provide coverage to more than 200 million Americans. AHIP's members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We appreciate this opportunity to testify on the unintended consequences and regulatory burdens of the medical loss ratio (MLR) requirements established by the Affordable Care Act (ACA). Recognizing that the new MLR requirements have far-reaching implications for health care consumers, employers, and health insurance plans, we believe it is critically important for Congress to closely examine this legislative provision and how it is being implemented.

Beginning in 2011, health plans are required to meet annual MLR requirements of 80 percent in the individual and small group markets and 85 percent in the large group market. This means that health plans must spend a specified percentage of premium revenue on either reimbursement for clinical services provided to enrollees or "activities that improve health care quality." Health plans are required to pay rebates to enrollees if they fail to meet the MLR requirements. On December 1, 2010, the Department of Health and Human Services (HHS) issued an interim final rule for the implementation of the new MLR requirements, based largely, but not entirely, on the recommendations of the National Association of Insurance Commissioners (NAIC). AHIP submitted extensive comments to both HHS and the NAIC at all stages throughout the regulatory process.

Our testimony focuses on three important areas:

- The unintended consequences the MLR requirements will have in disrupting health care choices for consumers, turning back the clock on quality improvement initiatives, stifling innovation by health plans, and reducing access to agents and brokers;

- The regulatory burdens and administrative costs the MLR requirements will impose on businesses and health plans; and

- Our recommendations for mitigating coverage disruptions and other adverse impacts of the MLR requirements through a transition and by recognizing fraud prevention programs and ICD-10 implementation startup costs as quality improvement activities.

II. Unintended Consequences of the MLR Requirements

The MLR requirements impose an unprecedented new federal cap on the administrative costs of health plans, strictly micro-managing their ability to invest in new initiatives and innovations to benefit their enrollees. This policy will have a number of unintended consequences for individuals, families, and employers.

Disrupting Choices and Coverage

The MLR requirements pose a risk to the health coverage that families and employers rely on today. This risk is exacerbated by the fact that the provision went into effect in January 2011 without a uniform transition period to allow health plans to adjust to the new requirement. Currently, most states either do not have MLR requirements or they have crafted regulatory loss ratio requirements that include existing actuarial standards to avoid market disruption. Without time to make the adjustments and changes needed to comply, some health plans will have no choice but to exit the market altogether. This breaks the promise that those who like their coverage can keep it.

Many state insurance commissioners have raised similar concerns in submitting waiver requests to HHS, seeking relief from the federal MLR standards. To date, 12 states have submitted MLR waiver requests and three of these have been approved with modifications by HHS. Moreover, HHS has acknowledged the validity of the commissioners' concerns in its recent letters to state officials. In a May 13, 2011 letter to Nevada Insurance Commissioner Brett Barratt, HHS stated that "there is a reasonable likelihood that immediate implementation of an 80 percent MLR standard may destabilize the Nevada individual market." HHS expressed "particular concern" that the withdrawal of two large insurers with a combined market share of 24 percent "would

adversely affect the Nevada individual market, potentially leaving their policyholders without coverage."

Similarly, in a May 13, 2011 letter to New Hampshire Insurance Commissioner Roger Sevigny, HHS stated: "We agree with the NHID that there is reasonable likelihood that, in this case, immediate implementation of the 80 percent MLR standard may destabilize the individual market. We recognize the potential losses that some issuers in the State may incur if the 80 percent standard were applied for 2011 and rebates were required... The possibility of potential losses could lead to issuers exiting the market, leaving consumers temporarily without coverage and reducing options available to consumers."

The Congressional Budget Office (CBO) also has recognized the potential for strict MLR requirements to force health plans out of the marketplace. In a December 2008 report, CBO stated: "Whether insurers serving the individual and small-group markets could increase their loss ratios simply because they were required to do so is not clear, so the effects of such requirements on those markets are hard to predict. If the requirement was set too high, insurers would probably exit the market."[1]

More recently, a March 2011 study[2] by researchers at the University of Minnesota concluded that the federal MLR regulation "has the potential to significantly affect the functioning of the individual market for health insurance." The authors cautioned: "Nine states would have at least one-half of their health insurers below the [MLR] threshold. If insurers below the MLR threshold exit the market, major coverage disruption could occur for those in poor health; we estimated the range to be between 104,624 and 158,736 member-years."

While the MLR is problematic for all types of health coverage, its impact may be particularly severe in limiting consumer access to high-deductible health plans (HDHPs). By Congressional design, these plans are intended to provide consumers a highly affordable coverage option that gives them more control over their spending, allows consumers to save for health care expenses through a Health Savings Account (HSA), and provides catastrophic coverage protection tied to a statutory out-of-pocket maximum. Consumer-driven HDHP/HSA policies were created in order to allow consumers to have a more direct stake in the cost of their health care. These plans

[1] Congressional Budget Office, Key Issues in Analyzing Major Health Insurance Proposals (December 2008)
[2] Jean M. Abraham and Pinar Karaca-Mandic, "Regulating the Medical Loss Ratio: Implications for the Individual Market" American Journal of Managed Care Vol. 17, no. 3 (March 2011)

are popular with consumers and employers – with 10 million enrollees as of January 2010. However, because these lower-cost benefit options are not necessarily less costly to administer on a per-enrollee basis, they naturally will have lower loss ratios and a greater likelihood of being noncompliant with the MLR rule. By failing to recognize the unique nature of these policies, the MLR regulation threatens to undermine Congress' intent, and could result in denying consumers the opportunity to obtain or maintain what has become a very popular and affordable coverage option.

Undermining Quality and Stifling Innovation

We also have serious concerns that the MLR regulation will turn back the clock on quality improvement by penalizing health plans for investing in certain activities that are highly beneficial to enrollees. Specifically, the MLR regulation falls short by: (1) only allowing recoveries from fraud programs to be counted toward the MLR, while capping expenses to prevent or deter fraud – in other words, rewarding and encouraging only the "pay and chase" system that Congress has moved public programs away from; and (2) failing to recognize as quality expenses the costs of transitioning to the ICD-10 coding system that will allow for better monitoring and tracking of health care quality. In Section IV of this testimony, where we outline our recommendations, we explain the rationale for recognizing both fraud prevention programs and ICD-10 implementation startup costs as quality improvement activities for purposes of calculating MLRs.

Another closely related concern is that the next generation of health plan innovations may be inhibited by the MLR regulation's approach of capping any expenses that do not meet the four criteria of "activities that improve health care quality." While the MLR regulation acknowledges many existing efforts to improve quality, it defines health care quality initiatives in a way that is too narrow, thus creating new barriers to investment in the many activities that health plans have implemented to improve health care quality. The recent HHS MLR Technical Guidance of May 13, 2011 notes that their examples are illustrative, not exhaustive. Yet the method of defining a quality improving initiative in the regulation is more restrictive than that recommended by the Institute of Medicine (IOM). A more dynamic approach to promoting investments in quality improvement would use the framework and criteria established by the IOM and the Agency for Healthcare Research and Quality (AHRQ), entities whose primary goal is to promote high quality health care for consumers. Both the IOM and AHRQ have long recognized that there are

multiple components to health care quality and that the goal is to provide care that is safe, effective, patient-centered, timely, efficient, and equitable.[3]

Health plans have a long track record in developing innovative approaches to payment and delivery system reforms that are helping to ensure greater coordination and less fragmentation in the health care system. These tools and innovations not only produce better clinical outcomes, but also result in significant cost savings.

Many health plans, for example, are seeking to reduce preventable hospital admissions, readmissions, and emergency room use through a wide range of patient-centered initiatives that focus on rebuilding primary care efforts, engaging patients, and recognizing the important role of pharmacists. Plan-specific examples, documented in a recent AHIP publication[4], include offering intensive case management to help patients at high risk of hospitalization access the medical, behavioral health, and social services they need; arranging for home visits by multidisciplinary teams of clinicians; expanding patient access to urgent care centers and after-hours care; and revamping physician payment incentives to promote care coordination. Greater clarity and flexibility is needed in the MLR regulation to ensure that plans can continue to pursue and build upon these initiatives.

Although the MLR regulation exempts costs associated with certain quality improvement activities, this exemption may not include vital research and data collection efforts. For example, health plans are increasingly using their own claims databases, along with publicly available claims and administrative cost data, to pinpoint indicators of sub-optimal care, such as high rates of hospital readmissions, medical errors and other adverse events, and higher-than-average mortality or morbidity rates. Health plans may use this information in developing their provider networks or in providing information directly to patients. Because this research is not directly related to patient outcomes, it likely would be counted toward administrative costs – not as a quality improvement activity – under the MLR regulation. Therefore, such research could be the first to be eliminated if a health plan's operations were near the MLR threshold.

The importance of continuing – and building upon – health plan initiatives to reduce preventable hospital admissions, readmissions, and emergency room visits is demonstrated by a series of

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[3] Institute of Medicine, "Crossing the Quality Chasm: A New Health System for the 21st Century," (2001)
[4] AHIP Center for Policy and Research, Innovations in Reducing Preventable Hospital Admissions, Readmissions, and Emergency Room Use (June 2010)

recent AHIP studies, conducted over the past two years by our Center for Policy and Research, which have compared certain utilization measures, including hospital readmission rates, for enrollees in the Medicare Advantage program and the Medicare fee-for-service (FFS) program. Our research findings demonstrate that health plan innovations are helping to keep patients out of the hospital and avoid potentially harmful complications:

- Based on a risk-adjusted comparison of patterns of care among patients enrolled in two large, multi-state Medicare Advantage HMO plans and in the Medicare FFS program, we found that the Medicare Advantage plans improved health care for their enrollees by reducing emergency room visits by 24 percent, reducing hospital readmissions by 39 percent, reducing certain potentially avoidable hospital admissions by 10 percent, and reducing inpatient hospital days by 20 percent.[5]

- Based on an analysis of hospital discharge datasets in nine states, we found that risk-adjusted hospital readmission rates were about 27-29 percent lower in Medicare Advantage than in Medicare FFS for each enrollee, 16-18 percent lower for each person with an admission, and 14-17 percent lower for each hospitalization.[6]

- Based on an analysis of data on gaps in time between hospital admissions and discharges in five states, we found that risk-adjusted 30-day readmission rates per hospitalization were about 12-18 percent lower in Medicare Advantage than in Medicare FFS, that risk-adjusted 30-day readmissions per patient with an admission were 12-27 percent lower in Medicare Advantage among patients with at least one admission, and that 30-day readmissions per enrollee (including enrollees not hospitalized in a year) were 22-43 percent lower in Medicare Advantage.[7]

These studies consistently show that the innovations developed by private health plans are reducing the need for preventable hospitalizations. As a result of this success, health insurance plans not only are improving the health and well-being of their enrollees, but also achieving greater efficiencies and cost savings. Health reform should encourage – not impede –

[5] AHIP Center for Policy and Research, Working Paper: Comparisons of Utilization in Two Large Multi-State Medicare Advantage HMOs and Medicare Fee-for-Service in the Same Service Areas (December 2009)
[6] AHIP Center for Policy and Research, Working Paper: Using State Hospital Discharge Data to Compare Readmission Rates in Medicare Advantage and Medicare's Traditional Fee-for-Service Program (May 2010)
[7] AHIP Center for Policy and Research, Using AHRQ's 'Revisit' Data to Estimate 30-Day Readmission Rates in Medicare Advantage and the Traditional Fee-for-Service Program (October 2010)

investments in these initiatives. However, there is some uncertainty about whether many of these now time-tested and successful initiatives would have been permissible had the MLR requirements been in place during their development. We are concerned that the potential lack of flexibility and lack of certainty in implementation standards in the regulation will stifle similar forward-looking and innovative programs in the future.

Reducing Access to Agents and Brokers

Finally, the MLR regulation includes commissions paid to licensed agents and brokers in the MLR calculation. This decision, unless it is reversed, will reduce individuals' and small employers' access to agents and brokers who provide a valuable service to help them find the coverage that best meets their financial and health care needs.

In a health care system that is highly complex, extremely costly and constantly changing, consumers and employers value the services of trusted advisors who can assist them in making coverage decisions that best meet their specific needs and circumstances. Unfortunately, the current MLR regulation threatens the ability of consumers to obtain these vitally important personalized advisory services. AHIP believes that broker compensation should be removed from the MLR calculation to prevent millions of individual and small group customers from losing access to the services of trusted health benefits advisors.

This issue has significant potential to create disruptions in coverage and, as a result, reinforces the need for establishing a transition to the 2014 reforms as we discuss in our recommendations in Section IV. Establishing a transition policy to move from the current system to the new system in 2014 will help ensure that the MLR regulation does not undermine access to the valuable services provided by agents and brokers.

III. Regulatory and Administrative Burdens

The MLR regulation imposes significant regulatory burdens on employers and health plans, and ultimately will have the unintended consequence of increasing administrative costs across the health care system, rather than decreasing them. This runs counter to the President's Executive Order on regulatory streamlining which recognizes that "regulations have costs."[8]

[8] Executive Order 13563, "Improving Regulation and Regulatory Review" (January 18, 2011)

By imposing an open-ended obligation on health plans for the distribution of rebates in a group coverage setting to employees even where health plans lack the information to determine the appropriate distribution, the regulations establish an unnecessarily burdensome framework for health plans and employers to navigate. Lacking a "safe harbor" outlining reasonable activities that can be undertaken to fulfill this requirement, the ultimate impact of the requirement will be to cause employers, especially small employers, to devote scarce resources to compliance activities that may provide little value to them or their employees.

Meanwhile, health plans will face higher administrative costs due to a variety of new reporting and compliance activities that go far beyond what plans currently are required to undertake. This will necessitate the creation of new information technology systems, contracts, and administrative compliance centers to address and manage the complexity of the proposed requirements, and the unprecedented involvement of the federal government into the records of plans and their business partners.

We want to highlight three areas where the MLR regulation overreaches by imposing requirements not established by the statute and not recommended by the NAIC:

- The regulation goes far beyond the ACA's requirement that health plans pay rebates when they fail to meet the MLR requirement. It takes the additional step of holding health plans fully liable for the calculation and dissemination of rebates to employees in group plans, without recognizing that it is unreasonable to hold plans responsible for making payments based on the information of entities they do not control, and being subject to penalties for late payments even if the entities have not provided the necessary information for plans to act on. The unintended consequence of this policy is likely to be a significant increase in administrative costs tied to new audit processes and procedures designed to assess compliance for both health plans and employers.

- The regulation contains language and examples suggesting that when a health plan pays a vendor, those vendors must report the types of costs in their billings: what percentage is for quality improvement activities and what percentage is for administrative costs. The health plan is responsible for ensuring that this cost breakout is accurate. This requirement creates a

system that increases administrative costs for insurers without providing any new value to consumers.

- The regulation requires that health plans permit, or by contract require, access for HHS audits of parent organizations, related entities, contractors, subcontractors, agents or transferees that "pertain to any aspect of the data reported to HHS or to rebate payments calculated and made under this part."[9] This reflects a significant expansion of federal government activity into the daily operation of participants in the commercial health care system, substantially implicating a range of entities and individuals whose businesses are not, by Congressional design, subject to HHS authority under the MLR. We believe HHS should consider other options for achieving appropriate oversight without creating an unnecessarily burdensome regulatory environment effecting virtually every entity contracting with a health plan.

AHIP has reached out to our member plans, seeking feedback on the costs they will incur in complying with the new MLR requirements. Because the regulation is relatively new, many health plans are only beginning to tally its costs and assess its implications. However, the preliminary information[10] provided by our members indicates that the initial costs of implementing the MLR will be substantial for many plans – necessitating the installation of new accounting systems, new forms of data collection, and increased auditing costs to prove compliance with the MLR calculations and rebates. Some large, multi-state plans have identified preliminary compliance costs exceeding $20 million.

Three major themes emerged from our discussions with our member health plans: (1) the requirement for health plans to break out administrative and quality-of-care expenses at provider and vendor levels will require new accounting and system development costs; (2) the requirement to pay rebates directly to employees and former employees in group plans is problematic; and (3) the auditing costs to prove compliance with MLR calculations and rebates could be substantial in some cases.

In addition, we anticipate that the compliance costs of the MLR regulation are likely to have the greatest impact on health plans with a large portion of their enrollment in the small group and individual markets, where MLRs are commonly below 80 percent. MLRs are lower for

[9] 45 CFR §158.501(b)
[10] AHIP Center for Policy and Research, The Federal Medical Loss Ratio (MLR) Calculations – Background and Initial Costs of Compliance (June 2011 – forthcoming)

individual policyholders and the smallest groups for two reasons: (1) the costs of servicing individual and small-group policies tend to be higher than for large groups (where employers assume many administrative functions); and (2) individual and small-group policies tend to have lower benefit levels (such as higher deductibles or copayments) and thus may have lower premiums.

Overall, it is clear that health plans expect to incur significant new administrative costs to comply with the MLR regulation. The initial compliance costs – especially those relating to accounting, auditing, and contracts with providers and employers – likely will exceed the estimates that accompanied the regulation by a substantial amount for many health plans.

IV. Recommendations for Mitigating the Adverse Impacts of the MLR Requirements

In an effort to mitigate the adverse impacts of the MLR regulation, AHIP has offered several recommendations that would take important steps toward protecting consumers and employers from the unintended consequences and regulatory burdens of the MLR. These include implementing an effective transition to the 2014 reforms for all markets and, additionally, recognizing fraud prevention programs and ICD-10 implementation startup costs as quality improvement activities.

Adopting an Effective Transition to the 2014 Reforms

We have urged HHS to place a high priority on minimizing disruption and preserving consumer choices in the marketplace during the 2011-2014 period leading up to the implementation of the ACA's major insurance market reforms. Recognizing that state standards for MLRs were either lower than the federal standard, crafted to include existing actuarial standards to avoid market disruption, or did not exist in some states prior to the ACA, we have asked HHS to adopt a predictable and effective transition plan to reach the individual, small group, and large group markets.

From now until 2014, it is vitally important to minimize disruption in the pre-reform marketplace. Four-fifths of the individual market will remain medically underwritten, guided by

the rules and regulations in each state. A transition policy is needed to move from the current system to the new system that will be created in 2014 and to allow individuals and those receiving coverage through employer group health plans to maintain their coverage. In addition, a smooth transition and preservation of the marketplace leading up to 2014 will provide consumers with continued choices and stability until the Exchanges are operational and the rest of the market reforms become effective. Until that time, consumers in the individual and small group markets will rely on brokers to review their insurance options and consider which ones best suit their needs. Thereafter, brokers will continue to have an important role to play, but will operate in the context of new mechanisms for making coverage available to consumers and employers.

Similarly, the large group market typically has not been subject to MLR requirements. This reflects the customized nature of benefit packages and associated cost and quality programs often demanded by large group purchasers. The imposition of the MLR standards will cause some large groups to incur significant new administrative costs they do not incur today, and will require a substantial period of adjustment to promote stability.

To further emphasize the need for an effective transition, we point out that rates currently in effect in today's 2011 market were filed and approved many months before the components of the MLR standards were known. This regulation was published on December 1, 2010, with an effective date of January 1, 2011. Rates were filed with states in some instances in February and March of 2010, even before the legislation itself was signed into law. Failing to include some form of transition, or some safe harbor for health plans whose rates were appropriately based on their states' existing MLR requirements, damages the solvency assumptions those health plans – and their state regulators – made at the time the rates were developed and approved. HHS should provide specific transition guidance leading to 2014 to ensure that these solvency assumptions are not ignored.

To be effective, a transition should recognize structural issues associated with each of the individual, small group, and large group markets now and in 2014. Key among these are issues concerning current market cost structures and operating models, which when understood make the case and need for transition clear. In particular, health plans have developed cost structures and operating models to meet the needs of consumers and employers across different insurance markets. These structures also reflect existing regulatory requirements and market rules that remain substantially unchanged for most types of coverage prior to 2014.

Below is a chart showing why the pre-2014 market is structurally different from the 2014+ market:

Differences Between Pre- and Post-2014 Market & Regulatory Structure	
2011-2013	**2014+**
Volatility in MLR calculation • Annual, state specific MLR calculations, creating significant issues in volatility in MLRs across states year by year • No risk adjustment	*Mechanisms introduced to provide less volatility in MLR calculation* • 3-year averaging to smooth the volatility of results • Introduction of risk adjustment, and transitional reinsurance and risk corridors
Higher costs relating to underwritten individual markets in most states • "Durational" issues meaning MLRs rise with the passage of time • Administrative costs relating to underwriting	*New rating rule and guarantee issue reduce administrative costs* • Durational issues minimized because market is no longer underwritten • No underwriting costs
Distribution channel through agents & brokers • Principal distribution channel for individual and small group coverage • Source of human resources type functions for individuals and employer groups	*Exchanges established and functional* • Alternative distribution mechanism • Possible assistance of brokers, ombudsman, and others with human resources type functions

The policy goal should be to create a transition that works. Three elements in this regard are essential:

1. Recognize that the basic structure of the market is unchanged in 2011, 2012, and 2013 as illustrated above.

2. Use an application process that minimizes the burden on states and encourages rather than discourages them to apply for a transition in each of the individual, small group, and large group market segments as necessary.

3. Provide adequate flexibility to ensure that transition plans can address key fundamental differences between the current market and the reformed market, especially as they relate to cost structure and volatility.

In addition, an effective transition would take the form of a bridge, at least allowing states adequate time to evaluate and put together an appropriate transition plan that meets their citizens' needs. In this regard, the need for a bridge is present across all market segments, including in the large group market where time is needed to restructure existing contractual arrangements with employers. As an example from the large group segment, one complexity that arises and requires time to address involves multiple contracts between a carrier and a single employer, but where the arrangements are structured to ensure that the employer is treated consistently across its enterprise, even where the employer operates in multiple states.

A transition would help guard against disrupting or impairing these existing contractual obligations and related arrangements, reducing the risk that MLR implementation becomes a source of inefficiency and concern in the workplace, and could provide time for a state-based application process to be put into place and made effective.

Providing for An Adequate "Credibility Adjustment" to Address Volatility

A critical concern across the individual, small group, and large group markets is whether the MLR for a small block of business in a state is based on enough experience to be "credible" to ensure that if a health plan fails to meet the MLR standard, this result (and the requirement to pay a rebate) is not due to random statistical fluctuation.

The handling of this issue is of vital importance because the structure of the MLR requires that health plans pay rebates in years when their performance is below the threshold, but are not allowed to net these effects with experience that is above the thresholds. This means that in years when plans lose money, they cannot recoup those losses, but when they are successful in other years, they must pay it out to policyholders. In effect then, in the years in which plans sustain financial losses, they are never permitted to recover them.

In practice, there are high levels of variation in claims from year-to-year. This disproportionately impacts smaller plans or health plans with smaller blocks of business (even larger plans with small blocks of business), because the smaller the block, the greater the

variation that can be caused by even one critical or large claim. In today's market, many health plans manage these effects by balancing the variation across a range of states in which they do business, or across their entire book of business if they only operate in one state. However, because the MLR is to be calculated on a state-by-state legal entity block-of-business basis, it is no longer possible to manage this variation through a portfolio approach that balances the effect of random, annual variation in claims (commonly reflecting the occurrence and impact of high cost claims). Likewise, it is not possible to manage this issue through reinsurance based on the expected rules because the cost of purchasing reinsurance is to be treated as an administrative cost under the MLR.

The issue of volatility and credibility is not limited to the individual and small group markets, nor is it limited to smaller carriers – recognizing that even large carriers have small blocks of large group coverage when measured on a state-by-state basis as the MLR regulation requires.

The regulation acknowledges the issues and problems associated with credibility by including a credibility adjusted factor that appears to have been based on a confidence interval of 50 percent, as opposed to the 80 percent confidence interval recommended by the American Academy of Actuaries. The Academy has written regarding its concerns about the sufficiency of the credibility adjustment reflected in the regulation, raising issues of stability and potentially impairing smaller competitors in the market. Similarly, the actuarial firm Milliman wrote in its report prepared for the NAIC that: "[T]he use of a two-sided 50th percentile basis would likely be considered a very low confidence interval for a study concerned with plan solvency implications of the MLR refund requirement."

Finally, the MLR regulation contains a highly complex provision that denies *any* credibility adjustment at all in 2013 if the relevant block of coverage was under the MLR in each of 2011, 2012, and 2013 after the credibility adjustment in those years. This creates a further risk point for carriers, and penalizes those carriers that attempt to stay in the market and continue providing coverage and choice (even after paying rebates), and threatens to make it extremely difficult for a health plan to stay in the market over the long-term. Moreover, this provision is of special concern because 2011 pricing is and typically was set well before publication of the regulation. This means that plans will have only two years – 2012 and 2013 – to try and avert this increased risk. In sum, by creating a 2013 cliff for plans subject to its effects, this provision threatens to lessen competition going into the 2014 market reforms and operation of the exchanges, to the detriment of consumers and employers alike.

In light of these serious concerns, we believe the credibility adjustment in the MLR regulation should be strengthened to address volatility and ensure that small blocks of business can withstand purely random variations in the frequency or severity of claims.

Recognizing the Role of Fraud Prevention and Credentialing Activities in Quality Improvement

Health insurance plans devote significant resources to fraud prevention and detection programs as part of a broad-based strategy for improving health outcomes and achieving the optimal use of health care dollars. Recognizing that fraud has far-reaching implications both for health care costs and quality, health plans have developed cutting-edge techniques to identify fraud and halt practices that lead to substandard care – including the delivery of inappropriate or unnecessary services that may harm patients. These efforts involve the use of special investigations units (SIUs) that are staffed with qualified personnel, including many with statistical, medical, and law enforcement experience. These SIUs perform sophisticated tasks that include investigating claims, coordinating with law enforcement personnel, training in-house personnel to identify and report possible fraud, developing and using sophisticated software to identify possible fraudulent claims, initiating civil actions seeking to recover improper claims payments, and preparing "evidence packages" of suspected fraudulent providers for the benefit of law enforcement entities.

These health plan anti-fraud initiatives are strongly focused on preventing fraud before it takes place, rather than "paying and chasing" after the fact. This approach serves as a powerful deterrent in preventing not only inappropriate billings, but more importantly, preventing inappropriate delivery of unnecessary or inappropriate services from occurring in the first place. The success of health plans' fraud prevention initiatives is evidenced by the fact that government programs now are incorporating these innovative private sector practices.

Given the role that health plan fraud prevention and detection programs have played in establishing effective models for public programs, improved data for law enforcement, and successful prevention efforts, we believe the MLR regulation's treatment of such programs should be reevaluated. The specific concern is that the MLR regulation only provides a credit for fraud "recoveries" – i.e., funds that were paid out to providers and then recovered under "pay and chase" initiatives. It does not include the cost of developing and administering anti-fraud

programs that detect fraud before claims are paid and in the process protect consumers, purchasers, and patients. As a result, the regulation would penalize health plans for committing resources to innovative programs that prevent and detect fraudulent conduct or prevent the delivery of unnecessary services or care.

By taking this approach, the MLR regulation's treatment of fraud prevention expenses works at cross purposes with new government efforts to emulate successful private sector programs, and it is at odds with the broad recognition by leaders in the private and public sectors that there is a direct link between fraud prevention activities and improved health care quality and outcomes.

Similarly, the MLR regulation categorically excludes provider credentialing from the definition of activities that improve health care quality. As now recognized in government programs, provider credentialing is a critical function that helps ensure, among other things, that the providers from whom an individual or family seeks care are properly licensed and qualified – thereby contributing directly to patient safety.

We are urging a reconsideration of potential options for the treatment of fraud prevention and credentialing programs. Excluding these expenses is contrary to the health reform goals of developing a system to deliver consistently high quality care, optimizing the use of health care resources, and enhancing anti-fraud cooperation between private and public entities.

Recognizing ICD-10 Implementation as a Quality Improvement Activity

We strongly believe that the definition of health care quality initiatives should include the startup costs that health plans incur in meeting the October 1, 2013 compliance deadline for ICD-10 implementation. The goal of ICD-10 was to provide health plans and health care providers an expanded understanding of diagnoses and procedures at institutional settings of care, thereby enhancing the ability of providers and plans to categorize disease states, document medical complications, and track care outcomes. These advances would, in turn, support efforts to gain a deeper understanding of disease, causes of death, and ways to make significant improvements in health care quality.

The ICD-10 conversion, which was mandated by the federal government, was not undertaken in order to enhance claims payment capabilities. In fact, HHS has publicly recognized that implementation of ICD-10 represents "a giant step forward toward developing a health care

system that focuses on quality" and is one that will "enable HHS to fully support quality reporting bio-surveillance, and other critical activities."[11] Additionally, the MLR regulation specifically requested comments regarding the inclusion of ICD-10 costs, noting that there is "general recognition that the conversion to ICD-10 will enhance the provision of quality care through the collection of better and more refined data."[12]

An AHIP study[13], published in September 2010, collected significant data from health plans showing the costs of implementing the conversion from ICD-9 to ICD-10. The study outlines findings, based on a survey of 20 health insurance plans, which indicate an average implementation cost for ICD-10 implementation of about $12 per member, ranging from $38 per member for small health plans (less than one million members) to $11 per member for large plans (more than 5 million members). The overall incremental cost for ICD-10 implementation for all responding plans is estimated to be $1.7 billion. Since the 20 responding health plans do not comprise the entire U.S. health insurance market, the estimated total system-wide cost for insurers is likely to be in the range of $2-3 billion.

To view the broader implications of ICD-10 implementation costs, it is important to recognize that health plan investments in information technology (IT) infrastructures are consistently challenged to meet the needs of the populations they serve and the growing demands of federal and staff regulators. Numerous reports have stressed the need for timely health information exchange both to improve patient outcomes and efficiency in care delivery. The HITECH Act and other legislative and regulatory requirements point to the need for sustainable health IT infrastructures across the health care delivery system to enable the exchange of such information at the point of care, inclusive of clinically-enriched administrative data available from health plans such as recent care received, missed preventive screenings, and alerts pertaining to medication interactions or recalls. Such infrastructures require ongoing investments in transitioning existing health plan IT systems, experienced staff and other resources that consistently compete with ICD-10 requirements. Other important investments pertaining to health information exchange that will improve the overall efficiency and effectiveness of the health care system are being delayed to meet the arbitrary ICD-10 timelines.

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[11] CMS News Release, "Proposed Changes Would Improve Disease Tracking and Speed Transition to an Electronic Health Care Environment" (August 15, 2008)
[12] 75 Fed. Reg. 74877
[13] AHIP Center for Policy and Research, "Health Plans' Estimated Costs of Implementing ICD-10 Diagnosis Coding" (September 2010)

We have strongly urged HHS to recognize that ICD-10 implementation is a major quality improvement initiative and not merely an administrative task surrounding the payment of claims. The ongoing maintenance of the system, once it is built and operational in 2013, may legitimately be deemed an administrative cost. The "conversion" or investment costs to build the system, however, are clearly being undertaken in order to improve the quality of our nation's health care system and should be included in the quality portion of the MLR.

Recognizing Promising New Approaches to Cost Containment

At a time when the nation is facing a health care cost crisis, we believe the MLR regulation should recognize the promising new strategies that health plans are employing to achieving cost containment. To discourage investment in these initiatives is penny-wise and pound-foolish.

Health plans are leading the way in developing cost containment strategies that promote administrative simplification, advance health information technology, adopt payment models that reward quality and value, encourage clinical decision-making based on best evidence, empower patients to more effectively engage in the health care system, and design benefits that encourage consumers to choose the safest, highest quality and most cost-effective drugs, devices, and procedures. The broad range of strategies used by health plans to contain costs should be encouraged by the MLR regulation, rather than undermined.

A Health Care Cost Summit recently sponsored by AHIP highlighted a new "shared incentive" payment model launched by one of our member plans in partnership with several large health systems. Under this innovative program, the health plan gradually phases down the fee-for-service portion of reimbursements while adding payments tied to measurable improvements in health care quality and the overall cost of care. A list of quality, outcomes, wellness, and patient satisfaction measures is used to evaluate improvement in providing care for chronic illnesses such as diabetes, heart disease, and hypertension. Over the length of the health plan's contract with participating care systems, the proportion of payments tied to quality and cost become the dominant reimbursement and incentive system. The gradual shift toward incentive-based payment is intended to allow health care providers to transform health care delivery without putting their solvency at risk. As part of the new model, the health plan shares data with health care providers to identify and address cost drivers and quality gaps so they can improve care processes. This initiative is just one example of the types of innovative strategies that health

plans are developing and that should be encouraged by the MLR regulation to achieve meaningful cost containment.

Finally, health care spending is impacted by certain dimensions of the MLR regulation that discourage or even disadvantage certain care management and quality initiatives. These include, for example, the potential squeeze on quality improvement initiatives or other innovative programs, failing to recognize the value of ICD-10 implementation startup costs, and failing to include the cost of fraud prevention and detection. If administrative cost pressures discourage investments in these areas, medical care costs will go up. This is a perverse incentive that should be avoided at all costs.

V. Conclusion

Thank you for considering our perspectives on the new MLR requirements and the likely impact on consumers and the marketplace. We stand ready to work with the committee to advance a high quality, affordable, patient-centered health care system.

Mr. PITTS. Thank you. Dr. Harrington?

STATEMENT OF SCOTT E. HARRINGTON

Mr. HARRINGTON. Chairman Pitts, Ranking Member Pallone, Mr. Burgess, I am pleased to testify on rate review and minimum medical loss ratio regulation under PPACA.

These regulatory schemes entail costly, complex bureaucratic interference with insurers' legitimate business decisions and with State regulatory prerogatives. They are not going to increase competition or improve the availability and affordability of health insurance. The rate review scheme will not enhance consumer choice or significantly lower premiums. It will increase insurers' costs and risk, reducing their willingness to expand coverage or offer new products and ultimately undermine their financial soundness.

The minimum medical loss ratio scheme is going to distort insurers' legitimate operating decisions, including some actions that would help reduce costs. Without significant waivers, it will destabilize some States' markets. It represents a significant move toward government micromanagement of health insurers.

It is desirable to replace the rate review and medical loss ratio regulations with pro-competitive forms including State option of policies that promote thoroughly informed competition and consumer choice.

In my remaining few minutes, I want to focus on rate review. The Act does not authorize HHS to explicitly approve or deny proposed rate changes but it requires individual and small group health insurers to justify "unreasonable" rate increases, either to State regulators if the States pass muster with HHS for having reasonable effective review, or otherwise to HHS. The complex HHS regulations initially specify a 10 percent threshold for determining whether or not a rate increase is potentially unreasonable and requiring additional justification. State-specific thresholds will likely begin in 2012. Any insurer that goes ahead and tries to implement a rate increase that is held to be unreasonable will be publicized and most likely publically condemned. It also can be excluded from participation in the exchanges.

The law grants monies to States to enhance their rate review. It grants monies in the future to States that have prior approval rate regulation or adopts such regulation, further promoting direct price controls on health insurance.

These provisions reflect the views that competition and prior State regulation did not adequately discipline health insurers' expenses and profits, but health insurers' expenses and profits are not significant drivers of high and rapidly growing health insurance costs. According to the National Health Expenditure Data, for example, the estimated annual private heath insurance medical loss ratio, the ratio of medical cost to premiums, including self-funded plans, has averaged about 88 percent since 1965, ranging from 85 to 90 percent with little or no trend over time. Now, there is a lot of variation across companies. Health insurers' profit margins typically average 3 to 5 percent of revenues, lower for not-for-profit insurers. Administrative expenses average 11 to 12 percent of premiums.

Market concentration is often relatively high at State and metropolitan levels, but it varies widely across regions, and that does not imply adverse effects on consumers.

State oversight for individual and small group health insurance of rate changes is very diverse and in many respects similar to automobile and homeowners' insurance regulation. The Act's rate review provisions establish significant federal authority over rate increases, and those State review process, these provisions and their implementation will further publicize insurance pricing without enhancing consumer choice, increase in quality or lowering cost.

Research has not provided detailed evidence on health insurance rate regulation, but the adverse consequences of binding rate controls, politicization of insurance pricing, have been aptly documented for automobile insurance, workers' compensation insurance and more recently, homeowners' insurance in catastrophe prone regions. There is no reason to believe that requiring prior regulatory approval or tighter review of health insurance rates will be any different.

A large body of research indicates that rate regulation cannot and does not lower insurance rates without reducing coverage availability or causing exit by insurers. Analyses of automobile insurance, for example, found no consistent difference over time in premiums relative to loss costs in States with and without prior approval, but prior approval rate regulation has been associated with less coverage availability, short run rate suppression, increased market volatility and increased insurer exits.

In short, the rate review and MLR provisions are unnecessary and counterproductive. It would be better to repeal these provisions and replace them with pro-competitive regulation and disclosure at the State level.

Thank you.

[The prepared statement of Mr. Harrington follows:]

Statement of Scott E. Harrington
Alan B. Miller Professor
The Wharton School, University of Pennsylvania

On "PPACA's Effects on Maintaining Health Coverage and Jobs: A Review of the Health Care Law's Regulatory Burden"

Before the
Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives

June 2, 2011

Chairman Pitts, Ranking Member Pallone, and members of the Subcommittee:

I am pleased to have this opportunity to provide testimony on the health insurance rate review and minimum medical loss ratio (MLR) provisions of the Patient Protection and Affordable Care Act (PPACA). My main points are as follows: [1]

1. The PPACA's rate review and MLR provisions represent costly, bureaucratic interference with insurers' legitimate business decisions and state regulatory prerogatives that will do little to enhance competition in health insurance markets and the availability and affordability of health insurance.
2. The rate review provisions and their implementation will not enhance consumer choice or lower premiums, but instead will increase insurers' costs and risk, reduce their willingness to offer coverage, undermine their financial strength, and possibly increase pressure for even tighter regulation and/or enactment of a public option.
3. The MLR provisions will distort insurers' incentives for legitimate business decisions, destabilize some states' markets, and could reduce incentives for certain beneficial innovations in coverage and payment.
4. The PPACA's rate review and MLR regulations should be replaced with pro-competitive reforms that would encourage states to adopt policies that promote informed competition and consumer choice.

Introduction

Although the PPACA does not authorize the U.S. Department of Health and Human Services (HHS) to approve or deny proposed rate changes, it requires health insurers to justify "unreasonable" rate increases to state regulators in states with HHS approved rate review procedures, or to the HHS if a state's procedures are not approved. Insurers with "unreasonable" rate increases can be excluded from participation in the health insurance exchanges scheduled to commence operation in 2014. The law authorizes grants to states to "enhance" their rate review, and the HHS proposes supplemental financial awards to states that adopt prior approval regulatory of rate changes.

In addition to its rate review provisions, the PPACA requires that health insurers' spending on medical care and "activities that improve health care quality" must equal or exceed 85 percent of premiums (net of certain taxes and fees) for large group coverage and 80 percent of premiums for individual and small-group coverage. If necessary, insurers must rebate premiums to achieve these minimum "medical loss ratios" (MLRs).

Health Insurer Competition, Expenses, and Profits

The PPACA's rate review and MLR provisions reflect views that health insurance competition and previous state regulation did not adequately discipline insurers' expenses and profits and that federal regulation and oversight of health insurers is the preferred response. However, aggregate data do not support the notion that health insurers' expenses and profits are major drivers of high and rapidly growing health insurance premiums. According to National Health Expenditure (NHE) data, the projected "net cost" of private health insurance (premiums less benefits, including for self-funded plans) for 2010 was $96.4 billion, representing 11.6 percent of $829.3 billion in projected expenditures for private health insurance and 3.8 percent of $2,569.6 billion in projected total health care expenditures.[2] The estimated MLR for all private health insurance (ratio of medical benefits to total premiums, including premium equivalents for self-funded plans) has averaged 87.8 percent since 1965, with little or no trend (see figure 1).[3]

Health insurers' profit margins typically average about 3-5 percent of revenues (less for not-for-profit insurers). MLRs for insured plans average roughly 85 percent

(higher for not-for-profit than for-profit insurers); administrative expense ratios average about 11 to 12 percent.[4] Expense and profit data reported to state insurance regulators during 2006-2009 indicate that aggregate MLRs ranged from 85 to 88 percent for all insured coverage (including Medicare supplement and Medicare Advantage plans) and from 83 to 87 percent for comprehensive major medical coverage.[5]

While often high at the state and metropolitan levels, health insurance market concentration varies widely across regions, and high concentration does not necessarily imply adverse effects on consumers.[6] Market concentration is highly correlated with Blue Cross Blue Shield plan market shares. Many large Blues are not-for-profit and operate with high MLRs and very low profit ratios, making it difficult for other insurers to gain market share.

The extent and scope of economies of scale or other entry barriers in health insurance are uncertain. Consolidation in many health insurance markets has coincided with consolidation among hospitals and hospital-provider networks, in some cases increasing insurers' ability to negotiate favorable rates with providers, and in other cases the opposite, depending on relative bargaining leverage.[7] Third-party administrators and employer self-funding and administration in general represent significant sources of competition for insurance companies in the employer-sponsored market, except for small-group coverage.

The limited antitrust exemption for the "business of insurance" has little effect on health insurers; there is no evidence that it has raised prices, profits, or market concentration. Insurers' relationships with medical care providers, such as the inclusion of "most favored customer" clauses in contracts with hospitals, are not protected. In contrast to property/casualty insurance, health insurance has no history of joint ratemaking activity that is protected by the exemption. Health insurer mergers have been subject to federal antitrust jurisdiction since at least the early 1970s, and mergers and acquisitions of health insurers are subject to approval by state regulators.

Rate Review

State oversight of health insurance rate changes is highly diverse across and within states for individual and small-group coverage, and, in some states, health maintenance organizations. Similar to personal automobile and homeowners' insurance, in 2009 about half the states required prior regulatory approval of rate changes for individual health insurance.[8] Approximately twenty states required regulatory approval of rate changes for one or more types of group health insurance (for example, coverage for small groups). About a quarter of the states required individual market rates to be filed with regulators before use without a prior approval requirement, but often providing regulators with the ability to challenge filings or disapprove rates after they take effect. The remaining states generally required that rates be filed, at least for the individual market. Many states required actuarial certification that small-group rates comply with relevant law.

Section 2794 of the PPACA, "Ensuring that Consumers Get Value for Their Dollars," stipulates that the Secretary, in conjunction with the states, establish a process for annual review of "unreasonable" rate increases. Insurers must provide the Secretary and the relevant states with justification of unreasonable increases prior to implementation, and "prominently post such information on their Internet websites," with public disclosure otherwise ensured by the Secretary. As a condition for receiving federal grants for rate review and stimulating creation of research data, states must provide the Secretary with information about trends in premium increases and make recommendations "about whether particular insurers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases." Section 2794 does not require prior approval of rate changes by states or explicitly permit HHS to deny increases.[9]

The HHS rate review regulations for the individual and small group markets are scheduled to become effective for rates filed or effective on September 1, 2011 or later. The regulations specify a 10 percent annual increase for a given "product" in a state as the threshold for potentially unreasonable rates, with state-specific thresholds likely to begin in 2012. Insurers that propose greater increases must file a preliminary justification

with HHS and the state, to be published on the HHS website. If HHS deems a state as not having an effective rate review process, HHS will conduct the review. If a state's review process is deemed effective, it will determine whether the proposed increase is unreasonable, with the consequences governed by state law. If not, the HHS will evaluate whether the increase is unreasonable ("excessive," "not justified," or "unfairly discriminatory"). If the HHS deems an increase unreasonable and the insurer nonetheless implements the increase, the insurer must submit a final justification to HHS and post it on the insurer's website.

Even without formal prior approval regulation, federal requirements for justification of unreasonable rate increases – at the federal level if state regulation does not receive approval from HHS – and the threat of exclusion from the exchanges establishes significant federal authority over rate increases and state rate review processes. As I noted above, the rate review grants program will provide supplemental financial awards to states that have or adopt prior approval requirements.

The rate review provisions will further politicize health insurance pricing. They will not enhance consumer choice, increase quality, or lower costs. They will instead increase insurers' costs and risk, reduce choice and availability of coverage, undermine insurers' financial strength, and possibly increase pressure for even tighter regulation and/or enactment of a public option.

The adverse consequences of prior approval rate regulation and politicization of insurance ratemaking have been demonstrated by decades of experience with state rate regulation for automobile insurance, workers' compensation insurance, and, more recently, homeowners' insurance in catastrophe-prone regions. The evidence indicates that rate regulation cannot be used to lower average rates without reducing coverage availability and/or causing exit by insurers.[10] In the 1980s and early 1990s, for example, rate regulation led significant numbers of insurers to exit the automobile insurance market in Massachusetts, New Jersey, and South Carolina, and some workers' compensation insurers withdrew from states with unfavorable regulatory climates during the late 1980s and early 1990s.

Despite its self-defeating consequences, regulatory rate suppression in environments of rapid cost growth can be politically popular before its adverse effects become apparent. The direct costs of administering and complying with rate regulation or review are ultimately born by consumers. Prior approval rate regulation produces delays in adjusting rates to loss trends. It increases variation over time in insurers' profitability and willingness to offer coverage and expand to meet growing demand. It has sometimes caused slower expansion or exit of efficient firms.

The rate approval process in some states and periods has been costly, lengthy, and periodically biased toward unjustified rate suppression. Uncertainty about permissible rate levels increases insurers' risk and the capital and premiums needed to maintain solvency. At the same time, the threat of regulatory rate suppression reduces insurers' incentives to commit capital to enhance solvency and support the sale of coverage. The likely results include both higher prices (to the extent achievable) and increased insolvency risk.

While empirical research to date has not provided detailed evidence of the effects of state regulation of health insurance rate changes, many studies have compared loss ratios for other types of insurance, most often for automobile insurance, in states with and without prior approval rate regulation to examine whether regulation affects average rate levels in relation to claim costs.[11] The analyses indicate that short-run regulatory suppression of rates in some states and periods of rapid cost growth resulted in higher automobile insurance loss ratios in states with prior-approval rate regulation (for example, during the mid- to late-1970s and early-1980s).

On the other hand, and consistent with an inherent inability of regulation to lower rates persistently, studies have found no consistent difference over time between loss ratios in states with and without prior approval laws. In a 2002 study, for example, I analyzed automobile insurance loss ratios, coverage availability ("residual market" shares), and volatility in premium growth by type of rate regulation with state-level annual data during 1972–98.[12] The estimated average difference in loss ratios between states with and without prior-approval regulation was positive but negligible in magnitude, primarily attributable to the 1970s, and at most weakly significant in a

statistical sense (see figure 2 for mean loss ratios by type of regulation by year). Consistent with other studies, I found that prior approval regulation was persistently and reliably associated with less availability of coverage and greater volatility in loss ratios and premium growth. There is no reason to believe that requiring prior regulatory approval or tight review of health insurance rate changes would be any different.

The Minimum MLR Requirements

About half the states had pre-PPACA requirements that premium rates achieve a minimum MLR (ratio of medical expenses to premiums) standard for individual health insurance.[13] The minimums generally ranged from 60 to 75 percent. About twenty states had MLR requirements for the small-group or large-group markets, also generally ranging from sixty to seventy-five percent. Most states' minimum MLR rules were designed to deter aberrant players from selling coverage to unsophisticated buyers with a large proportion of premiums (30 to 40 percent) going towards administrative expenses and profits rather than medical expenses.

Section 2718 of the PCACA requires health insurers to pay premium rebates to the extent that the sum of reimbursements "for clinical services" and expenditures "for activities that improve health care quality" to the "total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees)" is less than 85 percent for the large group market or less than 80 percent in the individual or small group market. It permits the HHS Secretary to adjust the 80 percent standard if its application would destabilize the individual market. The PPACA's requirements differ from existing state MLR requirements given the inclusion of expenditures to improve quality in the numerator and exclusion of certain taxes in the denominator. The requirements are nonetheless materially higher than many states' minimums.

Section 2718 reflects the premise that a higher MLR (lower margin for non-medical expenses and profits) necessarily implies better value for consumers. While that might be true holding equal premiums, quality and access to care, claims and other service, and availability of coverage, those factors vary widely across insurers and plans.[14] A given consumer, for example, could prefer coverage with more cost sharing, tighter utilization review, and a lower expected MLR to more generous coverage with a

higher expected MLR and much higher premium, or to not being able to find any coverage. Moreover, minimum MLR requirements will inherently exert upward pressure on premiums of some insurers that expect to achieve the minimums. As long as there is some chance that an insurer will have to pay rebates as a result of unexpectedly low medical costs, its expected MLR net of rebates will be higher than its pre-regulation target MLR. It will need to charge somewhat higher premiums to expect to achieve that target.

HHS/NAIC Regulations. Section 2718 and the HHS MLR regulations, which largely adopted proposed regulations developed by the National Association of Insurance Commissioners (NAIC),[15] are remarkable for their emphasis on allowing expenses that increase health care costs and premiums to be included in the MLR calculation, while largely excluding expenses that help reduce health care costs and premiums. As recommended by the NAIC and adopted by HHS, expenses that improve healthcare quality encompass those:

> . . . for all plan activities that are designed to improve health care quality . . . in ways that are capable of being objectively measured and of producing verifiable results and achievements. . . . They should not be designed primarily to control or contain cost, although they may have cost reducing or cost neutral benefits as long as the primary focus is to improve quality.

Eligible quality improvement activities are defined further as those primarily designed to improve outcomes and reduce disparities; prevent hospital readmissions; improve safety, reduce errors, and lower infection and mortality rates; increase wellness and promote health activities; and enhance the use of data to improve quality, transparency, and outcomes. Specific exclusions include expenses for retrospective and concurrent utilization review; fraud prevention, with the exception of "detection/recovery expense up to the amount recovered that reduces incurred claims"; developing and administering provider contracts, networks, and credentialing; marketing; accrediting providers; and calculating and administering individual enrollee or employee incentives.

MLRs and rebates must be calculated at the licensed entity and state level, without aggregation across affiliates, increasing the likelihood and amount of rebates compared with allowing aggregation, and providing incentives for firms to consolidate

affiliates. The regulations specify "credibility adjustments" that decrease the MLR minimums for smaller plans for which average medical costs are subject to greater statistical variation. But the regulations do not consider that plans with higher average deductibles and other forms of cost-sharing tend to have lower MLRs because non-medical expenses grow at a slower rate than expected medical reimbursement. Some entities that specialize in high-deductible or other high-cost-sharing plans could find it difficult or impossible to meet the minimums.

Expenses on quality-improving activities notwithstanding, variation in insurers' MLRs arises from numerous sources that need bear no relationship to market power or efficiency.[16] In addition to statistical variation and the effects of differential cost sharing, differences in the mix of fixed and variable administrative costs will cause MLRs to vary in relation to differences in the average number of enrollees in an insured's group plans and differences in average medical-care costs across regions or customer groups within a region. Other factors causing variation in MLRs include differences among insurers in expenditures on fraud detection/prevention and utilization review and management; the use of managed care and provider contracting; marketing costs, including agent compensation; customer turnover and duration; possible cyclical variation over time in average premium rates; and the extent to which health plans with different expense structures and expected MLRs are offered by separate corporate subsidiaries rather than a single entity.

Market Destabilization and Waivers. Section 2718's implementation could destabilize markets in numerous states, especially for individual coverage. The NAIC leadership expressed concern to Secretary Sebelius of possible destabilization, including potential effects on premiums, insurer solvency, the number of insurers marketing products, consumers' ability to find coverage should their carrier leave the state, benefits and cost sharing of existing products, and consumers' access to agents and brokers. It urged the Secretary to consider a transition period for implementation and for deference to waiver requests.[17] HHS has thus far granted waivers to three states.

Incentives and Innovation. Potentially binding minimum MLRs will produce some distortions in insurers' legitimate business decisions. A minimum MLR requirement caps the percentage of premiums available for nonmedical expenses and

profits: the lower the cap, the lower the potential for profit, and the less incentive for innovation. By reducing potential returns from investment, the minimum MLR rules will likely deter some innovation to develop new coverage arrangements, more cost-efficient provider networks, and information to guide consumer choice, including evidence on medically and cost-effective care.

As noted, the MLR requirements will also likely discourage some coverage designs that could lower premiums but involve relatively high nonmedical costs in relation to insured benefits, such as certain high-deductible plans. They could discourage potential innovations in coverage design and managed care that might require a lower MLR in conjunction with lower premiums and better value for buyers. They could cause some plans to contract with narrower provider networks and/or enter into arrangements shifting more administration to providers.

Mandatory Public Reporting. Section 2718 requires regulators to develop systems for publicly reporting insurers' MLRs, ostensibly to assist consumers in identifying high-value coverage. Given the complexities described above, providing reliable and meaningful information on insurers' MLRs is problematic.

Public provision of information should focus on key attributes that affect consumer value, including covered benefits, premiums, cost sharing, access to providers, quality of claims administration, and insurer financial strength. Given information on those attributes, an insurer's MLR for individual, small group, or large group coverage in a state will not provide reliable information to enhance decision-making, including consumer evaluation of tradeoffs between attributes (for example, higher premiums and lower cost sharing versus lower premiums and higher cost sharing). Promulgating MLR metrics will instead provide consumers with noisy, confusing, and potentially misleading information.

Pro-Competitive Reform

The PPACA's rate review and minimum MLR provisions are unnecessary and counterproductive. Appropriate policy would instead promote informed competition and consumer choice with pro-competitive regulation and disclosure at the state level (and thus without a significant federal bureaucracy) through targeted minimum standards for

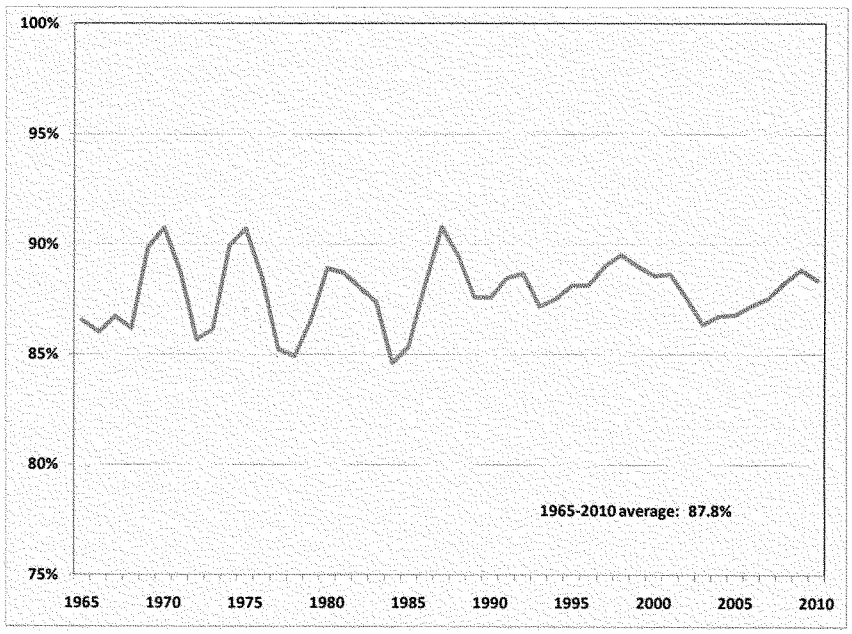
state regulation, providing the states with flexibility to meet regulatory objectives given differences in consumer needs, preferences, and economic conditions, and given that local regulators can better respond to such differences. Relying primarily on state-level action would also help identify approaches that are most effective, promote regulatory competition, and localize regulatory mistakes.

To stimulate further competition, the Congress could authorize a health insurer that is licensed in any state to be automatically licensed to write coverage in additional states by appropriate notification of the states' regulators. A minimum level for such licensing would require an insurer to comply with all state regulation in each state where it writes business, including rate regulation and benefit mandates. A broader approach would allow consumers in a state to choose from a different mix of regulations that lowers their premiums by permitting an insurer to designate a home state for regulation of rates and coverage but requiring it to comply with solvency and market-conduct regulation in each state where it writes business.

Enacting such an agenda would promote consumer choice and informed competition to make coverage more affordable and available. Compared with the PPACA's regulatory scheme, there would be much less interference in insurers' legitimate business decisions and practices, far less bureaucracy, lower administrative and compliance costs, and more available and affordable coverage.

Figure 1

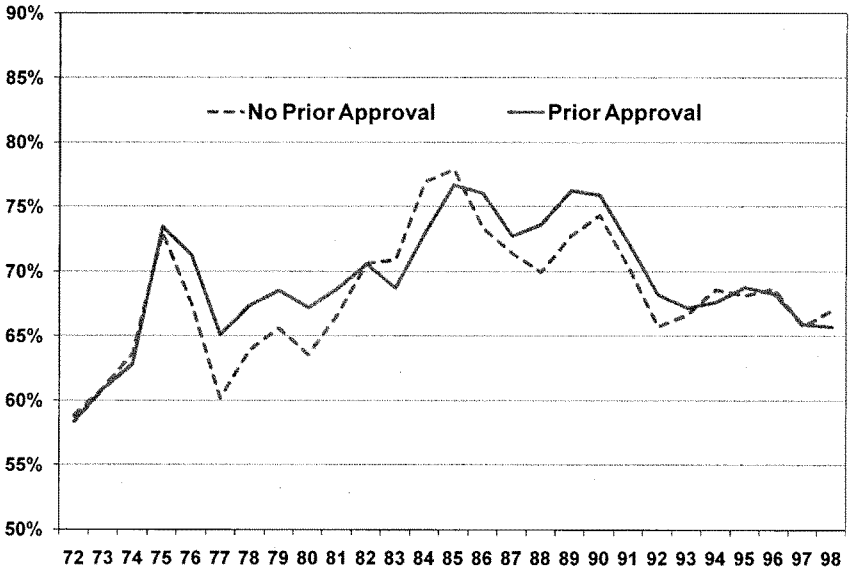
Estimated Private Health Plan Benefits as Percent of Premiums: 1965–2010
(includes self-funded plan premium equivalents)



Note: Author's calculations with national health expenditure data. Projections for 2009-2010.

Figure 2

Mean Automobile Insurance Loss Ratios by Type of State Regulation: 1972-1998



Source: Harrington (2002).

Notes

[1] My study, *Regime Change for Health Insurance Regulation: Rethinking Rate Review, Medical Loss Ratios, and Informed Competition*, American Enterprise Institute, December 2010 (available at www.aei.org/docLib/Regime-Change-for-Health-Insurance-Regulation.pdf) provides additional detail and also considers the PPACA's provisions dealing with health insurance policy rescissions and claims practices.

[2] The data (http://www.cms.gov/) are from NHE tabulations by type of expenditure and source of funds, calendar years 1965-2019, with projections for 2009-2019. The projections are based on the 2008 version of the national health expenditure accounts released in January 2010.

[3] The NHE data report estimated premium expenditures and the estimated difference between premiums and benefits (denoted the "net cost" of private health insurance in the expenditure accounts). The ratios in Figure 1 equal one minus the ratio of net cost to premiums.

[4] My article, "The Health Insurance Reform Debate," *Journal of Risk and Insurance* 77, no. 1 (2010): 5-38 summarizes other evidence from a variety of sources.

[5] Debra A. Donahue, "Health Plans See Revenue Shift Away from Commercial," *Healthcare Business Strategy*, Mark Farrah Associates, May 10, 2010, available at http://www.markfarrah.com/healthcarebs.asp?article=80 (accessed November 9, 2010).

[6]Christopher Conover and Thomas Miller, "Why a Public Plan is Unnecessary to Stimulate Competition," (AEI Working Paper No. 162, Washington, DC, January 2010), available at http://www.aei.org/docLib/MillerConoverworkingpaper.pdf (accessed November 9, 2010), provides a detailed review of health insurance market concentration and its implications for competition.

[7] Research has provided mixed evidence of the effects of increased concentration on healthcare markets (see Christopher J. Conover and Thomas P. Miller, "Why a Public Plan is Unnecessary to Stimulate Competition"). Asako S. Moriya, William B. Vogt, and Martin S. Gaynor, "Hospital Prices and Market Structure in the Hospital and Insurance Industries," *Health Economics, Policy, and Law* 5, no. 4 (2010): 459-479, for example, present evidence that increased concentration in health insurance reduces hospital prices. Using a proprietary panel dataset of health plans offered by a large sample of U.S. firms, Leemore Dafny, "Are Health Insurance Markets Competitive?" (NBER Working Paper w14572, National Bureau of Economic Research, Washington, DC, December 2008), available at http://www.nber.org/papers/w14572.pdf (accessed November 9, 2010), provides evidence that health insurers on average charged higher premiums to employers with relatively high profitability in more highly concentrated markets than in less concentrated markets. The implication that higher concentration raises premiums is thus based on the interaction between concentration and employers' profitability. Using the same dataset, Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, "Paying a Premium on Your Premium: Consolidation in the U.S. Health Insurance Industry," (NBER Working Paper w15434, National Bureau of Economic Research, Washington, DC, October 2009), available at http://www.nber.org/papers/w15434 (accessed November 9, 2010) provide evidence that health insurance rates increased with increases in market concentration associated with the merger of health insurers Aetna and Prudential. The possible implications of the relatively poor profitability of Prudential's health insurance business prior to the merger are not addressed.

[8] National Association of Insurance Commissioners (NAIC), "Filing Requirements Health Insurance Forms and Rates," in *NAIC's Compendium of State Laws on Insurance Topics* (Washington, DC: NAIC, February 2009), II-HA-10; *Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable*, Kaiser Family Foundation, December 2010 (available at http://www.kff.org/healthreform/upload/8122.pdf).

[9] A variety of consumer groups and advocates recommended that the PPACA's rate review provisions be implemented with elaborate, public-utility-style regulation with regulatory authority to approve rates. See Elizabeth Abbott, Amy Bach, and Deeia Beck et. al., *PPACA Implementation: Consumer Recommendations for Regulators and Lawmakers*.

[10] See, for example, J. David Cummins, ed., *Deregulating Property-Liability Insurance* (Washington, D.C.: AEI-Brookings Joint Center for Regulatory Studies, 2002), Patricia Danzon and Scott E. Harrington, *Rate Regulation of Workers' Compensation Insurance: How Price Controls Increase Costs* (Washington, D.C.:

American Enterprise Institute, 1998), and Scott E. Harrington, *Insurance Deregulation and the Public Interest* (Washington, DC: AEI-Brookings Joint Center for Regulatory Studies, 2000).

[11] See my study, "Effects of Prior Approval Regulation in Automobile Insurance," in J. David Cummins, ed., *Deregulating Property-Liability Insurance* (Washington, DC: AEI-Brookings Joint Center for Regulatory Studies, 2002) for detailed discussion and references. Also see Cummins (J. David Cummins, "Property-Liability Insurance Price Deregulation: The Last Bastion," in J. David Cummins, ed., *Deregulating Property-Liability Insurance* (Washington, D.C.: AEI-Brookings Joint Center for Regulatory Studies, 2002)).

[12] Scott Harrington, "Effects of Prior Approval Regulation in Automobile Insurance."

[13] National Association of Insurance Commissioners (NAIC), *NAIC Response to Request for Information Regarding Section 2718 of the Public Health Service Act* (Washington, DC, May 12, 2010), available at www.naic.org/documents/committees_e_hrsi_hhs_response_rr_adopted.pdf (accessed November 9, 2010); America's Health Insurance Plans (AHIP), *Individual Health Insurance 2009 – A Comprehensive Survey of Premiums, Availability, and Benefits* (Washington, DC: AHIP Center for Policy Research, October 2009), available at http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf (accessed November 9, 2010).

[14] James C. Robinson, "Use and abuse of the medical loss ratio to track health plan performance," *Health Affairs* 16 (1997): 176-187 provides detailed discussion of many of these factors.

[15] In order to prevent disruptions in the market for plans with annual limits of $250,000 or less and for specialized plans covering U.S. citizens residing abroad, HHS modified the NAIC recommendation to permit multiplying those plans' loss ratios by two in determining whether they meet the minimums.

[16] James C. Robinson, "Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance."

[17] National Association of Insurance Commissioners, letter to HHS Secretary Kathleen Sebelius, October 13, 2010, available at http://www.naic.org/documents/committees_ex_grlc_mlr_sebelius_letter_101013.pdf (accessed November 10, 2010); National Association of Insurance Commissioners, letter to HHS Secretary Kathleen Sebelius, October 27, 2010, available at http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf.

Mr. PITTS. The Chair thanks the gentleman and recognizes Ms. Trautwein for 5 minutes for her opening statement.

STATEMENT OF JANET TRAUTWEIN

Ms. TRAUTWEIN. Thank you. My name is Janet Trautwein, and I am the CEO of the National Association of Health Underwriters. NAHU is the leading professional trade association for health insurance agents, brokers, and consultants representing more than 100,000 benefit specialists nationally.

I am here today to tell you about a desperate economic situation that has developed over the past 18 months. It has caused real people to suffer real harm. This dire situation was triggered by the issuance of the Interim Final Rule on Medical Loss Ratios. Since the rule was issued by the Department of Health and Human Services on December 1, 2010, health insurance carriers across the country have been forced to cut administrative costs to comply.

One of the first places that was hit was agent commissions. Now, in reality, agent commissions being considered an insurer expense is really not even accurate. The consumers who purchase health insurance coverage are the ones who hire and can fire their brokers, not insurers. Independent agents pay 100 percent of their own business expenses. Whether accurate or not, the Interim Rule categorizes commissions as an insurance expense largely because these commissions were not specifically listed as an item that could be carved out of the MLR calculation as were taxes, and as a result, our members report that most health insurance carriers changed commission rates as of January 1, 2011, the date the MLR rule became effective.

These commission changes have already decreased many of our members' incomes by 20 to 50 percent. About 3/4 of the members of my associations are principals of their own small businesses and employ multiple individuals from their communities, operate in every State and in every community, large and small. As a direct result of the new law provisions, these individuals are reporting that they are being forced to reduce services to their clients, to cut benefits to their employees and eliminate jobs just to stay in business. In some instances they are reporting they are just closing their doors. This means that in the future, unless something is done, there will be far fewer health insurance agents to provide for consumers' needs.

Now, some of you have probably have never had the good fortune to work with a broker, and you may not understand what this really means or consumers. So I would like to tell you a story that illustrates what I am talking about. This is a story that I know well, and I know it because I personally experienced it. I am here today not just as the head of an association but as someone who knows the people who have been affected. And before I came to NAHU, I was an insurance broker myself for almost 20 years in Texas. And I had a large number of clients that I built up over many years, and I did that by providing them great service and benefits at the lowest possible cost. I promised them that I would help them with any issue that came up relative to their plan, and I am proud to say that during the 20 years that I was in business, not a single one of my clients or a single one of their employees or dependents

ever had to go to appeal on a claim and that is because we took care of issues before it required that type of action.

And I want to tell you quickly about one situation that I remember in particular, and it is hard to forget a situation like this. This particular employee had AIDS, and his health plan had already paid out hundreds of thousands of dollars for traditional types of treatments, and none of these had really been effective in preventing the progression of his disease.

He came to me in desperation because his doctors had given him 6 months to live, and he said, look, I have done some research, and I found this one treatment that I really want to try, but he wasn't able to go through with the treatment because it was considered experimental by his plan.

After a lot of work negotiating with his health plan as well as the providers for his treatment, we got that treatment covered because we knew how to do it, and he never would have been able to do that on his own. It was difficult to do, but we managed to make it work.

You might think that this kind of service would be very expensive. The fact is that most agents and brokers just really don't make a lot of money. The Bureau of Labor Statistics says that the average for agents and brokers is $45,000 to $62,000 a year. Entry-level agents only make about $25,000 a year, and this is before the cuts that occurred on January 1.

So you can understand the desperation of the situation that we are in, and none of us would find it very easy to take those types of cuts.

There is a simple solution. As many of you are aware, Representatives Mike Rogers of Michigan and John Barrow of Georgia, both of whom serve on this committee, have introduced H.R. 1206, the Access to Professional Health Insurance Advisors of 2011. Currently it has 85 bipartisan co-sponsors, 21 on this committee.

And I realize that I am out of time, but I would like to ask for your immediate consideration of this legislation. It is a reporting change, but it something that would provide immediate relief to many, many people across this country.

Thank you very much.

[The prepared statement of Ms. Trautwein follows:]

United States House of Representatives

Committee on Energy and Commerce

Subcommittee on Health

June 2, 2011

"PPACA's Effects on Maintaining Health Coverage and Jobs: A Review of the Health Care Law's Regulatory Burden"

Testimony Submitted by

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June 2, 2011

Good afternoon. My name is Janet Trautwein, and I am the CEO of the National Association of Health Underwriters (NAHU). NAHU is the leading professional trade association for health insurance agents, brokers and consultants, representing more than 100,000 benefit specialists nationally. Thank you for inviting me here today to talk about the regulatory impact that the Patient Protection and Affordable Care Act (PPACA) has had on my members directly, as well as on their clients.

NAHU members 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 the members of my association are principals in their own small businesses and employ multiple individuals from their communities.

Since the passage of PPACA last year, our members are spending significant amounts of time both educating their clients about the new law's provisions and helping them comply with its resulting regulations. They are working to provide options to millions of employers struggling with grandfathered plan concerns. They are searching for coverage for families who cannot find child-only individual health plans in certain states any longer, and they are helping older children with working parents get back on their parents' health policies. They are trying to find small employers who qualify for the new small business tax credit and place uninsured and uninsurable clients in the new preexisting condition insurance programs. Most of all, they are answering many client questions about the pending employer responsibility requirements, the individual mandate, premium tax credits, essential benefits, actuarial equivalence, how exchanges may work and other changes that will occur both now, during this transition period, and in 2014. In short, they are busier than ever.

Unfortunately, the financial livelihood of independent health insurance agents and brokers nationwide is directly threatened by PPACA's medical loss ratio (MLR) requirement, which mandates 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 rule crafting by the Department of Health and Human Services (HHS) requires health plans to treat agent and broker commissions as part of their administrative costs. While carriers collect these fees, they don't count one nickel of them as part of their revenue stream, but instead pass along 100 percent of broker compensation. As a result brokers servicing the individual and small business markets – where their services are most needed by consumers and entrepreneurs – are seeing their compensation slashed by 20-to-50 percent. This means fewer agents and brokers will be able to afford to stay in business and will no longer be able to provide the counseling and advocacy services to their clients as they have in the past.

NAHU is seeking all possible solutions – be they regulatory or legislative -- to this critical problem, and to avoid any unintended job losses as a result of the MLR regulation.

I am here today to tell you about a desperate economic situation. I am not here to score political points. Before coming to NAHU, I was an insurance agent for 20 years, so I can speak about what brokers do from personal experience. Since the MLR requirements in PPACA became effective on January 1, 2011, they have had a devastating financial impact on my association members, their employees, and their millions of employer and individual clients. 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.

A survey of NAHU members done in February shows that as a result of the new MLR requirements and the resulting commission reductions, 21 percent of agents have been forced to downsize their businesses, including laying off employees, and 26 percent have also had to reduce the services they provide to their clients. Many agents are no longer able to travel to clients' homes and offices to walk them through the application process, and employee-hours spent resolving billing and claims issues have also been drastically cut. Five percent of respondents who were not principals in their agencies have lost their jobs due to producer revenue reductions caused by the MLR regulation as it currently exists.

Role of the Insurance Agent/Broker

To clearly explain why the PPACA MLR regulation is having such a serious financial impact on this country's approximately 500,000 health insurance agents and brokers, I would now like to take the opportunity to briefly explain what exactly NAHU members do every day, who they work for, and what limitations existing state laws place on how they are paid.

Independent health insurance agents and brokers do not work for health insurance companies. They run their own businesses, hire their own employees and pay all of their own office expenses, such as professional liability insurance. To be in business, each state requires agents and brokers to take an examination, maintain a license and complete continuing education requirements. Agents and brokers are highly regulated by their state insurance departments, and they also have a legal responsibility for the performance of products they sell and the advice and assistance they provide to their clients.

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. Only the individual consumer or employer can decide whether to keep their agent. The agent's customer base (their book of business) has value, so it is in the agent's best interest to maintain client satisfaction not just at the point of sale, but throughout the life of each insurance policy. Major health insurance carriers report that policies originated by independent agents have better client retention rates.

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. They are responsible for solving all the problems that consumers may have once coverage is in place. An agent from Arizona recently wrote to NAHU describing the service calls she handled in one typical day. It is a fairly representative account, so I will share it with you.

> *"A recent call I had was from a client who found himself in the hospital from an unexpected accident, needing insurance information that he was not in any position to deal with at the time. The call before that was from a client whose son needed assistance in upgrading his insurance plan. Another call was from an older client who was very insecure in purchasing insurance and had a question about her recent bill. Another call was from a frantic young woman wanting to know what to do because she had not paid her premium and her policy was cancelled—I was able to get it reinstated."*[1]

Brokers also help their clients save significant sums on their health insurance premiums as this story from another NAHU member shows.

> *"The second case I ever wrote was for a lumber company down in southern Mississippi. I met with the owner and showed him a plan with a new carrier that would save him $40,000 a year...On seeing this new plan and the savings generated, he commented, 'Do you know how much work we have to put in to make that kind of money?' After two years of having that case, I've kept them under their costs when I took over the case—even with them incurring $40,000 more in claims than they paid in premium the first year. I had to use every tool in my toolbox for that one. But that's also why we spend 20-30 hours per year in Continuing Education and another 40-80 hours per year studying new plan designs and new regulations during long seminars at various hotels and such—to be able to provide the kind of expertise that I was able to with my lumber company."*[2]

Many times the role of the agent is invisible, particularly to the employees of a company. Typically when a worker has an issue 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 contact the health insurance agent. Most smaller companies do not even have an HR department for

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[1] *Brokers Making A Difference: Real Life Testimonials.* National Association of Health Underwriters, 2009-2011. http://www.brokersmakingadifference.com/forms/BMDBooklet.pdf
[2] Ibid.

employees to contact, and so, as the Congressional Budget Office (CBO) 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."[3]

Impact of the MLR on Broker Compensation:

Instead of agents billing their clients directly for their services, health insurance carriers have been including agent and broker commissions as a small percentage of the cost of each and every insurance policy for almost 100 years. This payment structure is a consumer convenience, but it is also deeply embedded in state-level licensing, consumer protection and tax laws.

Not one penny of agent/broker commission ever goes to a health insurer's bottom line. Instead it is a pass-through fee that goes directly from the consumer to their health insurance agent. Unfortunately, the PPACA MLR regulation not only includes independent agent and broker compensation in an insurer's MLR calculation, but also classifies it as an insurer-borne administrative expense.

Since the interim final rule on MLR was issued by the Department of Health and Human Services (HHS) on December 1, 2010, health insurance carriers across the country have had to reduce the amount of commissions they embed in health insurance premiums. Our members report that most health insurance carriers changed commission rates as of January 1, 2011, the date the MLR rule became effective. These commission changes have already decreased the majority of our members' incomes by 20 percent to 50 percent.[4]

Some health insurance carriers have held off on making commission payment changes this year, in 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 this year, they will be forced to reduce the amount of producer commissions for 2012 and beyond. Because many insurance carriers renew and adjust their commission rates on July 1 of each year, further cuts could be on the horizon in the near-term.

Most health insurance agents and brokers do not have high incomes. 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.[5] 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

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[3] Congressional Budget Office, *Key Issues in Analyzing Health Insurance Proposals*. Pub. No. 3102, December, 2008, p. 70.

[4] *Economic Impact of Health Reform*. Survey conducted by the National Association of Health Underwriters. February 2011.

[5] *Occupational Outlook Handbook, 2010-11 Edition*. Bureau of Labor Statistics, US Department of Labor. December 17, 2009. Accessed at: http://www.bls.gov/oco/ocos118.htm.

scarce, the MLR as currently structured is causing irrevocable harm to tens of thousands of small businesses and jeopardizing desperately needed American jobs.

Some may wonder why insurance agents and brokers do not just change their business models and charge a fee for their services instead. Unfortunately, it is not that simple. The reasons why agents are compensated this way, and cannot easily charge a separate fee for services, are a myriad of state-level licensing, consumer protection, anti-rebating and premium tax laws. These laws exist in each and every state, and PPACA did not include provisions that would pre-empt these laws.

The most obvious changes to agent compensation caused by the MLR rule are direct reductions in commission percentage rates. These cuts are widespread, and have most significantly occurred in the individual and small group health insurance markets. Beyond specific percentage commission reductions, though, the MLR has affected agent and broker compensation dramatically in other ways.

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 hurt 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.

Other Trends Affecting Broker Compensation

Particularly in the small and mid-size employer group markets, our members report that carriers are shifting from paying commissions on a percentage of premium basis to a per-member or per-employee per month (PEPM) basis. However, the new flat PEPM fees being introduced in many cases are not comparable to the old percentage rates, resulting in a huge reduction of commissions for certain market segments. For example, agents report that one large state carrier's shift to PEPM payments has reduced their income in certain parts of the small group market by 75 percent.

Some carriers are changing what premium is used as the basis for commission payment. Instead of paying commissions based on the actual premium charged, the carrier is using commission-eligible premium formulas. These formulas are based on the preferred rate at the time of a consumer's initial enrollment. As a result, the commission payment does not include any premium increases that an individual pays for things such as a tobacco use surcharge and would not include premium rate increases in the future. This decreases the amount of the overall commission both initially and over time and also could impact enrollment targets, since the agent's commission remains the same regardless of the individual's health and resulting claims needs.

Another trend that has both the potential to not only dramatically effect agent/broker compensation, but also consumer plan choices, is to vary commission levels by the

volume of business an agent places with the health insurance issuer. For example, one major carrier has specified that if any producer fails to meet new minimum production requirements, then they will be ineligible to sell individual and group product lines for that carrier for a minimum of two years. This practice may help the companies save on administrative costs by reducing the number of producers they do business with, but it also means that agents will be able to offer their customers fewer product options, which will have a negative impact on both consumer choice and market competition.

Another MLR-driven trend hurting both choice and competition is that some health insurers have left specific health insurance market segments in certain states and that carriers nationwide are refining their business models to focus on market segments less affected by the MLR rules. Many smaller health insurance companies and regional carriers have reported to our members that unless MLR relief comes soon, their very ability to survive is threatened.

The small businesses our members own, and the individual and employer health insurance consumer clients they serve, are being seriously harmed by these sudden compensation changes, all of which have occurred since the MLR regulation was released.

Removing Commissions from the MLR Calculation:

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 80 bipartisan cosponsors, including 22 members of this committee. NAHU fully endorses this legislation.

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.

Besides stabilizing revenue for licensed producers and their employees, removing agent and broker pass-through commissions from the MLR calculation would also 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.

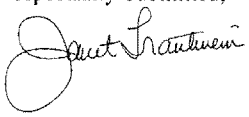
An optimal and expedited solution to the MLR calculation problem for health insurance agents and brokers and their clients is imperative. As we have documented, the need for health insurance agents and brokers is greater now, after the passage of PPACA, than ever before. Regardless of what the final 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.

Conclusion

Without immediate relief, the financial impact on our members, their employees and their clients has already been significant and will only 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 now and in the years to come -- a change to the MLR calculation is urgently needed. 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.

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. Thank you again for this opportunity to testify, and I would be glad to answer any questions you may have.

Respectfully Submitted,



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

Mr. PITTS. The Chair thanks the gentlelady and recognizes Ms. Hayes for 5 minutes.

STATEMENT OF KATHERINE HAYES

Ms. HAYES. Thank you, Mr. Chairman, for giving me the opportunity to be here today and also members of the subcommittee.

The last time I was in this room was 20 years ago as a 20-something health staffer for a member of the Health Subcommittee, Mickey Leland, from Texas. And knowing that Mickey was first a Texan and second, a Democrat, it is nice to see that Texas is still well-represented on the subcommittee.

Today I am here to talk to you about insurance market reforms, generally the impact on individuals and small businesses. I am a Professor at George Washington University, and my research focuses on implementation of the health reform bill.

This committee and subcommittee has a really long history of working to protect not only low-income individuals but individuals in the small group and individual non-group health insurance market. Chairman Bilirakis, former subcommittee chairman, and Chairman Tom Bliley put together the Health Insurance Portability and Accountability Act which laid the foundation for the Accountable Care Act. What it did was preserve McCarran-Ferguson and allowed health insurers or allowed States to regulate health insurance with certain minimum standards. And the reason Congress stepped in and did that, it was after health reform failed back in 1993 and 1994, was they saw the burden and the dysfunctional markets in the non-group or individual and small group health insurance markets and wanted to step in to do something. And the Affordable Care Act insurance markets reforms really build on that.

And it is important to recognize, too, that both parties, when the debate began in health care reform, were supportive of these insurance market reforms, although their views of it were different. Both were very concerned about individuals and small groups.

The problems in the small group market are well-documented. Although health insurance plans are prohibited from denying coverage for small groups, for small businesses, they can charge whatever they want; and quite frankly, although some States have implemented rate bans to limit that, generally, in some States small businesses can pay a 100 percent surcharge because of the risk, the high-risk individuals that they employ.

The Affordable Care Act was really laid out in two phases if you look at the statute itself. One, there was envisioned a transition period that began with date of enactment, ending in 2014 when most of the insurance market reforms went into place. There were a number of experts, insurance experts and regulations, came before Congress and told Members of Congress that yes, it is very important to reform these markets, but you need to be careful. You need to phase in things slowly. You need to build in protections, and the Affordable Care Act does include that. Some examples of the protections and the transition rules that were put in to the Affordable Care Act include grandfathering of health insurance plans. They include high-risk pools, small business tax credits and the insurance market reforms which include the immediate reforms, annual

limits on coverage and coverage of dependent children, as well as medical loss ratios.

In a review of the—it is easy to see the administration is following the pattern that was set out in the Affordable Care Act, which is namely to get through the transition period to full implementation in 2014.

Ultimately, small businesses have quite a lot to gain under the Affordable Care Act. They will be able to purchase health insurance coverage through exchanges. They will have options. And they will be able to pool both risk and some of their administrative costs. And finally, even though small businesses that choose not to provide health insurance coverage for their employees, because for the smallest businesses, it isn't a requirement to provide coverage at all, their employees will benefit from the tax credits and in the Affordable Care Act and can purchase through the exchanges. At the end of the day, this will benefit small businesses because their employees will be ensured, they will have less absenteeism, and ultimately, those with health insurance coverage have better health outcomes and better health status.

In conclusion, Mr. Chairman, and members of the subcommittee, the Affordable Care Act has tremendous potential to lower costs for small business and to make their health benefits competitive with large businesses, an important factor in recruiting and retaining a workforce.

Thank you very much.

[The prepared statement of Ms. Hayes follows:]

Statement of
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The George Washington University
School of Public Health and Health Services,
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On

The Affordable Care Act's Effects on Health Coverage and Jobs

Before the

U.S. House Committee on Energy and Commerce, Subcommittee on Health

June 2, 2011

Thank you Mr. Chairman and Members of the Subcommittee for the opportunity to be with you today. I am an Associate Professor of health policy at the George Washington University, School of Public Health and Health Services, where I teach federal policymaking and advocacy. I am also co-principal investigator of Health Reform GPS: Navigating Health Reform, a website devoted to tracking and analyzing implementation of the Patient Protection and Affordable Care Act ("Affordable Care Act"), a project supported by GW's Hirsh Health Law and Policy Program and the Robert Wood Johnson Foundation.

Background

The Energy and Commerce Health Subcommittee has a long history of leadership in assuring the availability of private health insurance to individuals and small businesses. In 1996, former Health Subcommittee Chairman Mike Bilirakis (R-FL) and former full Committee Chairman Tomas Bliley (R-VA) sponsored legislation to assure portability in the small group and individual (non-group) insurance markets, establishing the portability provisions of the Health Insurance Portability and Accountability Act (HIPAA). Under that law, Congress established a federal floor for insurance regulation to assure that certain individuals with prior coverage and small businesses could not be denied health insurance coverage. HIPAA's structure leaves untouched states' authority over the regulation of health insurance under the McCarran Ferguson Act, including the power to adopt more stringent standards, if they so choose.

The Affordable Care Act builds on the structure established under Title I of HIPAA to strengthen insurance market reforms. These reforms are most notable in the small group and individual markets. Similar to the structure established under HIPAA, states may continue to regulate insurance subject to federal standards, and may choose to establish

more stringent standards. Should states choose not to adopt those standards, the Secretary of the Department of Health and Human Services (HHS) has the authority to enforce them.

During Congressional consideration of the Affordable Care Act both political parties expressed concerns about the cost and availability of health insurance for individuals and small businesses. While recommending changes in federal law to stabilize these markets to make coverage more available and affordable, insurance plans, regulators and expert analysts advised Members of Congress that in the absence of the availability of Exchanges to provide private plan options, an individual requirement to purchase health insurance, and tax credits and other financial assistance to purchase the health insurance, special transition policies would be needed. In their absence, past unsustainable and unacceptable premium and underwriting practices would continue and could be made worse.

The Affordable Care Act contains a series of provisions designed to address these concerns including provisions, that among others, 1) grant "grandfather" status to health plans in existence prior to date of enactment, providing an exemption from certain insurance market reforms, 2) provide tax credits to certain low-wage small businesses that provide health insurance coverage to their employees, and 3) provide a series of insurance market reforms to make health insurance more accessible.

Agency Implementation

Since the ACA's enactment, the Administration has issued six major regulations directly affecting to insurance markets. These regulations, implementing provisions included in the ACA, include standards applying to: 1) "grandfathered" health plans;[1] 2) pre-existing conditions, lifetime and annual limits, rescissions and other patient

[1] 75 FR 34537. (June 17, 2010); amendment 75 FR 70114. (November 17, 2010).

protections;[2] 3) coverage of preventive services;[3] 4) internal claims and appeals and external review;[4] 5) medical loss ratios;[5] and 6) rate increase disclosure and review.[6] Collectively, these rules form the basis for regulation of health insurance during the transition period from enactment until full implementation of the law in 2014.

In implementing health insurance market reforms, the administration has clearly attempted to strike a balance between improving the availability of meaningful health insurance coverage and preventing disruptions in coverage for those who have coverage today. In attempting to strike this balance, they have received criticism from patient advocates who want them to be more aggressive and criticism from opponents of the law who charge the use of the transition policies is validation of the weakness of the law.

Effect of Health Reform on Jobs and Small Businesses

I have reviewed reports from the National Federation of Independent Businesses (NFIB) Research Foundation[7] estimating job losses of 1.6 million over the first 5 years of implementation. This estimate prepared prior to passage of the Affordable Care Act, assumed that the law would require all employers to offer coverage. In contrast, the legislation exempts the vast majority of these employers who have less than 50 employees. Indeed, Harvard economist David Cutler and USC professor Neraj Sood project that the law will create 4 million new jobs over the next decade – (largely the result of slowing of the growth in health care costs and reversal of the economic drain on companies resulting

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[2] 75 FR 37187. (June 28, 2010).
[3] 75 FR 41726. (July 19, 2010).
[4] 75 FR 43329. (July 23, 2010).
[5] 75 FR 74863. (December 1, 2010); corrections 75 FR 82277 (December 30, 2010)
[6] 76 FR 29964. (May 23, 2011).
[7] M. Chow and B. Phillips, "Small Business Effects of a National Employer Healthcare Mandate," January 26, 2009.

from that growth in costs). What is not in dispute, however, is the longstanding hardship faced by small businesses in being able to find affordable health insurance coverage for their employees absent the Affordable Care Act.

Although many of the Affordable Care Act's reforms in the insurance and health benefit plan markets apply to all employers regardless of size, the insurance market reforms are expected to have a greater impact on the individual and small group insurance markets than on large groups, which already meet many of the federal requirements. The Kaiser Family Foundation reports considerable variation in what insurers are permitted to charge small businesses, including the health status of the employer group.[8] Although some states currently utilize rate bands whose purpose is to limit the amount by which insurers can vary premiums based on health status, these bands vary substantially across states, with employers exposed to additional surcharges of 100 percent or greater based on health status.

According to an American Academy of Actuaries report issued in February of 2010,[9] relatively lower customer participation rates in the individual and small group markets result in higher claims volatility, which requires higher risk margins. In addition, per policy administrative costs in the individual and small group markets are higher than in the large group market because of a variety of factors including lower benefit levels, underwriting expenses related to risk assessment and classification, and agent and broker expenses, all of which result in higher per-policy administrative expenses.

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[8] Kaiser State Health Facts, "Small Group Health Insurance Market Rate Restrictions." Available online at: http://www.statehealthfacts.kff.org/comparetable.jsp?ind=351&cat=7. Accessed June 1, 2011.
[9] American Academy of Actuaries, "Critical Issues in Health Reform: Minimum Loss Ratios," February 2010.

Depending on how health insurance markets react to implementation of reforms in the individual small group markets, some argue that the Affordable Care Act will result in premium increases or an exodus by insurers from the marketplace. A review of regulations indicates, however, that the Administration is implementing the law within the scope of authority provided under the Act to minimize disruptions in these insurance markets. Indeed, the Administration has permitted waivers to plans using high deductibles or offering limited benefits in order to avert marketplace disruption until full reforms are available in 2014. While these plans do not provide comprehensive coverage, many Americans do not have any alternative plan available to them. Although the comprehensive reforms available in 2014 will eliminate the need for these types of limited benefit plans, in the meantime they remain an important form of affordable coverage.

Ultimately, small businesses have much to gain under the ACA. Indeed, aiding small business and lessening the burden of health insurance costs was a central aim of the law. For small businesses with lower-wage payrolls that desire to offer coverage to their employees, tax credits are available. Beginning in 2014, small businesses will have the option of providing coverage through health insurance Exchanges designed to offer greater choice of plan offerings, and potentially slow the rate of growth in health insurance costs by lowering administrative costs and pooling risk. Regardless of whether or not they choose to offer through an insurance Exchange, small businesses will benefit from market reforms in the individual market. The elimination of insurance underwriting practices, guarantee issue and the virtual elimination of cost shifting from the uninsured to covered plans will assure that their employees have affordable coverage, which leads to better health status and less absenteeism. The law does not obligate small businesses with fewer than 50

employees to offer coverage, but those that elect to secure coverage through Exchanges will qualify for premium affordability credits. Finally, for the very poorest small businesses with low income workers, the Medicaid expansions will offer much needed additional help.

Conclusion

The Affordable Care Act has great potential to lower costs for small businesses, make their health benefits more competitive with large businesses -- an important factor in recruiting employees – and improve the health of their workforce. Repeal of the Affordable Care Act, in contrast will likely lead to continued reductions in coverage and increases in health insurance premiums for all businesses. According to the 2009 NFIB report discussed above, prior to enactment of health reform premiums for small businesses increased by nearly 130 percent over eight years, averaging 18 percent higher than those of large businesses, costs that, according to NFIB significantly hinder small businesses' ability to invest in and grow their business. While there is a clear difference of opinion about many aspects of the Affordable Care Act, it is hard to conclude that reverting to the previous system would serve small businesses well.

Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentlelady and recognizes Mr. Rome for 5 minutes for his opening statement.

STATEMENT OF ETHAN ROME

Mr. ROME. Mr. Chairman and members of the committee, thank you for giving me the opportunity to testify today.

Healthcare for America Now is the Nation's leading grassroots advocacy organization on healthcare and a strong supporter of the Affordable Care Act.

The ACA includes many sorely needed market reforms, consumer protections, extended coverage provisions, and cost savings already benefitting millions of Americans.

While much of the country is still struggling in this tough economy, health insurance companies have posted record profits with premiums that are crushing America's families, seniors and businesses. That is why the provisions of the law that hold the insurance industry accountable and the worst abuses incurred by unreasonable rates are so critical.

Thanks to the law, we have a new MLR rule that has been discussed that requires that insurers must spend on actual medical care a specific amount instead of on wasteful overhead, excessive profits and bloated executive compensation. The MLR combats the long-term downward trend and ensures insurers' spending on medical care as a percentage of premiums. While the MLR was about 95 percent back in 1993, it is 80 percent or less among large insurers today. That is thankfully changing already. The new rule is already cutting rates for some consumers like Aetna subscribers in Kansas, an intended consequence of the MLR and it promises up to 2 billion in rebates nationwide if insurers fail to meet the standard.

We also have the rate review regulations that have been discussed which will substantially reduce rates as well. We have seen over the last year several examples where the intervention of insurance commissioners have already reduced rates.

Aggressive rate review is imperative given the sharp rise in premiums, as has been discussed, 114 percent of the last 10 years for families with unemployment-based insurance, three times greater than wage growth. And while insurers blame these increases on the rising cost of medical care, premiums have been going up at double the rate of medical inflation.

The big driver is profits. The Wall Street-run health insurance companies, their profits jumped 51 percent from 2008 to 2010. In 2010 alone, their combined profits were 11.7 billion, up from 9.9 in 2009, despite a 4 percent decline in enrollment. New data indicate they are on their way to record profits in this as well.

But reported profits tell only a fraction of the story. Insurers have also amassed a capital surplus that vastly exceeds the Nation's major for-profit and non-profit, what they are required. According to CitiGroup analysis, the Nation's major for-profit and non-profit health insurance companies held an astonishing 90.3 billion in total risk-based capital to cover unexpected medical claims as of December 31, six times more than necessary. And virtually unnoticed by many, the for-profit insurers have steadily moved billions of dollars of cash off their balance sheets to buy back their

own shares on the New York Stock Exchange. This increases profits and share prices. It does nothing to improve patient care or the quality of their programs.

The profits are astonishing. Their CEO pay is breathtaking. But what is galling and unacceptable is that the insurance companies impose double-digit premium hikes on America's families and businesses year after year to pay for these—and they do so at a time when our families and businesses simply can't afford to pay more. And it is clear these rate hikes are not justified. They could reduce rates by dipping into their capital surpluses. They could reduce rates given that utilization is going down.

Two final quick things. We should not be spending our time talking about how to undermine the Affordable Care Act. For example, taking broker commissions out of the MLR equation. What that will do is jeopardize 1.4 billion in rebates for consumers, and as rates have gone up 100 percent over the last 10 years, so, too, have the commissions of brokers.

We can also increase rate regulation by expanding rate review by enhancing the Health Insurance Rate Review Act sponsored by Representative Schakowsky and Feinstein which will give HHS greater power to review rates.

America's families and small businesses desperately need relief. With aggressive implementation of the ACA, the days of health insurance price gouging will come to an end. Thank you very much.

[The prepared statement of Mr. Rome follows:]

Testimony of Ethan Rome
Executive Director, Health Care for America Now
Before the House Energy & Commerce Committee Subcommittee on Health

June 2, 2011

Mr. Chairman and Members of the Committee,

Thank you for giving me the opportunity to testify today on the regulatory impact of the new health law.

Health Care for America Now, the nation's leading grassroots health care advocacy organization, is a strong supporter of the Patient Protection and Affordable Care Act (ACA). The ACA builds on the existing employer-based, private health insurance system and includes many sorely needed market reforms, consumer protections, extended coverage provisions and cost savings that are already benefiting millions of Americans.

While much of the country is still feeling the effects of the economic downturn, health insurance companies continue to set profit records with premiums that are crushing America's families, seniors and businesses. That's why the provisions of the law that hold the health insurance companies accountable, end their worst abuses and curb unreasonable rate hikes are a critical part of the ACA.

Thanks to the law, we now have a minimum percentage of our premiums that insurers must spend on actual medical care instead of wasteful overhead, excessive profits, and bloated executive compensation. This rule, known as the medical-loss ratio, combats the long-term downward trend in insurers' spending on medical care as a percentage of premiums. In 2010, big companies again reported dramatic reductions in their medical-loss ratios, including a decline in spending on patient care of 3.8 percentage points by Cigna and 2.9 percentage points by Aetna. Now MLRs are 80 percent or less, compared to 95 percent in 1993, according to PriceWaterhouseCoopers. The new medical-loss ratio rules are working well, already cutting rates for some consumers, like Aetna subscribers in Connecticut, and promising up to $2 billion in rebates nationwide.

We also have new rate review regulations that will help states end unjustified rate hikes. The increased consumer choice and competition that will come with online insurance exchanges, coupled with disclosures of how insurers manipulate rate requests, will put insurers on notice that unjustified, double-digit premium increases won't be tolerated. For long-term success, state regulators must take full advantage of the rate regulation tools available to them under the new law.

Premiums have risen sharply, increasing 114% over the last 10 years for families with employment-based insurance. This is three times greater than wage growth, showing that health insurance is eating up an increasing portion of expenses for employers and families, strangling other priorities. Insurers blame these increases on the rising cost of medical care, yet premiums have been going up at double the rate of medical inflation as gauged by the Bureau of Labor Statistics. It is clear that insurers have found ways to substantially increase their profits, far beyond what is understood by the public.

The five largest Wall Street-run health insurance companies parlayed the economic meltdown of 2008 and the subsequent fragile recovery into a profitable year in 2010. The insurers made combined profits of $11.7 billion, up from $9.98 billion in 2009 , despite a 3.9% decline in enrollment, by charging more and reducing the share of premium dollars spent on health care. New data indicate they are on pace to break profit records this year as well. Things are so good now that some insurers this year are starting to pay cash dividends to their shareholders.

But reported profits tell only a fraction of the story. As the insurers have pursued excessive profits, they have amassed a capital surplus that vastly exceeds what state regulators demand. State insurance commissioners required them to hold $14.1 billion in risk-based capital to cover unexpected medical claims as of Dec. 31, according to a Citigroup analysis, but the nation's major for-profit and nonprofit health insurance companies held an astonishing $97.3 billion in total risk-based capital – six times more than necessary.

And virtually unnoticed by the media and the public, the for-profit insurers have steadily moved billions of dollars of cash off their balance sheets to buy back their own shares on the New York Stock Exchange. From 2003 through 2010, the five largest companies spent a breathtaking $64.1 billion in company assets on share repurchases.

Buybacks don't improve operations, make the health system run more efficiently or reduce premiums. Their sole purpose is to boost stock prices by reducing the supply of shares, a big benefit to CEOs who hold stakes in their own companies and take bonuses for raising share prices. This is one reason why a handful of CEOs at the 10 largest for-profit health insurance companies pocketed nearly $1 billion in total compensation in the 10 years ending in 2009.

Meanwhile, insurers claim they are one of the least profitable health care industries with an overall margin of only 4.4% -- less than one penny of every dollar spent on all health care in the U.S. But that penny is worth $347 billion over 10 years ending in 2019, enough to pay for more than one-third of the entire cost of health reform.

Insurers tout the 4.4% profit margin in order to shift attention from their impressive return on equity, a measure of profits as a percentage of the amount invested. That scores a robust 16.1% -- fourth highest of 16 health care industries. Health insurers deliver greater return for investors than companies that sell cellphones, beer, mortgages, life insurance, or groceries.

When we hear opponents of the ACA talk about repeal, what they're really trying to do is protect excessive insurer profits and undermine ACA consumer protections that break the industry's stranglehold on our health care. We need Congress to work on behalf of consumers to protect the ACA from efforts to undermine it, such as the proposal to weaken the medical-loss ratio by giving a special break to health insurance brokers and other special interests. That proposal would dramatically reduce the consumer rebates and increase premiums and the burden on taxpayers. Health care utilization and costs have been dropping in the last year, but insurers are not decreasing their premiums accordingly. Insurers will need to lower their premiums or face big rebates, but if the broker commissions are taken out of the law's MLR equation, premium rates will continue to increase even as health care costs drop.

We also should strengthen elements of the ACA. For instance, we should expand rate review by enacting the Health Insurance Rate Review Act (H.R.416/S.137), sponsored by Representative Schakowsky and Senator Feinstein, to give HHS the power to approve and disapprove excessive premium increases.

America's families and small businesses need relief. With aggressive implementation of the ACA, the days of health insurance company price gouging can end.

Thank you.

For Immediate Release—March 3, 2011
Contact: Avram Goldstein 202-587-1634
agoldstein@healthcareforamericanow.org

HEALTH CARE FOR AMERICA NOW

HCAN Analysis Shows Health Insurers Pocketed Huge Profits in 2010 Despite Weak Economy

Report Underscores Importance of Blocking Republican Efforts to Repeal Health Law

Washington, DC—The five largest Wall Street-run health insurance companies parlayed the economic meltdown of 2008 and the nation's subsequent fragile recovery into huge profits in 2010, the last year before market reforms in the Affordable Care Act (ACA) take full effect, according to an analysis by Health Care for America Now (HCAN). **The five insurers made combined profits of $11.7 billion by reducing the share of premiums spent on the shrinking membership in private health plans.**

Through the recession and its aftermath from 2008 to 2010, combined profits for UnitedHealth Group Inc., WellPoint Inc., Aetna Inc., Cigna Corp. and Humana Inc. increased a breathtaking 51 percent. Last year alone, the five companies' combined profits grew 17 percent, excluding a one-time $2.2 billion gain from the 2009 sale of a WellPoint subsidiary. On Wall Street, share prices for the five health insurers have risen 15 to 25 percent this year, compared with less than 5 percent for broad market indices.

	Full Year 2008 Profit (in millions)	Full Year 2009 Profit (in millions)	Full Year 2010 Profit (in millions)	2008-2009 Change in Profit	2009-2010 Change in Profit	2008-2010 Change in Profit
UnitedHealth	$2,977	$3,822	$4,634	28%	21%	56%
WellPoint	$2,491	$2,546	$2,887	2%	13%	16%
Humana	$647	$1,040	$1,099	61%	6%	70%
Cigna	$292	$1,302	$1,345	346%	3%	361%
Aetna	$1,384	$1,277	$1,767	(8%)	38%	28%
Totals	**$7,791**	**$9,986**	**$11,732**	**28%**	**17%**	**51%**

NOTE: 2009 profit numbers exclude WellPoint one-time after-tax gain of $2.2 billion for sale of NextRx subsidiary.
Source: Company earnings reports.

"While families are struggling to make ends meet and cope with rising health costs in a tough economy, health insurance companies are continuing to make excessive profits," said **HCAN Executive Director Ethan Rome.** "The companies made their profits by burdening families and businesses with unaffordable premiums and a bigger share of rising medical costs. The insurance companies' financial success is the result of a business model that avoids risk and provides less care. While running television ads claiming they care about their customers' health, the insurers continually devise ways to make more profit by giving inadequate benefits to their shrinking pool of private plan members."

The health insurance industry's profits resulted from the following Wall Street-driven trends:

1. Spending on Medical Care Grew More Slowly Than Premiums

In 2010 the five insurers collected $7.7 billion more in premiums than the year before, but growth in spending on patient care lagged behind. Insurers have been free to spend as big a share of premium revenue as they please on bloated CEO pay, marketing, administration, lobbying and a care-denial bureaucracy. Cigna led the industry in finding ways to avoid covering actual health care by shifting medical costs to working families and employers through skimpier coverage and higher deductibles. As a result, the share of premiums Cigna spent on medical care in 2010 (known in industry parlance as the medical-loss ratio) dropped to 80.1% from 83.9% the year before—a decline worth $709 million, according to a congressional report. Aetna also trimmed its health care costs, spending only 82.3% of premiums on patient care, down from 85.2% the year before, a change worth $708 million. UnitedHealth and WellPoint also reported lower spending on care.

	2009 Consolidated Medical-Loss Ratio	2010 Consolidated Medical-Loss Ratio	2009-2010 Change (in percentage points)
UnitedHealth	82.3%	80.6%	-1.7%
WellPoint	83.6%	83.2%	-0.4%
Humana	82.8%	82.8%	0.0%
Cigna	83.9%	80.1%	-3.8%
Aetna	85.2%	82.3%	-2.9%

Note: Medical-loss ratios as calculated by companies and in some cases restated for prior years. Consolidated medical-loss ratios tend to camouflage low spending on patient care in commercial lines of business.
Source: Company earnings reports.

2. High Premiums Blocked Consumers from Buying Coverage

In 2010, the companies reduced their private health plan rolls by 839,000 people after shedding 2.7 million in 2009. **In two years of economic crisis, the five companies' private health plans contracted by 3.9 percent, or 3.5 million people, at a time when 50.7 million people already were uninsured.** The poor economy, significant job losses and unaffordable health insurance premiums left millions of families to fend for themselves and seek government help or charity from providers to get needed care.

	Private Health Enrollment Dec. 31, 2008 (in thousands of members)	Private Health Enrollment Dec. 31, 2009 (in thousands of members)	Private Health Enrollment Dec. 31, 2010 (in thousands of members)	Change in Private Health Enrollment 2009-2010 (in thousands of members)	Change in Private Health Enrollment 2008-2010 (in thousands of members)	Percentage Change in Private Enrollment 2009-2010	Percentage Change in Private Enrollment 2008-2010
UnitedHealth	26,345	24,625	24,810	185	(1,535)	0.8%	-5.8%
WellPoint	31,753	30,722	30,308	(414)	(1,445)	-1.3%	-4.6%
Humana	3,601	3,381	3,078	(303)	(523)	-9.0%	-14.5%
Cigna	11,644	10,988	11,292	304	(352)	2.8%	-3.0%
Aetna	16,488	17,435	16,824	(611)	336	-3.5%	2.0%
Totals	**89,831**	**87,151**	**86,312**	**(839)**	**(3,519)**	**-1.0%**	**-3.9%**

Note: All enrollment figures include only medical care plans and exclude vision, dental, specialty, Medicare supplemental, and Medicare stand-alone prescription drug plans.
Source: Company earnings reports.

3. Insurers Turned to Medicare, Medicaid Programs for Enrollment Growth

In contrast to the downward private membership trend, since 2008 the five companies enrolled 2.1 million people in privately managed Medicare, Medicaid and military plans—a 15.9 percent increase to 15.6 million.

	Public Health Enrollment Dec. 31, 2008 (in thousands of members)	Public Health Enrollment Dec. 31, 2009 (in thousands of members)	Public Health Enrollment Dec. 31, 2010 (in thousands of members)	Change in Public Health Enrollment 2009-2010 (in thousands of members)	Change in Public Health Enrollment 2008-2010 (in thousands of members)	Percentage Change in Public Enrollment 2009-2010	Percentage Change in Public Enrollment 2008-2010
UnitedHealth	4,010	4,690	5,390	700	1,380	14.9%	34.4%
WellPoint	3,296	2,948	3,015	67	(281)	2.3%	(8.5%)
Humana	4,872	4,945	5,360	415	488	8.4%	10.0%
Cigna	35	52	145	93	110	179%	314%
Aetna	1,213	1,479	1,644	165	431	11.2%	35.5%
Totals	**13,426**	**14,114**	**15,554**	**1,440**	**2,128**	**9.3%**	**15.9%**

Note: Public enrollment figures include only Medicare Advantage, Medicaid and military medical care plans and exclude vision, dental, specialty, Medicare supplemental, and Medicare stand-alone prescription drug plans.
Source: Company earnings reports.

4. Health Insurance CEOs Pocketed Mammoth Paychecks

For their work rewarding Wall Street in the last decade, the CEOs at the 10 largest for-profit health insurance companies pocketed nearly $1 billion in compensation in the 10 years ending in 2009. As a group they received a 167 percent pay raise in 2009 while average American workers saw wages grow about 2 percent. Compensation figures for 2010 will be reported in the coming weeks.

5. Buybacks Magnified Profits for Insiders, Wall Street Investors

Investors and financial analysts were surprised by how well these strategies and tactics have worked. Things were so good that the insurers used $8.8 billion from soaring customer premiums in 2010 to buy back their own stock, according to the companies. The purpose of share buybacks is to push stock prices up by reducing the supply of shares, a big benefit to insurance company leaders and board members with stakes in their own enterprise. Buybacks do nothing to improve a company's operations, make the health system run more efficiently or reduce premiums. **From 2003 through 2010, the five companies spent $64.1 billion buying back their own shares and lining the pockets of their senior executives while imposing ever-bigger premium increases on America's families and businesses.**

	2008 Share Buybacks (in millions)	2009 Share Buybacks (in millions)	2010 Share Buybacks (in millions)	2010 Revenue (in millions)	2010 Share Buybacks as Percentage of Revenue
UnitedHealth	$2,684	$1,801	$2,500	$94,155	2.7%
WellPoint	$3,276	$2,638	$4,360	$58,802	7.4%
Humana	$106	$23	$100	$33,868	0.3%
Cigna	$378	-	$200	$21,253	0.9%
Aetna	$1,788	$773	$1,606	$34,019	4.7%
Totals	**$8,232**	**$5,235**	**$8,766**	**$242,097**	**3.6%**

Source: Company earnings reports.

The latest trend among the five companies is to depart from industry practice and provide substantial dividends to their shareholders. **WellPoint announced that it plans to pay $400 million in dividends this year, while UnitedHealth plans a dividend of $449 million and Aetna expects to pay $230 million.**

Affordable Care Act Provides New Consumer Protections

In the past, insurance companies have freely used premium revenue to pay for many things other than actual medical care, including excessive CEO pay, lobbying, underwriting (weeding out applicants or charging them higher rates because of their medical history) and administration. **Fortunately for middle-class families and employers, 2010 was the last year in which insurance companies will be free to take as much as they please from customer premiums.** The Affordable Care Act has new rules requiring insurers to spend on medical services at least 80% of premiums from people who buy coverage on the open market or through small employers. The minimum share for large-business customers is 85% of premiums. Companies that fall short of the minimums must rebate the money to consumers. The Health and Human Services Department estimates that insurers will owe up to 9 million customers as much as $1.4 billion in 2011 rebates payable next year. The law also has new rate-review rules that have already encouraged a growing number of state insurance regulators to resist the kind of double-digit premium hikes that have become common in recent years.

Industry-Backed Republicans Pushing for Repeal

The health insurance industry and other special interests are working with Republican members of Congress and GOP officeholders in the states to roll back the Affordable Care Act and its consumer protections and help health insurance companies preserve their profits. Meanwhile, private groups such as the National Federation of Independent Business have teamed up with Republican governors and attorneys general to pursue litigation challenging the constitutionality of the new health care law.

The Republican Party and its corporate allies are determined to repeal the law and take away dozens of benefits and important consumer protections that are making a real difference in people's lives right now. They want to take away people's newly won freedom from fear of insurers denying their care, dropping them when they're sick and imposing gratuitous double-digit premium hikes. The GOP wants to boot young adults off their parents' health plans, tell seniors to pay back the $250 donut hole checks they received last year to help buy prescription medications and end the 50% discount on brand-name drugs this year. If the Affordable Care Act is undermined, it will force nearly 900,000 American families a year into bankruptcy because of medical bills and take job-creating tax credits away from small businesses.

"The attacks on the health care law are attacks on America's working families, seniors and small businesses," Rome said. "The Republicans want to give our health care back to the insurance companies and put profits over patients. The new health care law eliminates the insurance company's worst abuses, like denying people care and jacking up their rates at will."

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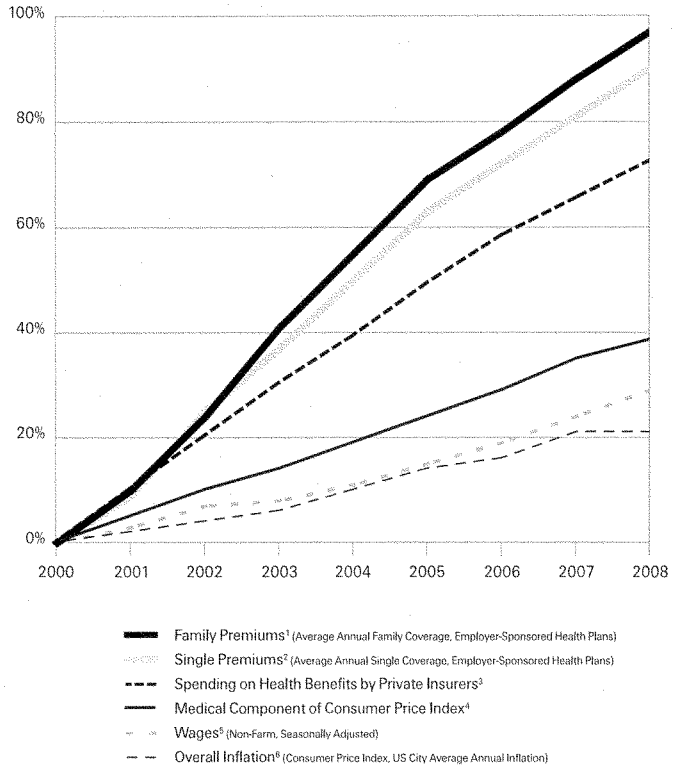
Health Care for America Now *is a national grassroots coalition of more than 1,000 organizations in 46 states representing 30 million people. HCAN led the fight over the past two years to win passage of health reform and to keep Congress from being steamrolled by corporate special interests.*

Cumulative Growth Rate of Health Insurance Premiums Dramatically Outstrips Inflation, Wages and Cost of Private Insurance Benefits, 2000–2008



[1]The Kaiser Family Foundation, "Average Annual Premiums for Single and Family Coverage, 1999-2009," Sept. 15, 2009. Accessed at http://ehbs.kff.org/?page=charts&id=2&sv=16&ch=1023.

[2]The Kaiser Family Foundation, "Average Annual Premiums for Single and Family Coverage, 1999-2009," Sept. 15, 2009. Accessed at http://ehbs.kff.org/?page=charts&id=2&sv=16&ch=1023.

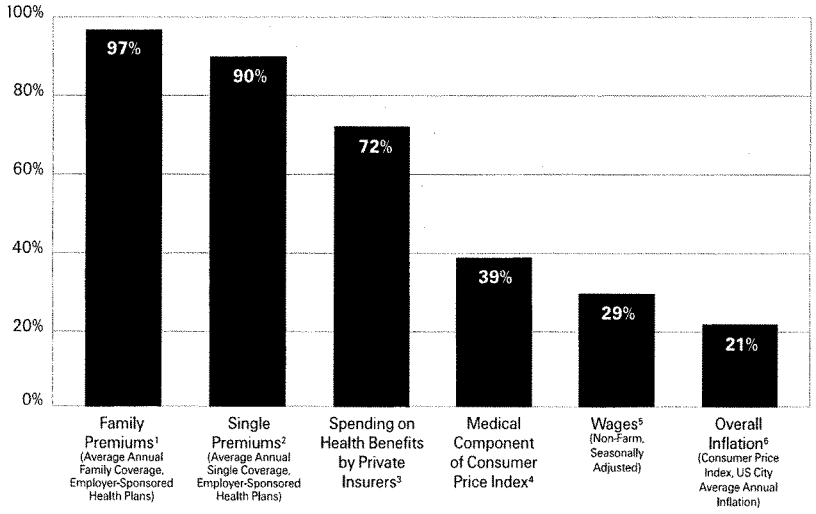
[3]U.S. Department of Health and Human Services, "Personal Health Care Expenditures Aggregate, Per Capita Amounts, and Percent Distribution, by Source of Funds: Selected Calendar Years 1960-2008." Accessed at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf; The State Health Access Data Assistance Center, "Health Insurance Coverage Estimates, CPS (SHADAC-enhanced), 0-64 Years, All Poverty Levels, United States: Calendar Year 2000," 2000-2009. Accessed at http://www.shadac.org/datacenter/tables/tables/4g/aedoa75f-1b11-4051-b0eb-ecdb2c7d4336.

[4]U.S. Bureau of Labor Statistics, EconStats, "CPI (SA) Yearly Data." Accessed at http://www.econstats.com/bls/blsmcq9.htm.

[5]Bureau of Labor Statistics, The National Compensation Survey, July 31, 2009. Accessed at ftp://ftp.bls.gov/pub/suppl/empsit.ceseeb1a.txt.

[6]U.S. Bureau of Labor Statistics, EconStats, "CPI (SA) Yearly Data." Accessed at http://www.econstats.com/bls/blsmcq9.htm.

Cumulative Growth Rates of Health Insurance Premiums Compared with Inflation, Wages and Private Insurers' Spending on Benefits, 2000–2008



[1]The Kaiser Family Foundation, "Average Annual Premiums for Single and Family Coverage, 1999-2009," Sept. 15, 2009. Accessed at http://ehbs.kff.org/?page=charts&id=2&sn=16&ch=1023.

[2]The Kaiser Family Foundation, "Average Annual Premiums for Single and Family Coverage, 1999-2009," Sept. 15, 2009. Accessed at http://ehbs.kff.org/?page=charts&id=2&sn=16&ch=1023.

[3]U.S. Department of Health and Human Services, "Personal Health Care Expenditures Aggregate, Per Capita Amounts, and Percent Distribution, by Source of Funds: Selected Calendar Years 1960–2008." Accessed at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf; The State Health Access Data Assistance Center, "Health Insurance Coverage Estimates, CPS (SHADAC-enhanced), 0-64 Years, All Poverty Levels, United States: Calendar Year 2000," 2000-2009. Accessed at http://www.shadac.org/datacenter/tables/tables/id/aedex76t-1b1f-405f-b0eb-ecdb2c7d4336.

[4]U.S. Bureau of Labor Statistics, EconStates, "CPI (SA) Yearly Data." Accessed at http://www.econstats.com/bls/blsnea9.htm.

[5]Bureau of Labor Statistics, The National Compensation Survey, July 31, 2009. Accessed at ftp://ftp.bls.gov/pub/suppl/empsit.cpsnaitbes.txt.

[6]U.S. Bureau of Labor Statistics, EconStates, "CPI (SA) Yearly Data." Accessed at http://www.econstats.com/bls/blsnea9.htm.

Insurance Market Concentration: Ranked List

Rank	State	Health Insurer with Largest Market Share	Market Share %	Health Insurer with No. 2 Market Share	Market Share %	Combined Market Share % of Top Two Insurers
1	Hawaii	Blue Cross Blue Shield HI	78	Kaiser Permanente	20	98
2	Rhode Island	Blue Cross Blue Shield RI	79	UnitedHealth Group Inc.	16	95
3	Alaska	Premera Blue Cross	60	Aetna Inc.	35	95
4	Vermont	Blue Cross Blue Shield VT	77	CIGNA Corp.	13	90
5	Alabama	Blue Cross Blue Shield AL	83	Health Choice	5	88
6	Maine	WellPoint Inc. (BCBS)	78	Aetna Inc.	10	88
7	Montana	Blue Cross Blue Shield MT	75	New West Health Services	10	85
8	Wyoming	Blue Cross Blue Shield WY	70	UnitedHealth Group Inc.	15	85
9	Arkansas	Blue Cross Blue Shield AR	75	UnitedHealth Group Inc.	6	81
10	Iowa	Wellmark BC and BS	71	UnitedHealth Group Inc.	9	80
11	Missouri	WellPoint Inc. (BCBS)	68	UnitedHealth Group Inc.	11	79
12	Minnesota	Blue Cross Blue Shield MN	50	Medica	26	76
13	South Carolina	Blue Cross Blue Shield SC	66	CIGNA Corp.	9	75
14	Indiana	WellPoint Inc. (BCBS)	60	M*Plan (HealthCare Group)	15	75
15	New Hampshire	WellPoint Inc. (BCBS)	51	CIGNA Corp.	24	75
16	Idaho	Blue Cross of ID	46	Regence BS of Idaho	29	75
17	Louisiana	Blue Cross Blue Shield LA	61	UnitedHealth Group Inc.	13	74
18	Michigan	Blue Cross Blue Shield MI	65	Henry Ford Health System	8	73
19	North Carolina	Blue Cross Blue Shield NC	53	UnitedHealth Group Inc.	20	73
20	Maryland	CareFirst Blue Cross Blue Shield	52	UnitedHealth Group Inc.	19	71
21	Oklahoma	BCBS OK	45	CommunityCare	26	71
22	Georgia	WellPoint Inc. (BCBS)	61	UnitedHealth Group Inc.	8	69
23	Kentucky	WellPoint Inc. (BCBS)	59	Health Partners	10	69
24	Illinois	HCSC (Blue Cross Blue Shield)	47	WellPoint Inc. (BCBS)	22	69
25	Nebraska	Blue Cross Blue Shield NE	44	UnitedHealth Group Inc.	25	69
26	Utah	Regence Blue Cross Blue Shield	47	Intermountain Healthcare	21	68
27	Massachusetts	Blue Cross Blue Shield MA	50	Tufts Health Plan	17	67
28	Connecticut	WellPoint Inc. (BCBS)	55	Health Net Inc.	11	66
29	Arizona	Blue Cross Blue Shield AZ	43	UnitedHealth Group Inc.	22	65
30	Delaware	CareFirst Blue Cross Blue Shield	42	Coventry Health Care Inc.	23	65
31	New Mexico	HCSC (Blue Cross Blue Shield)	35	Presbyterian Hlth	30	65
32	Tennessee	Blue Cross Blue Shield TN	50	Total Choice	12	62
33	Virginia	WellPoint Inc. (BCBS)	50	Aetna Inc.	11	61
34	Washington	Premera Blue Cross	38	Regence Blue Shield	23	61
35	Texas	HCSC (Blue Cross Blue Shield)	39	Aetna Inc.	20	59
36	New Jersey	Horizon Blue Cross Blue Shield	34	Aetna Inc.	25	59
37	Ohio	WellPoint Inc. (BCBS)	41	Medical Mutual of Ohio	17	58
38	Nevada	Sierra Health	29	WellPoint Inc. (BCBS)	28	57
39	Colorado	WellPoint Inc. (BCBS)	29	UnitedHealth Group Inc.	24	53
40	Oregon	Providence Health & Services	25	Regence Blue Cross Blue Shield	23	48
41	New York	GHI	26	WellPoint Inc. (Empire BCBS)	21	47
42	Florida	Blue Cross Blue Shield FL	30	Aetna Inc.	15	45
43	California	Kaiser Permanente	24	WellPoint Inc. (Blue Cross)	20	44

Source: American Medical Association, "Competition in health insurance: A comprehensive study of U.S. Markets: 2007 Update."
Some states are not presented because available data does not reliably capture a sufficient portion of the insured population.

CEO Total Compensation and Exercise of Stock Options at the Largest For-Profit Health Insurers, 2000–2009[1]

Company	2009 Total CEO Compensation (excluding stock option exercises)	2008 Total CEO Compensation (excluding stock option exercises)	2007 Total CEO Compensation (excluding stock option exercises)	2006 Total CEO Compensation (excluding stock option exercises)	2005 Total CEO Compensation (excluding stock option exercises)	2004 Total CEO Compensation (excluding stock option exercises)	2003 Total CEO Compensation (excluding stock option exercises)	2002 Total CEO Compensation (excluding stock option exercises)	2001 Total CEO Compensation (excluding stock option exercises)	2000 Total CEO Compensation (excluding stock option exercises)	Total CEO Compensation (excluding stock option exercises)
Aetna	$ 18,157,779	$24,399,349	$ 23,145,451	$ 44,969,500	$ 7,905,537	$ 4,010,815	$10,638,223	$ 8,927,005	$ 3,544,242	$ 4,028,919	$149,726,820
Amerigroup	$ 5,232,249	$ 5,292,546	$ 3,247,083	$ 3,198,382	$ 655,348	$ 2,009,837	$ 1,838,495	$ 1,911,083	$ 1,395,566	$ 1,261,561	$ 26,042,150
Centene	$ 6,077,900	$ 8,774,483	$ 8,750,751	$ 8,046,309	$ 2,082,493	$ 26,921,194	$ 1,742,943	$ 1,264,542	$ 595,331	$ 465,481	$ 64,721,427
CIGNA[2]	$136,344,388	$12,236,740	$ 25,839,777	$ 21,014,423	$12,373,300	$ 11,618,700	$ 8,676,200	$ 14,191,000	$10,482,900	$ 9,223,700	$ 262,001,128
Coventry Health Care	$ 25,653,780	$ 9,047,469	$ 14,869,823	$ 12,937,001	$ 6,355,139	$ 1,653,428	$ 10,081,451	$10,322,364	$ 5,822,386	$ 2,232,127	$ 98,974,968
Health Net	$ 3,643,342	$ 4,425,355	$ 3,686,230	$ 6,066,913	$ 1,787,682	$ 1,030,876	$ 4,096,037	$ 1,526,819	$ 757,487	$ 665,517	$ 27,686,258
Humana	$ 6,509,452	$ 4,764,309	$ 10,312,557	$ 5,798,613	$ 2,552,774	$ 2,374,406	$ 5,764,377	$ 1,648,972	$ 1,622,606	$ 2,727,004	$ 44,075,070
UnitedHealth Group	$ 8,901,916	$ 3,241,042	$ 13,164,529	$ 15,549,028	$ 10,697,442	$10,220,859	$ 10,001,499	$ 9,457,403	$ 7,666,999	$ 9,323,297	$ 98,224,014
Universal American Group	$ 4,514,670	$ 3,503,701	$ 1,564,293	$ 2,182,294	$ 1,572,063	$ 2,041,222	$ 2,054,750	$ 1,767,440	$ 1,543,160	$ 987,400	$ 21,730,993
WellPoint	$ 13,108,198	$ 9,844,212	$ 18,705,773	$ 23,886,169	$ 8,523,139	$ 5,599,779	$ 46,212,719	$ 6,857,839	$ 15,703,827	$ 2,517,142	$ 150,958,797
Total	**$ 228,143,674**	**$85,529,206**	**$123,286,267**	**$143,648,632**	**$54,504,917**	**$ 67,481,116**	**$101,106,694**	**$ 57,874,467**	**$ 49,134,504**	**$ 33,432,148**	**$ 944,141,625**
											Total Exercised Stock Options[3]
Value of Exercised Stock Options[4]	**$114,067,203**	**$13,510,405**	**$114,500,571**	**$244,647,767**	**$80,466,714**	**$51,634,429**	**$113,171,571**	**$ 16,568,418**	**$43,757,464**	**$50,543,446**	**$842,867,988**

[1]Compensation totals for each year include: base salary, bonuses, non-equity incentive plan compensation, stock awards, option awards, restricted stock grants and other reported compensation.
[2]CIGNA 2009 numbers represent total compensation for Edward Hanway, including $110.9 million in retirement pay, plus total compensation for successor CEO David Cordani.
[3]An unknown fraction of the value of the exercised stock options was reported by the companies in summary compensation reports in previous years. The precise fraction cannot be determined without research that goes beyond the scope of this survey. Thus, total CEO compensation cannot be simply added to the value of the exercised stock options to produce a definitive total figure.
[4]Includes exercised stock options reported on annual proxy statements. Excludes exercised stock options taken by former CEOs no longer required to report insider transactions.

Source: U.S. Securities and Exchange Commission filings.

Rates of Return on Equity

By Sector

Sectors	Return on Equity %
Health care	17.35
Basic Materials	15.23
Technology	14.98
Consumer Goods	14.67
Industrial Goods	14.24
Services	14.13
Conglomerates	12.90
Utilities	8.04
Financial	7.49

By Health Care Industry

Health Care Industry	Return on Equity %
Hospitals	177
Specialized Health Services	18.1
Drug Related Products	16.9
Drug Manufacturers—Major	16.8
Health Care Plans	16.1
Medical Instruments & Supplies	13.8
Medical Appliances & Equipment	13.7
Drug Manufacturers—Other	13.7
Home Health Care	13.4
Medical Practitioners	11.3
Biotechnology	9.3
Drugs—Generic	6.1
Diagnostic Substances	5.6
Long-Term Care Facilities	4.6
Medical Laboratories & Research	2.2
Drug Delivery	0

Sources:
Yahoo Finance as of May 27, 2011
http://biz.yahoo.com/p/s_ttmd.html
http://biz.yahoo.com/p/5ttmd.html

Mr. PITTS. The Chair thanks the gentleman and recognizes Mr. Fensholt for 5 minutes' opening statement.

STATEMENT OF EDWARD C. FENSHOLT

Mr. FENSHOLT. Chairman Pitts, Ranking Member Pallone and members of the committee, my name is Edward Fensholt and I am a Senior Vice President with Lockton Benefit Group headquartered in Kansas City, Missouri. Lockton Benefit Group provides employee benefits consulting services primarily middle-market employers, about 2,500 of them from coast to coast. Most of them self-insure their healthcare coverage, that is, they pay claims out of their general assets. Fewer than half buy group insurance from insurance companies.

Mr. Chairman, that stack of papers to your right has been my life for the past year. My day-to-day job is to run Lockton Benefit Group's Health Reform Advisory Practice where we steer our clients through the maze of regulations and rules. And I might add, Mr. Chairman, that that stack of regulations and rules is not only a burden on small business, it is a challenge to our clients in the middle market and to large employers as well.

If I could sum up the views of our clients in a couple of words, those words would be frustration and bewilderment. The men and women who run these companies and supply jobs in their communities provide valuable health insurance benefits to their employees, but they struggle to do that. They struggle with the financial aspects of that coverage and with the dazzling array of federal rules and regulations they must navigate in order to provide that coverage.

For example, today, as we speak today, there are more than 50 separate notices, disclosures and reports to the Federal Government that a health plan sponsor must make just for the privilege of sponsoring a group health insurance plan, never mind their notices on their 401(k) plans, their OSHA notices, their EEOC notices, EPA notices, whatever, a simple healthcare plan has north of 50 notices, disclosures and reports it might be required to supply under federal law alone. Nineteen of those have been added by the health reform law so far.

These obligations impose additional hassles, headaches and costs to our clients and subject them to all these penalties for failure.

The health reform law adds a variety of new benefit and coverage mandates that add additional costs and complexities the sponsorship of a group health insurance plan. Our clients understand why Congress would act to supply access to health insurance for those who do not have that access or cannot afford it, but they simply do not understand why, in a time when everyone agrees that health insurance and healthcare is too expensive, why Congress would act to make the provision of employer-sponsored insurance, to which about 150 million of us obtain, more costly and particularly more hassle prone.

We recently finished a 12-question survey of our clients on the impact of healthcare reform on them and the plans they sponsor. Over and over we received the same responses we have been hearing literally from them for the last year, comments such as these, taken verbatim from our survey results. We currently provide

healthcare coverage to our employees. The reform Act will do nothing but add cost and add administrative requirements. The law is burdensome with little benefit to employer or employee. In the long run, the law will reduce access to healthcare services and dramatically increase the cost to both the employer and the employee. What they, meaning the Congress, are planning is only going to penalize the employers and employees who actually are hard workers and are trying to make a living for themselves and not relying on the government to take care of them.

The law includes a grandfather clause ostensibly intended to shield existing group plans from the law's costly mandates and other provisions. But it is a poor shield indeed. It supplies no protection from several requirements such as the obligation to eliminate lifetime and annual dollar maximums the plans have used for years as—cost containment measures or the obligation to supply coverage to adult children, even if married, even if non-dependent upon the employer or living apart from the employee and spouse or even if the child is gainfully employed himself or herself.

The grandfather shield does protect plans from other mandates, but the grandfather protection is so easy to lose as a result of routine plan design changes that the vast majority of our—grandfather status immediately.

In our survey, 18 percent of our respondents said they would consider eliminating group coverage in 2014. To be fair, few have said they will do it for sure. Few have said they will definitely maintain coverage. Mostly they say we will wait and see. We may not be the first to cancel our group plan, but we will not wait to be third, either.

In closing, let me say it simply seems to us and our clients that if Congress were inclined to attempt to address health insurance access issues, it should not punish employers in the process. Our clients are not the bad guys. They don't understand why this law makes the provision of group health insurance more burdensome and more costly, rather than less so.

Thank you, sir.

[The prepared statement of Mr. Fensholt follows:]

LOCKTON COMPANIES, LLC TESTIMONY

HEARING ON

"PPACA'S EFFECTS ON MAINTAINING HEALTH COVERAGE AND JOBS: A REVIEW OF THE HEALTH CARE LAW'S REGULATORY BURDEN"

SUBCOMMITTEE ON HEALTH
ENERGY AND COMMERCE COMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES

JUNE 2, 2011

EDWARD FENSHOLT, J.D.
SENIOR VICE PRESIDENT
DIRECTOR, COMPLIANCE SERVICES AND
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Chairman Pitts, Ranking Member Pallone and members of the Committee, my name is Edward Fensholt and I am a Senior Vice President of Lockton Companies, LLC. Lockton is the largest privately-held insurance brokerage and consulting firm in the world. Domestically, Lockton employs 2,300 associates in 24 offices nationwide who serve the insurance risk needs of approximately 9,000 employer clients from coast to coast. Lockton Benefit Group ("LBG") is the employee benefits consulting arm of Lockton Companies, LLC, and provides employee benefits consulting services to approximately 2,500 of those clients.

I am the Director of LBG's Compliance Services Division, and also lead our Health Reform Advisory Practice, a multi-disciplinary team of professionals formed to steer our clients through the federal health reform initiative. On behalf of Lockton I thank you for the opportunity to appear here today to share our observations and our clients' views regarding the impact of aspects of last year's health reform law on the group health plans sponsored by our clients.

LBG provides consulting expertise related to qualified and nonqualified retirement plans, group life and disability insurance programs, voluntary supplemental benefits, dental, vision, and comprehensive group medical benefit packages. The majority of our 2,500 employee benefits clients employ us to assist in the design and administration of their group medical insurance programs.

Most LBG clients are "middle market" employers, employing between 500 and 2,000 employees, although we also have some small-group and some "jumbo" clients. Our clients include private and governmental employers, and employers across many industry segments, including construction, healthcare, manufacturing, transportation, retail, professional services firms, and the hospitality/entertainment industry.

More than half of LBG's clients maintain self-insured group health plans. The others purchase group health insurance from licensed insurance companies.

The PPACA and "Grandfathered" Medical Plans

The Patient Protection and Affordable Care Act of 2010 ("PPACA") contains a "grandfather" rule designed to give substance to the President's promise during the health reform debate that "if you like your current insurance plan, you can keep it." The grandfather rule shields medical plans in existence on the date of the PPACA's passage from some of the benefit and coverage mandates imposed by the law.

The grandfather rule does not provide complete protection, however. Some of the costliest mandates apply to grandfathered and non-grandfathered plans alike. In addition, under current regulatory guidance most grandfathered plans maintained by our clients have already lost (or shortly will lose) grandfathered protection, due to even modest or routine changes.

Grandfathered Shield is No Protection from Several Key Benefit and Coverage Mandates

Several of the PPACA's new mandates pierce the grandfather shield straightaway; that is, not even grandfathered plans are shielded from these requirements. For example, the obligations beginning in 2011 to cover adult children to age 26 (even if married and non-dependent upon the employee)[1], and to eliminate lifetime and annual dollar maximums on what the PPACA terms "essential health benefits," apply to grandfathered and non-grandfathered plans alike.

Similarly, the obligations beginning in 2014 to reduce waiting periods to 90 days, and to auto-enroll eligible full-time employees in available employer-based coverage, trigger additional expenses for even grandfathered plans. Depending on the employer's industry segment, these additional expenses can be substantial.

For example, our clients in the construction and transportation industries—where we find 6-month or even 12-month waiting periods—can expect to see significant cost increases. Our actuaries tell us these clients with 6-month waiting periods currently should see a cost increase of an additional 4% in 2014; those with a 12-month waiting period should see a cost increase of nearly 25%.

Across all industry segments other than retail and hospitality, our clients can expect to experience a 4.4% cost increase attributable to the automatic enrollment requirement.[2]

Additional Mandates Apply to Plans Losing Grandfathered Status

When a grandfathered plan loses its status as a grandfathered plan (on account of plan design or related changes, discussed below), additional benefit mandates and obligations apply to the plan. For example, non-grandfathered plans must comply with:

- A requirement to supply a wide variety of preventive care services at no cost (i.e., no deductible, copayment or coinsurance) to the enrollee
- A nondiscrimination rule that heretofore has not applied to fully insured (as opposed to self-insured) medical coverage
- Additional federal requirements regarding the processing of benefit claims, including a requirement to provide independent, third-party review of certain claim appeals
- An obligation to cover clinical trials (2014)

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[1] Under the PPACA a grandfathered plan, if it chooses to do so, may decline until 2014 to cover an adult child who has an offer of coverage from a source other than through his or her parents' employers. In LBG's experience, few employers with grandfathered plans have embraced this exception on account of the administrative burdens associated with attempting to determine whether such an alternative offer of coverage exists.

[2] In modeling the effect of the automatic enrollment provision, we assumed that 75% of employees who are eligible for coverage but have not affirmatively enrolled, and who are automatically enrolled by the employer, will opt out of coverage. These modeling results do not reflect the impact of the automatic enrollment feature on our retail, restaurant, hotel and entertainment industry clients. The modeling results for these clients are assessed separately because they are substantially different.

- An obligation to report quality outcomes and patient safety measures, as defined by HHS, to the federal government (2012), and
- A requirement to not discriminate in reimbursement rates etc., against providers acting within the scope of their respective licenses (2014).

Potentially the most significant of these additional mandates, in terms of cost to the plan, is the nondiscrimination rule that applies to fully insured medical coverage. Lockton has clients—such as national restaurant chains, retail establishments and other employers in the hospitality industry—who currently supply typical medical coverage to corporate staff and perhaps select others as well (such as restaurant, store or hotel managers) but who cannot afford to offer the same level of coverage (at the same rate of employer subsidies) to rank-and-file hourly employees. Maintaining the status quo, however, might subject these employers to excise taxes of $100 per day per rank-and-file employee who does not receive an equivalent offer of coverage.

It is possible, depending on how federal regulators flesh out the requirements of the nondiscrimination rule, that these employers will simply have to terminate their existing group coverage. However, the nondiscrimination rule has yet to be interpreted by the regulatory agencies and we intend to continue to urge that as they do so, regulators develop guidance that will minimize disruption to current coverage and provide employers the flexibility they need to provide health benefits to the wide range of employees' needs and circumstances.

Grandfathered Status is Easy to Lose

Under existing federal regulations, it's very easy for a grandfathered medical plan to lose its grandfathered protection. For example, a plan will lose that protection for making very modest, routine sorts of changes, such as:

- Eliminating or substantially eliminating a benefit
- Increasing any cost-sharing feature expressed as a percentage (e.g., increasing an enrollee's co-insurance rate from 10% to 11% of covered claims)
- Increasing fixed-dollar cost sharing amounts, other than co-payments (for example, deductibles) more than 15% above the health care inflation rate
- Increasing a co-payment more than the greater of $5 or 15% above the healthcare inflation rate
- Reducing the rate of employer contributions (as a percentage of the total cost of coverage) more than 5% for any coverage tier, or
- Installing a new overall annual maximum on the dollar value of all benefits, where the plan did not previously have an overall annual OR lifetime maximum on the dollar value of all benefits; reducing an existing annual maximum on the dollar value of all benefits; or installing an annual maximum on the dollar value of all benefits (to substitute it for an existing lifetime dollar limit that is being

eliminated) if the new annual dollar maximum on all benefits is less than the current lifetime benefit maximum.

Initial regulatory guidance on the "grandfather" rule provided that an insured plan which merely changes group insurance carriers would lose grandfathered protection. In autumn 2010, federal authorities responded to concerns from the employer community and rescinded this rule, for changes in carriers where the new contract is (or was) effective on or after November 15, 2010.

While we appreciate the challenges facing federal regulators, and are grateful for their willingness to rescind a troublesome rule, the relief came too late for many of Lockton's clients. Most of our clients operate their health plans on a calendar year basis, and finalized their 2011 insurance placements well in advance of November 15, while still under the belief that changing carriers meant a loss of grandfathered status. Those placements, if they involved a new carrier, thus assumed a loss of grandfathered status, and the new plan design incorporated the mandates that apply to non-grandfathered plans.

We note also that these "loss of grandfathered status" thresholds are *cumulative*. That is, a plan that makes a very modest change in 2011 and manages to retain grandfathered status, but then makes an additional modest change for 2012, must aggregate the changes to see if the thresholds described above are exceeded.

Most LBG Clients Lost or Will Lose Grandfathered Protection in 2011

According to a survey of LBG clients conducted late in 2010, the significant majority of our clients intended or expected to lose grandfathered protection in 2011, based on plan design changes the client intended to make in order to help reduce plan costs. Here are the survey results:

Client Size (Number of Employees):	Percentage Expecting to Lose Grandfathered Status in 2011:
<499	47%
500-1,999	73%
2,000+	69%

New Survey Reflects Employers' Concerns Regarding PPACA

Lockton recently surveyed clients regarding PPACA and its effect on clients' health plans this year, as well as the impact they expect it to have on their plans in the near future. This survey, completed in May, 2011, posed 12 questions to clients regarding the perceived benefits and burdens to them and their group medical plans, under the PPACA.

The response to the survey was tremendous, and some definite themes emerged. Employers of all industries weighed in, from hospitals to hospitality, from construction to universities. Employers are concerned – specifically about the potential for additional administrative obligations and the potential for additional costs.

Clients as large as 10,000 employees down to fewer than 50 employees are represented in the survey. Results of the survey are aggregated below.

Level of Concern or Lack of Concern Regarding Impact of PPACA on Group Medical Offerings

The survey asked LBG clients to rate their level of concern about the impact of the health reform law on their health insurance benefit offerings for their employees. Our clients responded:

45%	More concerned than I was last year
14%	Less concerned than I was last year
41%	No change from last year (the survey did not ask respondents to describe last year's level of concern)

Level of Concern or Lack of Concern Regarding Specific Topics

Employers were asked to rate their levels of concern or lack of concern regarding several specific aspects of health reform. The aspect of health reform that employers cited as being concerned or very concerned about – across all industries – was: ***Additional administrative obligations.*** This includes notices to employees, additional plan summaries, and a variety of reports to federal authorities, including W-2 reporting of health plan values. Local governmental employers, in particular, at 86% of those government employers responding, were concerned or very concerned about this area of health reform.

In order, the aspects that rated the most concern are as follows:

80% *Concerned or Very Concerned:*	Additional administrative obligations
71% *Concerned or Very Concerned:*	Potential impact of the employer "play or pay" mandate in 2014 (potential impact of penalties, cost of expanding coverage to avoid penalties, potential need to move some full-time employees to part-time to avoid penalties, etc.)
63% *Concerned or Very Concerned:*	Cost impact of 2010-11 benefit mandates (elimination of dollar maximums, coverage of adult children, etc.)

60% *Concerned or Very Concerned:*	Potential cost impact of 2014 automatic enrollment requirement
58% *Concerned or Very Concerned:*	"Cadillac Tax" excise tax on high value coverage in 2018
54% *Concerned or Very Concerned:*	$2,500 cap on health flexible spending account benefits in 2013
31% *Concerned or Very Concerned:*	Potential impact of nondiscrimination rule applicable to insured medical coverage (potentially requiring employers to offer the same level of coverage, same waiting periods, same employer subsidies, etc. to many rank and-file employees as are supplied to higher-paid employees)

Advantages (to Employers) of Aspects of PPACA

Our clients recognize that with health reform come some potential advantages. When asked to rank them, 37% found the increase in maximum permissible health condition-related wellness incentives/penalties to be the most attractive potential benefit to them, under the PPACA.

Overall, employer's identified the key advantages to be:

37%	The increase in maximum permissible health condition-related wellness incentives/penalties
31%	Insurance exchanges in 2014, as providing a way for their part-time or otherwise non-benefits-eligible employees to purchase subsidized medical coverage
23%	Insurance exchanges in 2014, as providing provide a way for the employer to eliminate pre-65 retiree medical coverage, knowing the retirees will be able to purchase subsidized coverage in an exchange
16%	Insurance exchanges in 2014, as providing a way for the employer to eliminate group health insurance coverage for active employees, knowing they can purchase subsidized medical coverage in an exchange

Increase or Lack Thereof in Administrative Obligations and Responsibilities

When asked if and how the PPACA's new reporting and disclosure obligations will affect their administrative responsibilities, employers across all industries made it clear: Yes,

more than half felt the health reform law will ***significantly*** increase administrative responsibilities.

Lockton further asked employers to quantify the cost each time they issued a new notice to employees that are enrolled in their health plan if the notice, under current federal rules, cannot be distributed electronically. The majority of responses: ***from $1-3 per employee***.

Play or Pay?

In 2014, the "play or pay" mandate (the PPACA refers to it as the "shared responsibility" provision) for employers takes effect. Employers must either offer qualifying and affordable coverage to each full-time employee (defined as an employee working 30 or more hours per week) or risk paying penalties to an insurance exchange. When asked what they would consider doing, here's how employers responded (checking any answer that applied):

44%	Will reduce the employer's subsidy toward employee coverage
43%	Will reduce the employer's subsidy toward dependent coverage
18%	Will consider terminating outright their group health plans, because the penalties payable to the insurance exchanges are far less than the employer's current and anticipated health care spend
17%	Will attempt to avoid penalties by hiring more part-time workers in lieu of full-time employees

What Would You Tell Congress If You Had the Chance?

We asked our clients, "If you could tell Congress one thing about the health reform law, what would it be?" The answers reflect that many are concerned – gravely concerned – about the cost implications of the PPACA. Here is a sampling of answers:

- "I do not believe that they considered the cost of this plan [the PPACA] to the employer in the short term. I think their only consideration was to the employees that do NOT currently have health coverage. Our rates went up an additional 7 - 9% in 2011 because of health reform."
- "Forcing these mandates on employers will lead to many employers currently offering coverage to their employees to terminate coverage offerings due to financial hardship."
- "It will increase our costs that we have to pass on to our employees with little increase in benefit. The mandates will add costs that we cannot control."
- "In the short-run, the provisions of the law are burdensome with little benefit to employer or employee. In the long-run, the law will drastically reduce access to healthcare services and dramatically increase the cost to both the employer and employee."

- "What they are planning is only going to penalize the employers and the employees who actually are hard workers and who are trying to make a living for themselves and not relying on the government to take care of them."
- "We currently provide healthcare coverage to our employees. The current healthcare reform act will do nothing but add cost and add administrative requirements."
- "The reporting requirements are extremely cumbersome and will add administrative burden and cost to our operations."
- "This plan [PPACA] doesn't fix the healthcare problems but shifts the burden to employers to take care of the issue without any type of assistance on covering the increase in costs."

Conclusion

Lockton greatly appreciates the opportunity to appear before you today. In assessing the impact of the health reform legislation, we urge you to place yourselves not only in the shoes of those Americans who need access to affordable insurance, but in the shoes of the employers who supply valued coverage to 160 million of us.

Employers are burdened and frustrated by aspects of the health reform law that add costs to their health plans and will cause some of them to eliminate group coverage and full-time jobs. They are perplexed by a federally-imposed reporting and disclosure scheme that has increased substantially under health reform and become far too cumbersome.

We welcome the opportunity to work with you to mitigate these burdens on the employer community.

Mr. PITTS. The Chair thanks the gentleman and recognizes Mr. Gardiner for 5 minutes for an opening statement.

STATEMENT OF TERRY GARDINER

Mr. GARDINER. Thank you, Mr. Chairman. Good afternoon, Chairman Pitts, and Ranking Member Pallone and members of the subcommittee. My name is Terry Gardiner. I am working with the Small Business Majority, and we are a non-profit national group advocating for small business owners out there. We represent the 28 million small businesses which many of those are self-employed and businesses from 1 to 100 employees. We do scientific opinion polls and economic research to try to understand what the problems and the solutions that small businesses need.

I myself started as a self-employed commercial fisherman for many years in Alaska until I got one of those entrepreneurial ideas to—a bigger company called Silver Lining Seafoods in 1981 and spent the next couple decades as an owner and CEO of that company growing it from start-up to $100 million with a thousand employees selling globally in 22 countries. So I have been through this as many of the other people in Small Business Majority have been of being out there and dealing with healthcare and access to capital and all these issues that all small business owners have to navigate to survive and be successful and create jobs.

So we are well aware that many times there are regulatory burdens, lots of reports to fill out there. I think with healthcare, we have also watched for decades and endured while it only got worse. And so we felt that something has to be done, and there is a legitimate role for government to step in when things are only getting worse, as we have seen over the decades with costs going up and less availability, and over half our small businesses don't even offer anymore.

So when we survey small business owners, what we find is that cost is really the biggest concern. Our research showed an average of 86 percent of small business owners cite cost as their biggest barrier. A major economic study we did found that small employers would pay $2.4 trillion in increased healthcare costs through the next decade if nothing changes. And in fact, we would lose 178,000 jobs and $52 billion in profits with no reform. This is why we have the Affordable Care Act, because that was the status quo. We needed to do something.

One aspect that we are here to talk about today is the medical loss provision, and certainly insurance companies and brokers have a stake in this. You have heard about that, but I think you need remember that employers are paying the bill. Small employers are paying the bill in the small group market. Self-employed people are generally purchasing in the individual market, and all of these dollars and costs we are talking about passed through. And so whether the MLR is effective or not is really going to come out of the bottom line of small businesses, and whatever small businesses pay and more and more cost is really going to reduce their ability to expand their company and create jobs, and if we want small business to continue to create 70 percent of the jobs, then we need to be thinking about this.

So we need to, you know, work out some of these problems. We need to make sure that the MLR is protecting the small businesses because what we hear in meeting after meeting is small business owners standing up saying I got a double-digit increase this year on top of one last year. That should really be our focus. What are we doing about that? You know, in general, these small business owners are paying 18 percent more than the larger business owners. So I think the other thing we are here to talk about today is the rate review, and really what we are talking about here is transparency. As has been pointed out, there is no real hammer of the Federal Government to do anything about it, but again, this is something that, as a small business owner, you never get an explanation of why the premiums have gone up double-digit. You are just told this is the way it is by your broker, and we certainly support brokers. I always used the broker. Everybody I know used brokers. They are an integral part, and we believe they will be a very important part in the exchanges going forward.

But again, somebody has to pay the bill, and if we just continue to shrink and shrink the number of small business owners because of double-digit inflation, that will be a reason, you know, that insurance companies' business shrinks and brokers' business shrinks.

So I would just like to conclude by saying I think these are important parts of overall health reform. We need to get on with the show and implement the exchanges and the tax credits, and if anything expands those tax credits along with these regulatory reforms so we can bring the cost down of health insurance for small businesses.

[The prepared statement of Mr. Gardiner follows:]

STATEMENT FOR THE RECORD

BEFORE HOUSE COMMITTEE ON HEALTH

ON

HEARING ON PPACA'S EFFECTS ON MAINTANING HEALTH COVERAGE AND JOBS: A REVIEW OF THE HEALTH CARE LAW'S REGULATORY BURDEN

JUNE 2, 2011

TERRY GARDINER
VICE PRESIDENT, POLICY & STRATEGY
SMALL BUSINESS MAJORITY

This testimony is submitted in support of the small business perspective on the Patient Protection and Affordable Care Act and its impact on America's 28 million small businesses and the economy as a whole.

Small Business Majority is a national nonpartisan small business advocacy organization founded and run by small business owners and focused on solving the biggest problems facing small businesses today. We represent the 28 million Americans who are self-employed or own businesses of up to 100 employees. Our organization uses scientific opinion and economic research to understand and represent the interests of small businesses.

We are testifying in support of the Affordable Care Act, which will help reduce the cost of insurance and medical care while making coverage affordable, fair and accessible. There is a legitimate role for government in passing laws that address private sector business activity.

That's why passage of the Affordable Care Act was so critical, because small businesses needed relief from the high costs of health insurance. Business owners are pragmatic and bottom-line oriented. Preventing or delaying all regulation that might in some way affect small business would be shortsighted and could actually remove an important tool that can stimulate small business innovation and contain costs. Indeed, our research has shown small business supports government as a facilitator and an arbiter that sets rules of the road.

The effects of legislation on the private sector should be carefully considered as each bill is being debated; not via a blanket one-size-fits-all approach. The first items on small businesses' list of concerns are the need for customers and finding ways to deal with burdensome expenses. In many cases, government can help.

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Our research shows that reforming our broken healthcare system has been and still is one of small business owners' top concerns, and that the majority of small employers believe reform is needed to fix the U.S. economy. It also shows that small businesses support key provisions in the law, specifically ones that help them better afford insurance, such as tax credits and insurance exchanges, and those that contain costs. Controlling skyrocketing costs is essential to ensuring small businesses' ability to obtain high-quality, affordable healthcare for themselves, their families and their employees. Our research also shows that absent reform, these costs would continue to escalate, undermining small businesses' success and our economic recovery. The new law goes a long way toward fixing our broken system and stemming these spiraling costs, while helping to create jobs and stimulate the economy.

Our research, which is discussed in more detail below, shows the impact this legislation will have on small businesses and reveals that small businesses support many provisions in the law, especially those that benefit them immediately, such as the small business tax credits. In July 2010, Small Business Majority partnered with Families USA to determine the number of small businesses eligible for a tax credit on their 2010 tax returns, one of the key provisions of the Affordable Care Act.

- We found that more than 4 million small businesses would be eligible to receive a tax credit for the purchase of employee health insurance in 2010. [1]

We also commissioned a national survey of 619 small business owners to determine their views on the tax credits and insurance exchanges, another crucial provision of the Affordable Care Act for small businesses. The survey, which was released on Jan. 4, 2011, found that:

- Both the tax credits and the exchanges, once they take effect, make small business owners more likely to provide healthcare coverage to their employees;
- One-third of employers who don't offer insurance said they would be more likely to do so because of both the small business tax credits and the insurance exchanges;
- 31% of respondents who currently offer insurance said the tax credits and the exchanges will make them more likely to continue providing coverage. [2]

However, the poll also found that the vast majority of small business owners don't know the tax credits or exchanges exist to help them afford coverage.

As Congress holds hearings critical of the Affordable Care Act, it's important to understand the consequences doing nothing would have had on small businesses and our fragile economy.

- Small businesses wouldn't have$4 billion per year in healthcare tax credits and many small business protections, including a ban on denying coverage for preexisting conditions. This provision will provide much-needed help to many

[1] Families USA and Small Business Majority, A Helping Hand for Small Businesses: Health Insurance Tax Credits, July 2010, http://smallbusinessmajority.org/small-business-research/tax-credit-study.php.
[2] Small Business Majority, Opinion Survey: Small Business Owners' Views on Key Provisions of the Patient Protection and Affordable Care Act, Jan. 4, 2011, http://smallbusinessmajority.org/small-business-research/small-business-healthcare-survey.php.

Americans, including the legions of self-employed individuals—many who currently can't get coverage because of this reason;

- Small businesses would have no ability to pool their buying power through state insurance exchanges, and the various cost controls the ACA puts in place would not exist;
- Tough enforcement measures in the law, which are saving billions in Medicare waste, fraud and abuse, would also not exist. This would result in higher taxes for employers and employees to fund Medicare, and higher taxes mean fewer jobs.

These are just some of the disastrous consequences our healthcare system absent of the Affordable Care Act would have on small businesses—consequences that are too severe on our nation's primary job creators. Small businesses create 70% of new jobs in our country. Spending less on health insurance will help them generate larger profits, which will help speed our journey down the road to economic recovery.

My testimony highlights the issues of greatest importance to small businesses in the Affordable Care Act. It explains what we have learned from our scientific research about both the opinions of small employers and the economic impact of reform on small businesses, including the consequences repealing the Act would have on them and the economy overall. The key issues are:

- Why healthcare costs are killing small businesses and sapping our economic vitality;
- How the ACA is already helping small businesses afford insurance and provide their employees with coverage;
- Small businesses' No. 1 priority: Controlling the skyrocketing cost of health insurance and how the ACA tackles this problem;
- What the price of repeal, dismantling or failing to implement the ACA is for small businesses and the economy;

Healthcare Costs are Killing Small Business and Sapping Our Economic Vitality

National surveys of small business owners consistently show that the cost of health insurance is their biggest overall problem. In fact, the crushing costs of healthcare outranked fuel and energy costs and the weak economy for 78% of small business people polled by the Robert Wood Johnson Foundation in 2008.[3]

Small businesses are at a disadvantage in the marketplace largely because our small numbers make rates higher. According to research supported by the Commonwealth Fund, on average we pay 18% more than big businesses for coverage.[4] Small businesses, including the self-employed, need a level playing field to succeed and continue as the job generators for the U.S. economy.

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[3] Robert Wood Johnson Foundation, Study shows small business owners support health reform, 2008, http://www.rwjf.org/coverage/product.jsp?id=36558.

[4] J Gabel et al, Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii is Up, Wyoming is Down, *Health Affairs*, May/June 2006, http://content.healthaffairs.org/content/25/3/832.full.

We hear stories every day from small business owners who can't get coverage because they've been sick in the past or the health plans they are offered are outrageously priced. Louise Hardaway, a would-be entrepreneur in the pharmaceutical products industry in Nashville, had to give up on starting her own business after just a few months because she couldn't get decent coverage—one company quoted her a $13,000 monthly premium.

Many other businesses maintain coverage for employees, but the cost is taking a bigger and bigger chunk out of their operating budgets. It's common to hear about double-digit premium increases each year, eating into profits and sometimes forcing staff reductions. Small business owner Walt Rowen, owner of Susquehanna Glass Co. in Columbia, PA, was quoted a 160% premium increase from his carrier last year, forcing him to find a new plan. These rising bills frequently force business owners to hack away at the insurance benefit to the point where it's little more than catastrophic coverage. That leaves employees with huge out-of-pocket expenses or a share of the premium they can't afford, forcing them to drop coverage. That concerns Larry Pierson, owner of a mail-order bakery in Santa Cruz, California, who says "the tremendous downside to being uninsured can be instant poverty and bankruptcy, and that's not something my employees deserve."

Small business owners want to offer health coverage, and our surveys show that most of them feel they have a responsibility to do so. Small Business Majority conducted surveys of small business owners in 17 states between December 2008 and August 2009.[5] Our key findings included:

- An average of 67% of respondents said reforming healthcare was urgently needed to fix the U.S. economy;
- An average of 86% of small business owners who don't offer health coverage to their employees said they can't afford to provide it, and an average of 72% of those who do offer it said they are struggling to afford it.

It should be noted that respondents to these surveys included an average of 15% more Republicans (39%) than Democrats (24%), while 27% identified as independent.

The exorbitant cost of insurance means that many small businesses are forced to drop coverage altogether. According to the Kaiser Family Foundation, 54% of businesses with fewer than 10 employees don't offer insurance.[6]

This makes small business employees a significant portion of the uninsured population. Of the 45 million Americans without health insurance in 2007, nearly 23 million were small business owners, employees or their dependents, according to Employee Benefit

[5] Small Business Majority, State Surveys Highlight Small Business Support for Healthcare Reform, August 2009, http://www.smallbusinessmajority.org/small-business-research/opinion-research.php.
[6] Kaiser Family Foundation/HRET, Employer Health Benefits Annual Survey, 2008, http://ehbs.kff.org/2008.html.

Research Institute estimates.[7] And nearly one-third of the uninsured—13 million people—are employees of firms with less than 100 workers.[8]

With staffs of 5, 10 or even 20 people, small businesses are tight-knit organizations. Owners know their employees well and depend on each employee for their businesses' success. They don't want to see their valuable employees wiped out financially by a health problem, or ignore illnesses because they can't afford to go to the doctor.

The Affordable Care Act addresses all these issues and more. Without reform, we will impede our overall economic growth. Small businesses with fewer than 100 employees employ 42% of American workers.[9] Traditionally, small businesses lead the way out of recessions. Continuing to address the healthcare crisis by implementing the Affordable Care Act is essential to our vitality as a nation. A repeal of this landmark legislation would send our primary job creators back into in a broken system that threatens their competitiveness, discourages entrepreneurism and jeopardizes our economic recovery.

The Affordable Care Act Is Already Helping Small Businesses Afford Insurance and Provide Their Employees with Coverage

Our research shows that small business owners are more likely to provide insurance to their employees because of the tax credits and exchanges provided through the new healthcare law. As I mentioned in my introduction, our most recent research includes a national survey of 619 small business owners that was conducted from November 17-22, 2010.[10] We wanted to gauge how entrepreneurs view two critical components of the Affordable Care Act: the small business tax credits—a provision allowing businesses with fewer than 25 employees that have average annual wages under $50,000 to get a tax credit of up to 35% of their health insurance costs beginning in tax year 2010—and health insurance exchanges—online marketplaces where small businesses and individuals can band together to purchase insurance starting in 2014. The survey's key findings include:

- One-third (33%) of employers who don't offer health insurance said they would be more likely to do so because of the small business tax credits;
- 31% of respondents—including 40% of businesses with 3-9 employees—who currently offer insurance said the tax credits will make them more likely to continue providing insurance;
- One-third (33%) of respondents who currently do not offer insurance said the exchange would make them more likely to do so;
- The same is true for those who already offer insurance, with 31% responding that the exchange would make them more likely to do so;

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[7] Employee Benefit Research Institute, Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population, http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3975.

[8] Center for American Progress, What Will Happen to Small Business if Health Care Is Repealed, July 23, 2010, http://www.americanprogress.org/issues/2010/07/small_biz_reform.html.

[9] U.S. Bureau of Census, 2006 County Business Patterns

[10] Small Business Majority, Opinion Survey: Small Business Owners' Views on Key Provisions of the Patient Protection and Affordable Care Act, Jan. 4, 2011, http://smallbusinessmajority.org/small-business-research/small-business-healthcare-survey.php..

- However, most respondents are not familiar with the exchange or the tax credits; only 31% of respondents are familiar with the exchange and 43% are familiar with the tax credits.

We believe that once the public, and small business owners in particular, become more familiar with the new law, they will understand the financial benefits and cost savings it provides. In fact, a Kaiser Family Foundation study conducted in January 2010 found that although the public was divided overall about reform, they became more supportive when told about key provisions. After hearing that tax credits would be available to help small businesses provide coverage to employees, 73% said it made them more supportive, and 63% felt that way after learning that people could no longer be denied coverage because of preexisting conditions.[11]

The huge number of small businesses eligible for a credit on their 2010 tax returns shows how wide-ranging the benefits of the ACA are: Small Business Majority and Families USA's study on the number of small businesses eligible for a tax credit on their 2010 tax returns shows that more than 4 million small businesses are eligible.[12] That equates to 83.7% of all small businesses in the country. Perhaps even more encouraging is that more than 90% of small businesses in 11 states are eligible to receive the tax credits, with nearly 1.2 million small businesses nationally eligible to receive the maximum credit.

A recent RAND Health study also examined the impact of the Affordable Care Act on health insurance coverage for workers at small companies. It found that once the new law takes full effect, the percentage of employers that offer insurance will increase from 57% to 80% for firms with fewer than 50 employees, and from 90% to 98% for firms with 51 to 100 employees.[13] Additionally, a study released Jan. 24, 2011 by the Urban Institute (funded by the Robert Wood Johnson Foundation) also shows the positive benefits of the ACA on America's employers. The study debunks claims that the ACA would erode employer-sponsored coverage by providing incentives for employers to stop offering coverage, or that businesses would face increased costs as a result of reform. To the contrary, the study found that overall employer-sponsored coverage under the ACA would not differ significantly from what coverage would be without reform, but that in fact employer-sponsored insurance premiums will fall noticeably, by nearly 8%, and total spending on healthcare by small businesses will also decrease by nearly 9% because of healthcare exchanges and other provisions of the new law.[14]

Aside from these important provisions, the Affordable Care Act gives small employers the power to keep their plan as long as it was in place before reform was enacted on March 23, 2010. These plans are often referred to as "grandfathered plans."

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[11] Kaiser Family Foundation, Americans Are Divided About Health Reform Proposals Overall, But the Public, Including Critics, Becomes More Supportive When Told About Key Provisions, Jan. 22, 2010, http://www.kff.org/kaiserpolls/kaiserpolls012210nr.cfm.

[12] Families USA and Small Business Majority, A Helping Hand for Small Businesses: Health Insurance Tax Credits, July 2010, http://smallbusinessmajority.org/small-business-research/tax-credit-study.php.

[13] RAND Corporation, "How Will the Affordable Care Act Affect Employee Health Coverage at Small Businesses?" 2010, http://www.rand.org/pubs/research_briefs/RB9557/index1.html.

[14] Urban Institute, "Employer-Sponsored Insurance Under Health Reform: Reports of Its Demise Are Premature," Jan. 24, 2010, http://www.rwjf.org/coverage/product.jsp?id=71749&cid=XEM_749842.

Small businesses are allowed to keep their grandfathered plans as long as they don't make any significant changes in coverage. If any of the following changes are made, the plan can no longer keep its grandfathered status—which means that all the new consumer protections introduced with reform will apply. These changes include:

- Increasing medical costs to employees;
- Reducing the employer contribution;
- Significantly cutting or reducing the plan's benefits; and
- Adding or tightening the annual limit.

This fair, practical approach gives small business owners more flexibility in the wake of healthcare reform, while also including important protections that do impact grandfathered plans. These protections include the extension of dependent coverage to the age of 26, the elimination of lifetime and annual limits, the elimination of preexisting condition exclusions and limits on rescissions.

Analysis after analysis shows that the new healthcare law holds significant promise toward empowering small businesses to provide their employees with health insurance, and to be able to do so without breaking the bank.

Small Businesses' No. 1 Priority: Controlling the Skyrocketing Cost of Health Insurance, and How the Affordable Care Act Tackles this Problem

Small business owners are deeply concerned about the exponentially rising cost of health insurance. As Harvard University economics professor David M. Cutler notes, while family health insurance premiums have increased 80% in the past decade after adjusting for inflation, median income has fallen by 5%.[15] When people have less disposable income to spend at local small businesses, small business owners feel the squeeze.

We know from our opinion surveys that small business owners want reform to lower these skyrocketing costs and believe it will be good for the economy overall.[16] The Affordable Care Act includes many provisions to contain costs. These measures will be felt throughout the entire healthcare system, lowering premium costs to small business owners and consumers alike. The Congressional Budget Office estimates the new law will lower federal deficits by more than $143 billion over the next 10 years, and by more than $1 trillion in the following decade. While there is still more that can be done to contain costs within the system, the new law is a great start. It moves our healthcare system toward greater financial stability and provides improved access to affordable, quality care for small business owners and their employees.

Along with small business tax credits and insurance exchanges, the ACA controls costs by reining in administrative costs for small businesses. As previously noted, small businesses pay 18% more on average than large businesses for comparable health

[15] D Cutler, Repealing Health Care Is a Job Killer, Center for American Progress, 2010, http://www.americanprogress.org/issues/2011/01/jobs_health_repeal.html.
[16] Small Business Majority, State Surveys Highlight Small Business Support for Healthcare Reform, 2009, http://smallbusinessmajority.org/small-business-research/opinion-research.php.

policies. This is largely due to high administrative costs, which can be up to 30% of premiums. The law includes administrative simplification programs, helping to put the country on a path to lower-cost, standardized administrative transactions, processes and forms. It also requires that any premium increase of 10% or more be reviewed by experts, which will help small businesses get relief from the double-digit rate increases they've suffered year after year.

Additionally, the ACA establishes insurer efficiency standards in the form of the Medical Loss Ratio, or MLR. It requires 80% of premium dollars be spent on care, not administrative overhead and executive compensation, for small group and individual plans. For large groups plans, the standard will be 85%. Ensuring the maximum amount of premium dollars go to pay for healthcare instead of administrative costs, the MLR will help keep premiums down so small businesses can save on healthcare-related expenses and invest in their companies. That means more jobs and greater economic growth. Without the MLR, healthcare reform would lack the teeth needed to lower health insurance premiums and hold insurers accountable for unnecessary overhead costs that have nothing to do with medical care and more to do with poor accounting policies and minimal oversight.

The ACA also includes numerous reforms in Medicare that will reward value of care, not the volume of care. It requires the Department of Health and Human Services (HHS) to adopt value-based purchasing and payment methods for Medicare reimbursements for both physicians and hospitals, and move away from the fee-for-service system that is so costly and inefficient. What's more, cost containment measures made to Medicare will have a ripple effect to other areas of the system, further reducing costs. Harvard professor David Cutler points out the steps the Affordable Care Act takes to cut these costs:

- Payment innovations including greater reimbursement for preventive care services and patient-centered primary care; bundled payments for hospital, physician, and other services provided for a single episode of care; shared savings approaches or capitation payments that reward accountable provider groups that assume responsibility for the continuum of a patient's care; and pay-for-performance incentives for Medicare providers;
- An Independent Payment Advisory Board with the authority to make recommendations that reduce cost growth and improve quality in both the Medicare program and the health system as a whole;
- A new Innovation Center within the Centers for Medicare and Medicaid Services, or CMS, charged with streamlining the testing of demonstration and pilot projects in Medicare and rapidly expanding successful models across the program;
- Profiling medical care providers on the basis of cost and quality and making that data available to consumers and insurance plans, and providing relatively low-quality, high-cost providers with financial incentives to improve their care;
- Increased funding for comparative effectiveness research;

- Increased emphasis on wellness and prevention.[17]

Rather than focusing on dismantling healthcare reform, lawmakers should focus on improving it, especially when it comes to cost containment. While the new law is a good start toward fixing our system and strengthening our economy, we should be bolstering it even more by including additional cost containment provisions. This will bring health inflation down and help businesses create more jobs.

What Failing to Move Forward with Reform Would Mean to Small Businesses and the Economy

The shock of failing to move forward with reform would reverberate throughout the U.S. economy. The nonpartisan Congressional Budget Office (CBO) projects repealing the law would add $230 billion over the next 10 years to the federal budget deficit, and more than $1 trillion in the decade to follow. The national debt is already at its limit, and expanding the deficit would only cause additional lack of confidence in our nation's ability to recover from the recession.

When you examine what a failure to implement the reforms would mean financially for America's 28 million small businesses, the picture is even bleaker. In June 2009, Small Business Majority commissioned noted economist and Massachusetts Institute of Technology professor Jonathan Gruber to apply his healthcare economics microsimulation model to the small business sector. He focused on businesses with 100 or fewer employees.[18] Our research showed that without reform:

- Small businesses would pay nearly $2.4 trillion over the next 10 years in healthcare costs for their workers;
- A staggering 178,000 small business jobs, $834 billion in small business wages, and $52.1 in profits would be lost due to these healthcare costs;
- Nearly 1.6 million small business workers would continue to suffer from "job lock," where they are locked in their jobs because they can't find a job with comparable benefits. This represents nearly one in 16 people currently insured by their employers.

In a recent article he wrote for the Center for American Progress, Gruber again addressed the issue of job lock.[19] He noted that "such a system significantly distorts our labor markets by forcing individuals to stay in jobs that offer health insurance rather than to move to newer and more productive positions where coverage is not available. Millions of U.S. workers are not moving to better jobs or starting new businesses because there is nowhere to turn for insurance coverage should they leave their jobs."

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[17] David Cutler, Repealing Health Care Is a Job Killer, Center For American Progress, Jan. 7, 2011, http://www.americanprogress.org/issues/2011/01/jobs_health_repeal.html.
[18] Small Business Majority, The Economic Impact of Healthcare Reform on Small Businesses, July 2009, http://www.smallbusinessmajority.org/small-business-research/economic-research.php.
[19] J Gruber, Be Careful What You Wish For, Repeal of the Affordable Care Act Would Be Harmful to Society and Costly for Our Country, *American Progress*, Jan 2010, http://www.americanprogress.org/issues/2011/01/aca_repeal.html.

The Affordable Care Act remedies this problem and levels the playing field to support entrepreneurs willing to take a risk and start a new enterprise. Insurance reforms provided in the new law protect these entrepreneurs, and the insurance exchanges established by the law allow the self-employed and small businesses to pool together for lower premium rates.

The Center for American Progress has also weighed in on what small businesses would lose if the Affordable Care Act were lost. The percentage of small businesses offering coverage has decreased from 68% in 2000 to 59% in 2007; without the ACA, this downward spiral would continue. Since 40% of small employers spend more than 10% of their payroll on healthcare costs, repealing or dismantling the law would cause those already providing insurance to do so at the expense of increased wages. This would result in less profits, business investment and job creation. Additionally, it would mean small businesses would continue to pay on average 18% more for health insurance than large firms. And they won't get the financial relief tax credits and insurance exchanges will provide.[20]

Healthcare reform will also reduce the "hidden tax" associated with health insurance. Repeal would keep this tax in place. The uninsured often delay treating their health problems until they become severe, and public and charity programs pick up a share. However, a portion remains unpaid. To cover the cost of this uncompensated care, health providers charge higher rates when the insured receive care, and these increases get shifted to consumers and small businesses in the form of higher premiums. This creates a "hidden health tax" that inflates the cost of premiums.[21]

Instead of helping us move forward, repealing or dismantling the ACA would send us back to the status quo and ensure that small businesses will be unable to play their historical role as the country's primary job creators. In fact, Harvard professor David Cutler projects repeal would destroy 250,000 to 400,000 jobs annually over the next decade, increase medical spending by $125 billion by the end of this decade and add nearly $2,000 annually to family insurance premiums.[22] His summary of what repeal would do to the country is as dismal as it is succinct: "It would hurt family incomes, jobs, and economic growth."

Conclusion

Healthcare reform is not an ideological issue; it's an economic one. Small business owners know this, which is why they overwhelmingly support reforming our broken system and containing the skyrocketing cost of insurance.

Without the reforms in the ACA, small businesses will once again be mired in a system that drains their coffers and stunts their growth—disabling them from playing their vitally important role as the nation's jobs creators. We hope Congress will spend its time

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[20] Center for American Progress, What Will Happen to Small Business if Health Care is Repealed, 2010, http://www.americanprogress.org/issues/2010/07/small_biz_reform.html.

[21] Kathleen Stoll and Kim Bailey, Hidden Health Tax: Americans Pay a Premium (Washington: Families USA, May 2009).

[22] D Cutler, Repealing Health Care is a Job Killer, Center for American Progress, 2010. http://www.americanprogress.org/issues/2011/01/jobs_health_repeal.html

focusing on ways to make implementation of the Affordable Care Act as smooth as possible, and on ways of strengthening the productive partnership the private sector can have with government; instead of trying to dismantle it, fix the parts that need improvement. Our small businesses and our economic recovery depend on it.

Mr. PITTS. The Chair thanks the gentleman. That concludes the openings statements. We are presently in a vote on the floor. There are seven votes scheduled, so with the appointment at the White House at 2:00 for the Democratic members, we will recess for questions of this panel until 4:00. If you can stay, we would like to ask that you can do that, and we will recognize the ranking member, who wants to express himself.

Mr. PALLONE. Well, Mr. Chairman, I mean, you know, this is the same thing that I said at the beginning. I told you so, I think the way we are proceeding is just not good. I mean, there is almost nobody here other than, you know, the three of us and I see that we were joined by one colleague on either side of the aisle, but I just think that most of the members have been discouraged from being here because the panel has now spoken, the questions are going to come later, we are going to have a second panel after that. I don't know what time. And I don't know what you are supposed to do now. I guess you have no choice.

But I just want to again object to the fact that we are proceeding this way. I think it is not good for the witnesses because they have to wait around for us to come back 4 hours later, and the result is that the members are not here to participate. So I don't know what to say. I mean, I keep saying the same thing over and over again. I just hope this is the last time that we proceed in this way because it is just not conducive to a good debate, frankly.

Mr. PITTS. I regret it is unfortunate we have to postpone the hearing. We will make a call to all the members to be back in 3 hours at 4:00 and ask the indulgence of the witnesses if they can return at that time.

Mr. PALLONE. Mr. Chairman, can I ask what we are going to do about the second panel?

Mr. PITTS. I think perhaps on the second panel we are going to have to delay the second panel for another day.

Mr. PALLONE. Well, again, I don't see why if he—

Mr. PITTS. He is limited on his time constraints at the end of the day.

Mr. PALLONE. I understand that, but we knew that from the beginning and now we are going to end up having the hearing when we come back after recess. My original request was that we postpone it until then anyway. So now we are going to have to postpone it. It just seems like the whole thing could have been handled better. We could have just had it when we came back, and everything would have been straight through and members would have been here. Now we are going to have a second hearing when we come back. I just, you know—it just seems like—let us just hope that this doesn't happen again.

Mr. PITTS. Unfortunately, we have got to work around the President's schedule, and I regret that. But we will reconvene. We will recess until 4:00.

[Recess.]

Mr. PITTS. The subcommittee will come to order, and I will now begin questioning and recognize myself for 5 minutes for that purpose.

Let me start with Ms. Trautwein. You talked about the dire situation facing brokers across the country. Do you believe the reduc-

tion in income and employment for agents and brokers as a result of the MLR rule will make more Americans dependent on Medicaid and the health coverage subsidies from PPACA? If so, would you elaborate?

Ms. TRAUTWEIN. Yes, thank you. Well, certainly as I testified earlier, if you look at what the average income of agents and brokers are today already, it is easy to see that many of them would be in the category where they would, if they were not insured through an employer-sponsored plan, already be eligible for subsidies and certainly with a reduction of 20 to 50 percent, that absolutely would put many of them down into the Medicaid levels, particularly when you consider the expansion of Medicaid that is associated with the law.

So yes, I would say that many of them probably, no doubt would definitely qualify for subsidies, and many of them would also qualify for Medicaid if this is not turned around.

Mr. PITTS. Now, some argue that insurance agents add no value to the system and are simply overhead in the system that can be eliminated at the stroke of a pen or regulation. Elaborate a little bit on the role agents play in the healthcare system please.

Ms. TRAUTWEIN. Well, the first thing I would like to say there is that, you know, agents and brokers have been used for 100 years to help people purchase health insurance coverage, and they have been used by insurance carriers for a reason, and it is because it is efficient. And from time to time, and I have been in the industry 30 years, I have seen carriers say look, we are going to try to get lean and mean here, and we are going to use our own people. And invariably it doesn't last very long. Usually it is a year or less, and they are back to using agents and brokers because it is more efficient, because they get a larger number of people enrolled, and they are able to do it at a lower cost.

Then you have the service aspect which I talked about earlier, and I gave you one example. But those types of things happen all the time, every sort of claims situation that you can imagine. And this is all at a time when it is taking much more time for them to do their jobs because they have so many questions about the new law, particularly from their employer clients, and for their small employers, they often serve as their HR department. You would be surprised all the things that they actually do.

Mr. PITTS. Thank you. On the issue of fraud, Ms. Reichel, a "60 Minutes" episode last year pegged the amount of fraud and abuse in the Medicare program at more than $60 billion a year. Some have estimated that it might be closer to 100 billion. Do you agree? Does anyone disagree that the amount of fraud and abuse in the Medicare program could be as high as $60 billion as "60 Minutes" reported?

Ms. REICHEL. I have seen that number on the "60 Minutes" report, yes, and I know that that is accurately what they have reported.

Mr. PITTS. Now using that small number of 60 billion that is about 12 percent of Medicare spending per year. Using the higher number of 100 billion, the percentage is about 21 percent. Would a private plan be able to stand—12 percent or 21 percent of its claims were a result of fraud and abuse?

Ms. REICHEL. I think it would be quite difficult for them.

Mr. PITTS. Will the MLR rule hinder Plans' ability to stop fraud before it happens and if Plans are forced to pay more fraudulent payments, will premiums increase?

Ms. REICHEL. You know, that is really an excellent question. The way the MLR is structured, Plans are not going to be able to get credit for preventing fraud. Fraud prevention activities are categorically excluded from the medical loss ratio, and the only thing that Plans can get credit for is the dollar amount that they have actually recovered after the payments have already been made and services that are potentially fraudulent have already been rendered.

Mr. PITTS. I only have 30 seconds left, but Dr. Harrington, I watched your reaction when someone else was testifying about the excess profits. Would you care to comment on your reaction to the testimony of the excess profits insurance companies make?

Mr. HARRINGTON. Two quick things, I think. Whenever I look at profits, I tend to look at profit margins because this is a big country with a big industry, and if you look at dollar amounts, they can be big dollars on a small percentage of total premiums.

I apologize for my reaction. My reaction was really to the issue of insurance companies' allegedly holding all this capital in excess of what is required by regulation. I have done a lot of work on insurance company capital requirements, regulatory requirements are the very bare minimum to keep regulators from taking over the company, and to me it really makes no sense to start comparing the amount of capital the company holds compared to that regulatory requirement as some measure of how much money it could disperse to—the leadings health insurers typically have financial strength ratings from rating agencies in the neighborhood of A to A-minus. They are not A-plus, they are not A-plus-plus. So certainly the rating agencies that are evaluating their solvency do not regard the amount of capital they are holding as excessive relative to their responsibility to meet unforeseen contingencies to their policyholders.

Mr. PITTS. Thank you. My time is expired. The Chair recognizes the ranking member, Mr. Pallone, for 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman. I want to ask Mr. Rome, your testimony notes that from 1999 to 2009 health insurance companies raised premiums 131 percent, three times the growth of wages and four times the rate of overall inflation. One of the regulations that Republicans are attacking here today is the so-called rate review regulation, which I think requires very little of health insurers. It only asks that they provide a justification to HHS for any premium increase of 10 percent more. Insurance companies with that amount of rate increase will be identified on a public Web site. It seems to me that this is the least we can do to try to stop excessive premium increases. So I just wanted to ask you, what more can you tell us about the state of profitability of the insurance industry today? Is rate review going to be an impossibly onerous burden for the insurance companies to meet? Have you seen an impact from rate review on premiums in any States in which it has been implemented so far?

Mr. ROME. Rate review does a couple of very important things. One is it brings transparency to this process, and if insurance companies are selling a good product with good rates—there ought to be no problem taking a close look at. Rate review, which just today the California Assembly passed and it—Senate, the good example there is auto insurance. They have had rate reviews since—prior rate approval, there is a robust and competitive market. But it has brought down rates. In just the last year-and-a-half, aggressive intervention by regulators has reduced rates in multiple places with health insurance. And so anytime you see rates getting reduced in Massachusetts from 18 to 10 percent, et cetera, you know that those rates have some room, and regulation helps find it.

Mr. PALLONE. The second question was mentioned I think or someone said that Aetna recently announced in Connecticut they will reduce premiums in the individual market there by 5 to 20 percent or 10 percent on average beginning in September. That is certain a welcome change to hear premiums go down instead of up.

But are you aware of why Aetna of Connecticut reduced its premium? And I know your testimony talks about large insurers having a significant amount of built-up reserves, so they should be able to afford some premium reductions. Is that what is happening with Aetna of Connecticut or is there some similar actions in the near future that we might see form other insurers?

Mr. ROME. Aetna is an example of the MLR in action. In order to avoid paying the rebate that they would have been required to pay as a consequence of not meeting their MLR target, they lowered rates. And they wouldn't have lowered rates if they weren't in a position to do so.

Mr. PALLONE. OK, and are we likely to see that with other insurers?

Mr. ROME. I think so, and I think what is important is that while we along with others point out the importance, $2 billion in rebates could come to consumers. The fact is that the MLR is not designed to produce rebates. It is designed to more—industry and lower premiums.

Mr. PALLONE. All right. Mr. Gardiner, I think I have time to ask you a question. As you know, the experience of small business with unrelenting health insurance rate increases is not surprising nor uncommon. Since 2000, premiums from employer-sponsored insurance have grown three times as fast as wages. These increases are crippling America's small businesses in my opinion, not health reform.

Over half of the small businesses in the country can't afford to offer health benefits to their employees which means the majority of uninsured Americans are small business owners, their employees or their families. In your testimony you talk about a small business owner who was quoted 160 percent premium increase from his carrier last year forcing him to change plans. So my question is can you talk about how different insurance reforms and the exchanges, you know, in the Affordable Care Act, will help lower premium increases over time, with regard to small businesses?

Mr. GARDINER. I think that one of the special problems that small businesses have faced, while everybody sees medical costs, premium costs, going up in the country and it is very well docu-

mented—small businesses are much more subject to a very much annual volatility. You know, every time we have a meeting, there is always somebody standing up talking about what their premium went up and other people chiming in. And a lot of times they can't even find out why their premium went up. And you know, we talk about people in the small group market. It is even more volatile if you are self-employed. If you are one of 22 million self-employed, you experience even more premium volatility. And I think we are not really going to see that premium volatility come down until the exchanges are up—and combined with the insurance reforms. At that point we are going to see an ability to level them out.

So I think the main thing we hear from small business owners, can we get these exchanges going sooner because, you know, we are going to have to bring those elements together of the exchanges and the insurance reforms before we will decrease that volatility on a year-to-year basis.

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

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

Mr. CASSIDY. By the way, I enjoyed all the time we had together. Now I am intrigued that you brought up Massachusetts, because frankly, Massachusetts concerns me. If you will, that appears to be the prequel, as someone described it, the beta version of Obamacare. Massachusetts appears to be the prequel or beta version of Obamacare. And their small group market has the highest premiums in the Nation. Now, they started off with an uninsured rate of about 10 percent. Now it is about 4 percent. And the economic drag or something has been incredible. Maybe it is not this, but they have actually had a negative—I did see that they had a crackdown on their MLR, but those are non-profit insurance companies. If you talk to the providers and the insurance companies, they say effectively, this is like the Soviet Union, that they are being ignored in terms of their true expenses. It is just arbitrarily being decreased. Clearly you disagree with that, so I just would like your response to those kind of ascertations.

Mr. ROME. I mean, I don't want to spend a lot of time on Massachusetts itself because I was citing it as an example of rate reductions that have come about because of prior rate approval or because of insurance regulators stepping in.

And so you see that in multiple cases. Certainly California had very large rate increases, 39 percent that went to 14 percent in 2009, looking at North Dakota recently, 27——

Mr. CASSIDY. Can I ask you then, knowing that those exist but obviously we may differ in terms of it, I am also concerned, I am still a practicing physician in a public hospital, and it has always been my observation that politicians overpromise and underfund. And there is this populace pressure to do something about climbing premiums. Do you see any risk that in the future some DHH secretary, whatever she is secretary, will say no, thou shalt not increase your premium. We are going to disregard this cost structure because frankly, it is a political pressure. It is the year before presidential reelection, for example, and there is—increase. Do you see no risk in that?

Mr. ROME. I don't see any risk in that because there isn't any demonstrate that that has occurred to date. There is 22 States that have prior rate approval. I mentioned the California example of auto——

Mr. CASSIDY. Now, wait a second. I think we can look at property and casualty rates in Florida and see that there was a political response to something which, you know, people objected. You are raising our premiums. The actuaries for the P&C companies said no, this is reasonable. We have huge exposure here.

Now, you may argue whether Citizens in Florida was a good thing or a bad thing, but clearly, that was a political response to an outcry which actuaries say is fiscally unsound. So there does seem to be precedent for this.

Mr. ROME. Again, I don't think that there is any significant precedent. What there is is a substantial history of regulators taking, whether it is on both sides of the aisle, taking a cool look at rate hike requests and making judgments based on the merits.

Mr. CASSIDY. Let me ask you——

Mr. ROME. It is an important——

Mr. CASSIDY. I have limited time, so I am sorry to be rude. Dr. Harrington, you see where I am going with my line of questioning. What are your observations?

Mr. HARRINGTON. We haven't had detailed statistical analyses of the relationship between regulation and health insurance and performance metrics like—and the like.

There have been dozens of studies of the impact of rate regulation and workers' compensation insurance and automobile insurance. You can have environments where an insurance company is in an environment of rapid claim cost growth will ask for 10 or 15 percent in a politicized environment. Maybe they can negotiate a rate increase of 8 or 9 percent. That can go on for a period of time. It reduces the company's incentive to write new business. It reduces their incentive to provide good quality. It reduces their financial strength. But it cannot persist.

The studies that have looked at long periods of time show that basically there is no difference by type of regulation in these markets, automobile and homeowners' insurance. Now, I can't attest to that in health insurance because people haven't looked at the data, but I don't think you can look at anecdotes for what happened in Massachusetts, for example, because in the short run, companies will take a rate increase less than the actuarial projection if the alternative is enormous legal fees—or having to leave a marketplace.

I would also just like to say we need to keep our facts straight. The California situation was highly publicized. Thirty-nine percent was touted all over. The weighted average increase was 25 percent. It eventually was only 14 percent, and there was—dispute about the numbers and so on. But it is not right to compare 39 percent to 14 percent, and it is also not right to assume as I said in a particular year if you get a lower rate increase because of some regulatory action, that that is really consistent with the underlying cost of the business in the long run viability of the company.

Mr. CASSIDY. Thank you very much. I am out of time almost. I yield back.

Mr. PITTS. The Chair thanks the gentleman and recognizes the gentleman from California, Mr. Waxman, for 5 minutes for questions.

Mr. WAXMAN. Thank you, Mr. Chairman. Ms. Hayes, Republicans have repeatedly claimed that the administration's rule on grandfathering plans will lead to people losing their plans. Is that true?

Ms. HAYES. Is it true that Republicans have claimed that? Is that the question? I am sorry.

Mr. WAXMAN. No.

Ms. HAYES. Is it true that they will actually lose their plans? No, Mr. Chairman. I am sorry, Mr. Chairman. That was a slip.

Mr. WAXMAN. I won't hold it against you.

Ms. HAYES. OK. And I apologize, Mr. Pitts, for that slip. No, the grandfather rules were established to provide a transition for health insurance, and first of all, you know, starting with the premise that an individual can keep their health insurance, with all due respect to the administration, is a false premise to begin with because any day an insurance plan could decide that they are no longer going to offer it in that market. And it is not so much that an individual I believe is so much attached to an insurance policy to begin with or an insurance carrier in particular, they are worried about whether or not they can continue to see their healthcare providers, they are worried about whether or not it is affordable, they are worried about what benefits are covered.

And under the grandfather rules, plans are required to meet—but frankly, if the plans change their policy so that they no longer meet the grandfather provisions, that is not the same policy anymore, either, because if they are losing grandfather status, they have made a significant change in their benefits. There has been a significant increase in cost sharing for beneficiaries, there has been a reduction in benefit coverage generally.

So the grandfather rule protects individuals and they can continue to keep the plans they have so long as the carriers keep the same——

Mr. WAXMAN. Right. Would you say employers won't drop coverage just because they may not qualify as for the grandfather?

Ms. HAYES. Oh, absolutely not. I think clearly every employer group that I have heard has said that they want to continue to offer healthcare benefits because it is an important tool for recruiting and retaining personnel. At the same time, there are provisions in the Affordable Care Act.

Mr. WAXMAN. Let me move on to some others in the limited time I have——

Ms. HAYES. Sure.

Mr. WAXMAN [continuing]. Because I wanted to ask Mr. Gardiner, Republicans continue to say, and this isn't a question of whether they continue to say it, I am asserting that they have said over and over again that the Affordable Care Act will cost small employers too much. However, we know this is not the case. The ACA contains multiple provisions in directly at reducing healthcare costs for small businesses and ensuring the small businesses, their employees will have access to affordable and quality health insurance. In your testimony you discuss some very important provisions

that are already helping millions of small businesses. For example, you talked about the small business tax credit that offers a credit of up to 35 percent of their health insurance costs. Four million small businesses—with the small business tax credit, and early evidence suggests that many are already benefitting from it. According to a survey by the Kaiser Family Foundation, the percentage of small employers offering health coverage has risen from 46 percent in 2009 to 59 percent in 2010, in part due to the reform's new tax credit. Can you please elaborate on how the healthcare tax credit for small business is helping create jobs and health security?

Mr. GARDINER. The direct linkage between the healthcare tax credit and any tax credit is that the more money is flung into the treasury of a small business, then they have more money to invest—for jobs is the fact that over the last decade 70 percent of the net new jobs have come from small business, and you know, there is a lot of other industries out there, and they invest in a lot of mergers and acquisitions and increased dividends and go offshore and everything. But really, you know, small businesses are there because somebody was an entrepreneur—that, and they pour their lives and their money back into growing their business.

So when we say that they can get a 35 percent tax credit that is going to reduce their cost, that is going to stay, you know, in the treasury of their company, and they are going to be looking at how to expand their business. And very much like this is last year Congress provided the tax equity for self-employed, the 22 million self-employed, which reduced their cost when they purchase healthcare by 15.3 percent. And we should keep that in mind as one of the benefits of the overall health reform that needs to be retained also.

Mr. WAXMAN. I see my time is expired.

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, and good afternoon to the panel. A similar vein of questioning as suggested by Mr. Waxman, Mr. Fensholt, in your testimony you state that many of your clients may lose their grandfathered status, due even to modest or routine changes, and I would like to suggest several examples and if you would comment on them please, sir.

Mr. FENSHOLT. Sure.

Mr. LANCE. A plan increases co-insurance from 5 percent to 6 percent, and a family believes the plan still provides good value for the family. In your judgment, would the plan remain grandfathered and could the family keep that type of plan?

Mr. FENSHOLT. Well, the plan loses grandfathered status, and the issue in my space, in the middle market, large market, is that when a plan loses that grandfathered protection, additional benefit mandates and requirements drop down on top of that plan, and those carry costs. And so the problem as we see it with the grandfathered rule, it is—grandfathered rule, very modest changes. I think here is where Ms. Hayes and I part company. It does not take a significant change in plan design.

Mr. LANCE. So for example, another situation, a co-pay is increased for prescription drugs from $5 to $10 or perhaps an owner asks her employees to increase their share of health premiums

from 2 percent to 8 percent. In your judgment, what would happen in those situations?

Mr. FENSHOLT. In those situations, the plan loses grandfathered protection. The additional mandate dropped down the plan. The plan incurs the additional cost.

Mr. LANCE. Thank you very much. Ms. Reichel, in your testimony you mentioned that the administrative and regulatory burdens of the medical loss ratio requirements will put significant challenges to employers and health plans.

In New Jersey where I live, there is a history of administering MLRs and overseeing administrative rebates, although one—PPACA, we have the situation but not as strict as PPACA. I would be interested in your thoughts on what effects the stricter MLR and would a State like New Jersey's insurance market be challenged in this regard, recognizing that what we have in New Jersey is not as strict as what is in PPACA.

Ms. REICHEL. What is in the ACA now I think is going to be a real burden on small businesses, and here is why we think that. Assume if you will that there is going to be a rebate owed to a small business. The insurance company has to do much more than simply determine that a rebate is owed to the employer and provide that back to the employer. What the small employer now, and large employer, too, needs to do in order to get that is to provide data to the insurance company that all the premiums that the employer has paid, he needs to determine what the premiums are that the individuals he employs pays. He also has to determine what the percentage of the rebate is coming back to the employee, and he has to provide documentation to the insurance company that he actually gave—so the reporting requirements on small employers is much greater than it ever was before.

Mr. LANCE. And as a follow-up to that, what if a State has never had to deal with the MLR? It seems to me it might face an even more significant effect on this market?

Ms. REICHEL. I would think that that would be absolutely true, not only from the small employer but also from the carrier point of view where a State that has no MLR currently in effect, effectively what the companies are doing, he is going from zero to 60 immediately, or I guess zero to 80 or 85 overnight.

If the State has no medical loss ratio now, then it, in effect at the federal level for policies that were in effect before the statute was effectively signed. So there is a retroactive application of the medical loss ratio. In a State where there hasn't been an MLR, I think that that climb is really steep for the carriers.

Mr. LANCE. Thank you. I conclude from the questioning and from the testimony that it is unlikely that the President's promise that Americans can keep their health plan if they like it is not accurate, and I think we have to move in the direction to making that possible in the greatest number of situations.

Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman. We will begin a second round of questioning here. Mr. Fensholt, in your testimony you state that employers' biggest concern about PPACA is the massive administrative burden imposed by the law. Do you believe that the healthcare law's administrative burden is merely a short-term

issue for employers as the law's implementation has begun or will the law present additional administrative headaches for job creators down the road?

Mr. FENSHOLT. Oh, it will definitely be the latter, Mr. Chairman. This is an ongoing trend at the federal level with regard to health insurance and the administrative burdens. There are federal rules put on plan sponsors, and I might add, by 2014, for example, employers are not only going to have to comply with the panoply of existing obligations but they will begin reporting to the insurance exchanges the various levels of coverage they are offering their employees, what they are charging for it, who is eligible for it, who is enrolled in it and do this on a regular basis, along with a variety of other reports and obligations.

The irony about these reporting and disclosure obligations is that if you look at any one of them individually, they may not appear all that onerous. But in the aggregate, none of these obligations is a sword thrust to the heart. But in the aggregate, you are asking an employer to supply more than 50 disclosures, notices and reports to the Federal Government. I mean, over time this is death by 1,000 cuts to employers. And I will tell you, sir, that we have clients who are at the end of their rope. Their view is this is just becoming too hard, too complicated. The—of the axe hanging over our head is too severe. We are not going to want to do this much longer. And rather than making that burden easier, health reform makes it harder, more complicated and more cumbersome.

Mr. PITTS. Thank you. Ms. Hayes, in a December 14 editorial, Secretary Sebelius and Attorney General Holder wrote, "It is essential that everyone have coverage. Imagine what would happen if everyone waited to buy car insurance until after they got in an accident. Premiums would skyrocket, coverage would be unaffordable and responsible drivers would be priced out the market." Yes or no, do you agree with Secretary Sebelius and the Attorney General that if the individual mandate is unconstitutional, would premiums skyrocket?

Ms. HAYES. If it is struck down, would premiums skyrocket? I believe that if the individual mandate were not a part of this law, it would be more difficult for insurers to continue to operate, yes.

Mr. PITTS. So it is fair to say that you believe that if the individual mandate were not in the bill, that would impact other parts of the law?

Ms. HAYES. Yes.

Mr. PITTS. Anyone. Medicare's plan to prevent fraud and abuse has often been described as a pay-and-chase model. Can anyone describe how pay-and-chase anti-fraud efforts work? Ms. Reichel?

Ms. REICHEL. I have seen people looking down at my end of the table. What pay-and-chase means is that once a service has been provided, the bill has been sent to the insurance company, the insurance company has paid it, there is a retroactive application if you would or an attempt to get the money back that somebody finds out after the fact has been provided fraudulently for a service that didn't occur, for a service that shouldn't have occurred, so somebody who wasn't there. That is pretty much what a pay-and-chase is as opposed to preventing the fraud from occurring in the first instance.

Mr. PITTS. All right. I am going to at this time yield 5 minutes to the ranking member for his questions because we are voting.

Mr. PALLONE. Thank you. Have we started the vote?

Mr. PITTS. Yes.

Mr. PALLONE. OK. I will try to be quick. I wanted to ask Ms. Hayes about the waivers. You know, Republicans, they spend a lot of time complaining about the inequities in the waiver process for annual limit requirements. They have made allegations that favored political allies of the democratic party, particularly unions who were being exempted from all the health reform bills, consumer protections and insurance regulations. And I think these claims have been wildly—they need a lot of consideration here, but for instance, union plans were more than five times more likely to be rejected for annual limit waivers than were other kinds of applicants—for annual limits of policies affect only a small number of people and are just one consumer protection of the law.

Your testimony describes the waivers as a kind of transitional policy from today's world to a much more rational insurance regime in 2014. Would you just elaborate on that a little bit?

Ms. HAYES. Yes, sir. I have seen no evidence to suggest that the administration is granting favors to anyone when it comes to waivers. Clearly, Congress anticipated and were warned during debate that there were going to be transitional issues, and that is built into the law itself. So I don't find it particularly surprising that waivers have had to be granted and particularly in the area of some of the mini-med plans that you have seen out there which I don't think anyone would argue are allies of the current administration.

Mr. PALLONE. All right. Thank you. I want to ask Mr. Gardiner and Mr. Rome, this is about the Affordable Care Act creating jobs because I obviously believe that it creates hundreds of thousands of jobs. But the opponents make strong claims that the law will kill jobs. They argue that requiring employers to offer health insurance and to improve their benefits will increase cost of labor. I don't think that is true because I think the ACA is in fact helping to create thousands of jobs in the public and private healthcare sectors.

In June 2010 funds were allocated to train more than 16,000 new primary care providers including physicians, nurses. It seems logical that the newly insured 30 million people will need doctors, nurses and other healthcare personnel to meet their medical needs. I know that the Republicans have said that the country may not have enough doctors and hospitals to serve these people, but the answer to that is to grow the workforce to create more jobs.

So I just wanted you to comment, one or both of you. Can you describe for us how the ACA is a job creator, not a job killer, and talk about some of the other factors, just to comment on that. I will start with Mr. Rome, I guess.

Mr. ROME. OK. I would just say two things before Mr. Gardiner. I mean, one is that one of the best things that we can do to help create jobs is reduce the expenses that employers face, and reducing healthcare costs is an important and significant part of that. And that is why the MLR, for example, which makes insurance more efficient and more affordable is an incredibly important part of job creation.

The second thing is when we do talk about medical personnel, simple example. Over the next 10 years, community health centers are going to go from treating 20 to 40 million people, and that is a substantial change in treatment, and that will obviously create jobs in the health sector, as just one example.

Mr. PALLONE. Mr. Gardiner?

Mr. GARDINER. Where we start from is what if we don't have healthcare reform? That is what we see as the job killer, and that was the study that we had done by MIT to start with. So we start from the premise if we don't do something about the ever-escalating, we are going to lose jobs. And we documented that as 178,000 jobs, but I think that is a very conservative number. But if we go forward with health reform and reduce costs, then firms can invest that money. And in fact, the other part that we have to look at is job loss. You have got 42 million employees at small firms under 100 employees, and it has been well-documented in the literature out there that people can't leave because they are worried about getting the benefit. Of course, this would be any size firm because they don't know if they are going to have healthcare where they go, especially when we have half of the small employers not providing it, and that is a shrinking base.

So employees can't move. They are unhappy. Everybody who has been an employer knows that that is not a good thing, that when an employee wants to move, they ought to be able to move. But it also applies to people starting companies, entrepreneurs. Why is somebody going to take the risk to leave a good job with good benefits and go out there and be a self-employed person, a start-up company, and then find out how expensive and how unattainable healthcare might be for them. So there are several ways that having healthcare available and having it more affordable and less volatile is going to help small businesses grow and make it easier for people to start companies.

Mr. PALLONE. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman. That concludes our first panel. The Chair thanks the witnesses for their testimony, for their patience. Despite the interruption, it was an excellent panel, excellent testimony.

The subcommittee will take testimony from the second panel at a date to be determined. The subcommittee is now in recess.

[Whereupon, at 5:17 p.m., the subcommittee was recessed.]

PPACA'S EFFECTS ON MAINTAINING HEALTH COVERAGE AND JOBS: A REVIEW OF THE HEALTH CARE LAW'S REGULATORY BURDEN—DAY 2

WEDNESDAY, JUNE 15, 2011

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

The subcommittee met, pursuant to call, at 3:00 p.m., in Room 2322, Rayburn House Office Building, Hon. Michael C. Burgess presiding.

Present: Representatives Burgess, Rogers, Gingrey, Latta, Cassidy, Guthrie, Pallone, Towns, Capps, and Waxman (ex officio).

Staff present: Brenda Destro, Professional Staff Member, Health; Paul Edattel, Professional Staff Member, Health; Julie Goon, Health Policy Advisor; Jeff Mortier, Professional Staff Member; Katie Novaria, Legislative Clerk; Debbee Keller, Press Secretary; Alli Corr, Minority Policy Analyst; Tim Gronniger, Minority Senior Professional Staff Member; Purvee Kempf, Minority Senior Counsel; Karen Lightfoot, Minority Communications Director and Senior Policy Advisor; Karen Nelson, Minority Deputy Committee Staff Director for Health; and Mitch Smiley, Minority Assistant Clerk.

Mr. BURGESS. The committee will come to order. This is a continuation of a hearing that actually began 2 weeks ago. The opening statements have already been given by the members on the committee, and so today we will conduct our hearing on the regulatory burden of the Patient Protection and Affordable Care Act.

We do welcome our only witness today, Steve Larsen, certainly no stranger to the committee. We welcome you back, sir. We are always glad to have you.

He is the Director of Consumer Information and Insurance Oversight for the Centers for Medicare and Medicaid Services.

Once again, we want to thank Mr. Larsen for agreeing to appear before our committee and the willingness to accommodate changes in schedule. We understand you, sir, have some other considerations today. There is likely to be a set of votes on the House floor sooner rather than later.

So with that, why don't we proceed directly to your opening statement in the interest of time.

STATEMENT OF STEVE LARSEN, DIRECTOR, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Mr. LARSEN. Thank you, Mr. Chairman, Ranking Member Pallone, members of the subcommittee. Thank you for the opportunity to discuss CCIIO's progress in implementing the Affordable Care Act, and I have submitted my full written statement for the record.

I am pleased to have the opportunity to describe the new programs that CCIIO has implemented under the ACA, programs that have been implemented in an open, transparent and balanced manner.

When fully implemented in 2014, the ACA will expand access to affordable quality coverage to over 30 million Americans. By increasing competition among private health insurers and reducing barriers to coverage, individuals will have coverage when they need it most. In the meantime, the reforms in the Affordable Care Act we have already implemented provide a critical foundation of patients' rights in the private health insurance market. Now, for example, consumers can get better information about available health care options in their State on healthcare.gov, and based on provisions which allow dependents under age 26 to have coverage under their parents' policies, over 600,000 young adults now have access to care.

CMS has worked to manage different statutory implementation schedules for these and other provisions, while still seeking, considering and accommodating public input and comment. CCIIO received and considered input from consumers, industry, States and other stakeholders through formal requests for comment and, in some cases, public forums, as we prepared our regulations implementing these programs.

Importantly, in each regulation issued, we seek to secure the protections intended by Congress in the most economically efficient manner possible, and we undertake a careful balancing of costs and benefits and examine regulatory alternatives.

As a result of these processes and the feedback received by CMS, the regulations that we have issued to implement the Affordable Care Act have been strengthened by the views and opinions expressed by stakeholders and, again, reflect a balanced approach to implementation.

For example, CMS issued the final rate review regulation in May after reviewing and considering more than 60 comments received on the proposed rule issued in December. The final rule includes several changes to the proposed rule that reflect the comments that we received. For example, based on public input, the final rule clarifies that CMS will work actively with States to develop State-specific thresholds beginning in September 2012 for the rate-review process, and this ensures that the rate-review process is based on the insurance and health care cost trends in each particular State.

We also extended the startup date for the new rate-review process until September. We also modified the requirements for what constitutes an effective rate-review process in the States based on comments that we received from the industry and State regulators.

Another program that reflects our balanced approach to implementation is the medical loss ratio regulation. In order to ensure consumers receive value for their premium dollars, the ACA establishes minimum standards for spending by insurance companies on clinical services and quality-improvement activities for their members. In December of 2010, we published an interim final regulation with the 60-day comment period implementing the MLR provisions of the ACA.

The interim final regulations certified and adopted the recommendations submitted to the Secretary by NAIC. And, importantly, the NAIC process included significant input from the public, from States and other key stakeholders, and was widely praised for its openness and transparency.

The MLR regulation we issued struck a balance among the interests of many affected groups and took into account the potential costs and benefits of the regulation on affected parties. Some of the provisions that may have been burdensome on small plans or new health plans were modified, and pursuant to specific provisions in the ACA, we established a process to allow States to seek a modification to the MLR standard in the individual market in order to allow an orderly transition for health plans to the new MLR standards. And this process provides flexibility to the States in how they implement the ACA.

In implementing the provisions of the Affordable Care Act in the future, CCIIO will continue to work closely with all interested stakeholders and to use the transparency of the regulatory process to ensure the new law serves the American people in an economically efficient manner.

We are proud of all that we have accomplished over the last year and look forward to 2014 when Americans will have access to more affordable comprehensive health insurance plans. And thank you for the opportunity to discuss the work that CCIIO has been doing to implement the Affordable Care Act.

Mr. BURGESS. Thank you, Mr. Larsen, for your testimony.

[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

PPACA'S EFFECTS ON MAINTAINING HEALTH COVERAGE AND JOBS: A REVIEW OF THE HEALTH CARE LAW'S REGULATORY BURDEN

BEFORE THE

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

JUNE 2, 2011

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

House Committee on Energy & Commerce, Subcommittee on Health

Hearing on "PPACA's Effects on Maintaining Health Coverage and Jobs: A Review of the Health Care Law's Regulatory Burden"

June 2, 2011

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee, thank you for the opportunity to discuss the Center for Consumer Information & Insurance Oversight (CCIIO)'s efforts to implement 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. I serve as Deputy Administrator and Director of CCIIO within the Centers for Medicare & Medicaid Services (CMS).

The Affordable Care Act expands access to affordable, quality 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 market reforms including eliminating most pre-existing condition exclusions for children, eliminating lifetime dollar limits on essential health benefits, prohibiting insurance companies from rescinding coverage absent fraud or intentional misrepresentation of material fact and enabling many dependent young adult children to stay on their parent's insurance plan up to age 26.

CCIIO has undertaken other efforts that include helping consumers access information about their rights and coverage options; ensuring compliance with new insurance market rules; helping States review unreasonable rate increases and implementing the new Medical Loss Ratio (MLR) rules; providing assistance to States in planning and developing State-based health insurance Exchanges (Exchanges), and administering the Consumer Assistance Program, the Pre-Existing Condition Insurance Plans (PCIP), and the Early Retiree Reinsurance Program (ERRP).

As CCIIO has implemented these new programs and processes, we have pursued them in an open and transparent manner. CCIIO has published extensive information on our rulemaking and other decisions on the website www.CCIIO.CMS.gov 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 rate review, medical loss ratio, and grandfathered health plans. We also held public forums on wellness and Exchanges to provide additional opportunities for public input by affected stakeholders. 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.

The process for seeking public input continues after the issuance of regulations. Based on comments and questions HHS, Labor, and the Treasury have received on regulations issued to date, we have provided additional interpretive guidance to affected parties on regulations relating to grandfathering, medical loss ratio, PCIP, ERRP, internal and external appeals, and provisions relating to annual limits on health plan coverage.

Partnering with States on Rate Review Policies

The Affordable Care Act establishes new protections from unreasonable insurance rate increases. CMS issued a final regulation (CMS-9999-FC) on May 19, 2011, after reviewing and considering more than 60 comments received from stakeholders. The final regulation reflects input received, makes certain that potentially unreasonable health insurance premium increases

will be thoroughly reviewed, and ensures that consumers will have access to clear information about those increases. Combined with other important protections from the Affordable Care Act, these new rules will help lower insurance costs and provide consumers with greater value for their premium dollar.

Starting September 1, 2011, the rate review rule requires independent experts to scrutinize any proposed rate increase of 10 percent or greater for most individual and small group health insurance plans. States will have the primary responsibility for reviewing rate increases. While most States will take on this responsibility, CMS will serve in a back-up role for States that do not have the resources or authority to effectively review rates.

The regulation (CMS-9999-FC) finalizes the proposed rule (OCIIO-9999-P) that was issued on December 23, 2010. The final rule includes several additions to the proposed rule that reflect feedback received through the comment process. For example, the final rule includes a requirement that States and CMS provide an opportunity for public input in the evaluation of rate increases subject to review. This will strengthen the consumer transparency aspects of the new rule. Based on public input, the rule also clarifies that beginning with rate increases filed or effective on September 1, 2012, in lieu of the 10 percent threshold, CMS will work with States to develop State-specific thresholds that reflect the insurance and health care cost trends in each State. In the final rule, due to comments received from State regulators and other stakeholders on the proposed rule, we requested further comment from the public on applying the rate review rule to individual and small group coverage sold through associations.

Partnering with States on the Medical Loss Ratio

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 consumers receive value for their premium dollars, the Affordable Care Act establishes minimum standards for spending by health insurance issuers on clinical services and quality improvement activities for their members, known as the MLR provisions. The Affordable Care Act established 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. The Act also requires issuers to provide rebates to policyholders starting in 2012, for premiums paid in the previous year, if these standards are not met.

On December 1, 2010, CMS published an interim final regulation with 60-day comment period implementing the MLR provisions of the Affordable Care Act (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 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.

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 interim final rule established the process and criteria for evaluating State requests for adjustments, based on recommendations made the NAIC.

Partnering with States on Exchanges

Beginning in 2014, State-based health insurance Exchanges will improve access to affordable, quality insurance options for Americans who previously did not have health insurance coverage,

had inadequate coverage, or were at risk of losing the coverage they had. State-based Exchanges will make purchasing private health insurance coverage easier by providing individuals, families, and small businesses with "one-stop shopping" where they will be able to compare a range of plans. Exchanges will provide a simple, accessible, transparent, and competitive market place where insurance companies will compete on cost, efficiency, and quality, rather than on their ability to exclude consumers with pre-existing medical conditions. Eligible individuals will also have new premium tax credits and cost-sharing reductions available to them to make coverage more affordable. By increasing competition between insurance companies, reducing the ability of plans to cherry pick their enrollees and providing financial assistance, Exchanges will help to lower health care costs for consumers, making health care more accessible and affordable for millions of Americans. The Congressional Budget Office estimates that in 2019, 24 million people will gain insurance coverage through the new State-based health insurance Exchanges.[1] Where States choose not to operate a State Exchange, HHS will establish one, either directly or through an agreement with a non-profit entity.

Although the Exchanges will not be operational until 2014, work is underway in the States and at CMS on planning and implementation. Grant funding has been made available to States and Territories to plan and establish their Exchanges. For example, HHS has awarded "Planning and Establishment" grants to 49 States, the District of Columbia and four Territories – including States that are represented on this committee, such as Pennsylvania, Texas, Kentucky, Michigan, New Jersey, and New York. States are using these grants to prepare carefully for implementing the new Exchanges. Michigan, for example, received a $1 million grant to develop a plan for implementing an Exchange that considers the needs of its individual stakeholders, while integrating seamlessly with existing State and Federal programs.

"Early Innovator" awards have been made to support States in developing an array of innovative models for the Exchanges' information technology systems. States also have the opportunity to apply for Exchange Establishment grants to assist in actual implementation of the infrastructure

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[1] CBO's March 2011 Baseline: Health Insurance Exchanges. Link, here.

needed to operate an Exchange. Washington, Indiana, and Rhode Island were recently awarded one-year grants totaling $35 million to develop business operations, support communications to individuals and small businesses, and develop eligibility and enrollment systems.[2]

The Affordable Care Act empowers States to implement the law in a way that respects their unique situation and needs. States are already taking their first steps toward 2014. For example, Michigan has developed a plan for five separate workgroups to meet to gain important insight from community stakeholders. The State has also contracted with several consultants to begin the work on the technical aspects of the Michigan Exchange.

Additionally, Maryland's Health Reform Coordinating Council has already carried out research to understand the State's health insurance marketplace and health expenditures. On May 26, 2011, Maryland Governor Martin O'Malley announced appointees to a nine-member board that will oversee Maryland's Health Benefit Exchange. This announcement follows the Maryland legislation that was passed in April 2011 that establishes the framework for a Maryland Exchange. Meanwhile, Colorado is holding regular community forums on issues around developing an Exchange, as well as conducting economic analyses of the State's health insurance market. CCIIO and States are well on their way toward giving consumers more control, quality choices, and better protections when buying insurance.

To assist States in the development of their Exchanges, HHS has provided technical assistance in the form of guidance on topics ranging from the Exchange's statutory requirements to the necessary information technology systems for an Exchange. In addition, HHS issued a Request for Comments (RFC) on August 3, 2010, with a 60-day comment period, and received nearly 600 comments. This RFC led to a discussion with States on an ongoing basis on issues related to the design and implementation of State Exchanges. HHS plans to issue a proposed regulation this summer that will provide further guidance to States and stakeholders. This proposed

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[2] http://www.healthcare.gov/news/blog/establishmentgrants05232011.html

regulation will reflect the input we have received on issues relating to State Exchanges, and will solicit further comment on a number of key issues in advance of issuing a final rule.

"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 comment period (OCIIO-9991-IFC) that HHS, Labor and the Treasury jointly published on June 17, 2010, and amended on November 17, 2010 (OCIIO-9991-IFC2), is intended to preserve the ability of Americans to keep their current plan if they like it, while providing new benefits and minimizing market disruption.

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. The rule states that these plans can continue to innovate and contain costs by allowing insurers and employers to make routine changes without losing grandfather status, such as cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, or voluntarily adopting new consumer protections under the new law. If a plan loses its grandfathered status, then consumers in these plans will gain additional new benefits including the patient protections provided by the Affordable Care Act, and in the small and individual group markets, review of potentially unreasonable rates and other new protections.

To assist stakeholders in understanding this new rule, CCIIO holds regular technical assistance calls with State regulators and has responded to a number of State inquiries on grandfathering in the last year. The three Departments have also held meetings with issuers and consumer assistance groups about the rule's standards for grandfather 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. The three Departments have also published six sets of technical guidance on grandfathered health plans, most recently on April 1, 2011, which are available in question and answer format on the CCIIO website.

Moving Forward

We are proud of all that we have accomplished over the past year and look forward to 2014 when Americans will have access to more affordable, comprehensive health insurance plans. In the meantime, I look forward to continuing to work on our bridge to 2014, year after year, strengthening CCIIO's partnership with Congress and 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. BURGESS. We will now, as is customary, take questions from the dais. We will alternate between Republicans and Democrats. Without objection, I will begin.

Now, you have been here in our subcommittee before, and the last time you were here, I asked and you agreed to provide a detailed budget. To date, I have only received some net totals for your obligations, such as the amount spent on the early retiree reprogram.

What we have discussed was a detailed budget that included all of your sources of funding and how those dollars were spent, and I have had both your word and Secretary Sebelius' word that this would be forthcoming, and I think I have been more than patient. When could the committee look forward to seeing action on this request?

Mr. LARSEN. Well, thank you for your question. I think we have submitted, I think, two responses, and I apologize if you don't feel they are fully responsive. I think we submitted kind of our spending to date, I think, as of March, and then our 2011 and 2012 budget.

But we would be happy to provide you with more detail. I don't know if you have provided—your staff has provided us with the specific level of detail that you would like, but if they have, I will certainly, after this hearing, talk to them to make sure we get you what you have asked for.

Mr. BURGESS. Well, just to refresh your memory a little bit, during that first hearing that we had, there was some concern—and I believe Mr. Engoff appeared with you at that hearing—and the questions were surrounding how did you know—in February of 2010, a month and a half before the bill was signed into law, how did you know what your startup expenses were going to be?

In other words, there was money written into the bill—when the legislative product was still a bill, there was money written in. And it almost seems like people were hired prior to the bill becoming law. So we were interested in how those funds were allocated, what they have been used for, what amount of money that was allowed for that initial allocation for startup costs remains unspent, just trying to get some finer detail on where the dollars came from and where they have ended up.

So, again, I apologize if we have not provided you that.

Mr. LARSEN. I apologize if we have not been responsive, and after this hearing we will convene and determine how quickly we can get that information to you.

Mr. BURGESS. Very well.

On the issue of the high-deductible health plans, I noticed in one of the publications that comes out here on the Hill every morning, yesterday's Politico Pro talked about how the number of people signing up for high-deductible health plans, HSAs, if you will, has increased. And I don't remember whether the number was 14 or 18 percent, but it was a significant increase.

Now, many of us are concerned, as the rollout of the Patient Protection and Affordable Care Act becomes established—these programs, high-deductible health plans, are extremely popular. In fact, President Obama himself, when the Republicans were down at the White House a few weeks ago, told us a little vignette about some

dermatologic preparation he had been prescribed during the campaign. It worked a little bit, not all that great, so he got it refilled. He had a little prescription card. It cost him 5 bucks for every prescription. But when he was out on the road, he ran out, went to the pharmacist, explained his difficulty. The pharmacist called the doctor; they got everything straightened out as to what prescription he needed. The pharmacist bagged it up and handed it to him and said, "That will be $400." And the President said, "You know, this rash is not that bad." And at that point, the President became an informed consumer and responded to a very clear market signal that the rash wasn't that bad, and $400 was not a necessary expenditure.

That is why so many of us really like the concept of people being able to control their own money for health care expenditures. Mitch Daniels, in Indiana, allowed that. Something magic happens when people spend their own money for health care, even if it wasn't their own money in the first place. That is, his State employees, where he funded a high-deductible health plan and funded the health savings account part of that, people tended to be very cost-conscious consumers. And as a consequence, he held down costs for his State employees by 11 percent over 2 years at the same time regular PPO, Medicare, Medicaid were increasing at 9 percent to double-digit increases every year. So it is something worthy of our consideration.

So what kinds of assurances can you give me, to those millions of people who have high-deductible health plans, that they will still have access to this as a health coverage option?

Mr. LARSEN. Well, I guess I would respond this way. I suspect there are a number of different reasons why people elect those plans. One is that I think it demonstrates the manner in which the current market is broken and, for many people, unaffordable, so that the only way they can get, you know, catastrophic-type coverage is to pay out of pocket up to particular limits.

I think many people end up purchasing these types of policies because, frankly, that is maybe what they can afford. It may not be what they want. I am not sure many people want to have to pay out of pocket the thousands of dollars that they may have to for a high-deductible plan. But in the current health care environment, prereform pre-2014, that may be your option. But we find that most people actually want comprehensive coverage for their cost.

Mr. BURGESS. Actually, the reason to have a high-deductible health plan and spend your own money and control your own money through a health savings account is to be in control of health care. When I spend money off of Visa debit cards that I have for my health savings account, no one in the government, no one at Aetna, no one at CIGNA tells me what to buy and where to buy it. I make those decisions myself. So I would also argue that there is an issue of control.

Can you just briefly tell me under the medical loss ratio rules that you are doing, are those contributions to the health savings account, are those counted as actual clinical expenses?

Mr. LARSEN. I would have to confirm that back with you, because that is a level of detail for the reg that is escaping me for the moment.

Mr. BURGESS. I would appreciate you getting back to me.

I will yield now 5 minutes to the ranking member of the subcommittee, Mr. Pallone of New Jersey.

Mr. PALLONE. Thank you, Mr. Chairman. I was listening to you, though I am not sure that I agree that it makes sense for people to forego treatment because it costs them more. But whatever, I am not going to get into that today.

I want to ask Mr. Larsen, one of the witnesses, I guess, at the previous hearing characterized the medical loss ratio regulation as "costly bureaucratic interference with insurers' legitimate business decisions."

And yet Consumer Reports calls the rate review rules a big win for consumers because insurers are going to have to start spending more on health care due to this new medical loss ratio that requires every insurance company to have a medical loss ratio of no less than 80 percent for individual and small group plans and 85 percent for large group plans. I don't understand how anyone could accept a situation in which insurers spend one-half or one-third of their health insurance premiums on CEO salaries, profits and administrative costs, and yet we have seen that situation in the private market.

So my question is can you tell us what benefit you see from setting some restrictions on what portion of the premium insurance companies are able to spend on overhead and administrative costs? Have you seen any benefits to date as insurers implement these new rules? And what about the process through which the MLR rules were adopted; what was the role of the National Association of Insurance Commissioners?

Mr. Larsen, I have to tell you, and, you know, we are continuing the previous hearing, I don't really understand how anyone could argue that these medical loss ratios are not a good thing. But in any case, if you could answer those questions.

Mr. LARSEN. Sure, I would be happy to. And I think that is a good example of a regulation and a program where the benefits so far outweigh the costs. I mean, first of all, when we looked at the economic impact of this as a percent of the premiums that health insurers issue, it is a very, very small percentage. They are already preparing this type of information for the NAIC filing. So it was a very small incremental portion.

Compare that with, for example, the estimates that both the NAIC and, I think, many Wall Street analysts have issued regarding the potential for rebates to consumers if this law had been in effect in 2010, which, depending on the estimate, is either 1.5- or $2 billion. And that dollar amount reflects the value that will go back to consumers when this law is in effect in terms of a rebate for 2011. So when you weigh the costs and benefits of that, I think it is so clearly to the advantage of the consumers and not burdensome to the industry.

And in terms of the process that was followed, you know, we adopted the recommendations of the NAIC. And I think, as we have testified to before, the NAIC followed a very open, transparent, thoughtful, thorough, considerate process, which is why we were comfortable adopting their recommendations.

Mr. PALLONE. All right, thank you.

Now, the other regulation the Republicans are attacking in this hearing is the rate-review regulation that requires that insurance companies explain and disclose publicly any premium increase over 10 percent for a given year. Last year, before the new rate-review process went into place, several State regulators had success in challenging insurance on rate increases and actually reversing them. I won't give you the examples, although we have several.

Again, Consumer Reports' Health News calls the rate-review rules a big win for consumers because insurers who want to raise rates by more than 10 percent have to say so to the public. Even in States where regulators can't deny insurance premium increases, this transparency gives consumers the ability to make better decisions.

So can you tell me about how Federal rules will relate to these ongoing State review efforts? I am sure you have heard the Republicans' charges the new Federal rules are duplicative of State efforts. Do you agree with that?

Mr. LARSEN. I don't. We think, and I think the NAIC agrees, that the rate-review regulation is really a supplement to existing State laws. And, as you know, I am a former commissioner, the Secretary is a former insurance commissioner. We are particularly sensitive to the role that States play and historically have played in regulating rates. So the rate-review regulation is really a supplement to existing processes to ensure that really in States where there isn't a robust rate-review process, the consumers can get that process where they might not get it today. But we are not taking the place of what States are doing today.

Mr. PALLONE. The last thing, I don't have much time here, but—you know, but we heard charges again from the Republicans on the committee about the waivers to the—you know, bias in granting waivers to the annual limits on essential benefits coverage, particularly with regard to unions, you know, favoritism and all of that. And I know the GAO report that came out said that that simply wasn't true. So I just—I have a few minutes. If you could just comment on these allegations that have been made of cronyism with regard to the waivers.

Mr. LARSEN. Well, I am happy to do that. As you know, I have testified here and other forums previously, including under oath, that we have applied the regulatory criteria to the waivers in a manner without regard to politics or favoritism in any way, shape or form.

As you indicated, I think the GAO report confirmed in the sampling that they took and the data that they looked at that when we reviewed these applications, we applied the criteria that we have published on our Website and that are available to applicants.

So, you know, again, I don't know how else to say it. There are no facts that support that, they have no merit, and I think that I have said it, and I think the GAO came to the same conclusion.

Mr. PALLONE. Thank you.

Thank you, Mr. Chairman.

Mr. BURGESS. The gentleman's time has expired.

We will recognize now Mr. Guthrie from Kentucky. Five minutes for questions, please.

Mr. GUTHRIE. Thanks for coming. I would just ask you a question based on you just said you were an insurance commissioner. I forget which State.

Mr. LARSEN. It was Maryland.

Mr. GUTHRIE. Maryland, oK. And then also the Secretary. And waivers, sort of the kind of theme that I was going to ask you. On the loss ratios, I know that Kentucky is a State that has asked for a waiver.

Mr. LARSEN. That is right.

Mr. GUTHRIE. And I know that it is what, 80 percent for small plans——

Mr. LARSEN. And individuals.

Mr. GUTHRIE. And individuals; 85 percent for large companies.

Mr. LARSEN. That is right.

Mr. GUTHRIE. Some States are lower. I think Maine has a waiver, or Nevada——

Mr. LARSEN. That is right.

Mr. GUTHRIE [continuing]. Has a waiver with changes. And one other. Delaware. Not Delaware, they are asking——

Mr. LARSEN. New Hampshire.

Mr. GUTHRIE. New Hampshire.

In, I guess, the deference to State insurance commissioners, because I know our insurance commissioner is asking for the waiver believing that it would be disruptive of the market if we have to go to 80, 85 percent, and so as a former insurance commissioner, why is there more deference given to that instead of the Federal 85 percent, 80 percent?

Mr. LARSEN. Well, you know, the Affordable Care Act set up kind of a baseline of the 80, and the 85 for the large group. I think that the statute specifically recognizes the possibility that an immediate transition in some States to the 80 could be disruptive. And so the statute provides for this modification process. I have to say it is not really a waiver because we can set a new number, but you are not—companies aren't waived from the general MLR requirements.

But I guess my point is that the Affordable Care Act specifically recognizes that there may be individual cases where flexibility is needed. And so, you know, I think we set up a process that was fairly straightforward for the commissioners to apply. You know, every State is different, and we have got, you know, 10 or so pending applications, and I think we are pretty close to moving on Kentucky.

Mr. GUTHRIE. Yes. I think in the final rule, or the interim final rule, I can't think—the individual market can be—if a State has to say I have a reasonable likelihood to disrupt the market, they can—not a waiver but——

Mr. LARSEN. Right. A modification adjustment, just for an individual market.

Mr. GUTHRIE. And would that not—you don't think that supplies the small—we have a lot of problems in Kentucky with individual markets and even small markets where people purchase. The ERISA plans and larger, of course, are separate.

Mr. LARSEN. Yes. I know that—I mean, I am aware that there has been concern expressed about the impact on the small group

market. I mean, we haven't read the ACA to kind of permit the same type of adjustment in the small group market.

Mr. GUTHRIE. But the same negative effects could happen to the small group that would happen——

Mr. LARSEN. Personally I think it is much less likely, and I am presuming that is why the ACA didn't provide for the same type of accommodation to the small group market. The individual market is typically very fragile. A number of States have gone through disruption in their individual market. And so I am assuming that is why that provision was put in.

Mr. GUTHRIE. I have got a couple minutes, and why don't I get to one more. The loss ratio, the agent's fee is part of the loss ratio?

Mr. LARSEN. Yes.

Mr. GUTHRIE. And we have had the National Association of Health Underwriters survey. Agents are seeing income losses from 20 to 50 percent, and 20 percent of agents have said they have downsized their business in response.

And my question is the decision of including the agent's fee into the—I think that was an administrative decision, not in the ACA.

Mr. LARSEN. It was not.

Mr. GUTHRIE. The negative impact on jobs.

Mr. LARSEN. Yes. I mean, the manner in which the MLR is calculated, we took almost 100 percent our guidance from the very deliberative process that the NAIC conducted.

And although they expressed some concern about the potential impact on agents and brokers, they did not—in their recommendations to us did not recommend that the commissions be pulled out. Now—and so we adopted their recommendations, and that is in the interim final rule.

We certainly, as part of the administration—and we recognize the important role that agents and brokers play in the community, we acknowledge that. As we sit here today, my understanding is that the NAIC has taken up this issue, and they have done some preliminary work on that. So we are monitoring the type of work that we are doing, and we look forward to seeing whether they ultimately make recommendations to pull or make changes.

Mr. GUTHRIE. So I understand you are actually engaging agents and brokers now to try to——

Mr. LARSEN. We have met with them.

Mr. GUTHRIE. I am into the high-risk pool, so——

Mr. LARSEN. Yes.

Mr. GUTHRIE. You see the value of what they do.

Mr. LARSEN. Yes. We are moving towards paying commissions to agents and brokers for the high-risk pool, and I do want to point out, not to belabor it, but the modification process that we were talking about early, one of the criteria for whether a market is destabilized that we took at the suggestion of the NAIC was whether there was going to be diminished access to agents and brokers. And some States have asserted that that might be the case if we were to apply the 80 percent, it is part of their application. So we are looking at that issue.

Mr. GUTHRIE. I appreciate that. I appreciate that answer. Thanks.

I yield back my 5 seconds.

Mr. BURGESS. Thank you.

The chair recognizes the ranking member of the full committee Mr. Waxman. Five minutes for questions, please.

Mr. WAXMAN. Thank you very much.

Mr. Larsen, good to see you again. I think you have attended this subcommittee—I think you have a better attendance record than I do, so good to see you again.

Republicans, some Republicans, have repeatedly claimed that the grandfathering rule issued by HHS will result in tens of millions of people losing their health care. That is, of course, contrary to the spirit of the Affordable Care Act, that if you like what you have, you can keep it.

Is it accurate to say, as some are saying, that the grandfathering rule will result in people with employer-sponsored coverage being denied or losing their health insurance coverage because of HHS or by their employer?

Mr. LARSEN. No. We don't see that happening.

Mr. WAXMAN. So where would Republicans get the idea that tens of millions of people are losing their health care?

Mr. LARSEN. I don't know. I think the only point is that there are, you know, estimates that we have made about the transition from some health plans that may decide to make changes to the provisions, and they may not continue to be grandfathered health plans. But that doesn't mean that people won't be able to continue their coverage under those plans.

Mr. WAXMAN. Well, it appears to be another case where 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 his or her health insurance. In fact, they gain some consumer protections like rights to external appeals and coverage of preventive services.

In any case, these requirements will not be prohibitive for employer plans because they usually already meet the rules. In fact, one employer benefits consultant noted that, quote, "Large companies realize they already comply with many of the requirements of nongrandfathered plans, so the changes they will need to make aren't likely to add a significant cost or administrative burden," end quote.

Opponents of the Affordable Care Act, there was a recent study, Mr. Larsen, from McKinsey & Company that claims that a significant number of employers will stop offering insurance to their workers in 2014. However, other well-respected organizations have examined whether employers will continue to offer coverage, and they have come to different conclusions. The RAND Corporation, the Urban Institute, and Mercer all conducted studies and found that the percentage of employees offered insurance will not change significantly. In addition, nonpartisan experts, including CBO, have predicted that employer coverage will not be affected significantly by the Affordable Care Act.

What is your take? Are employers likely to drop coverage once exchanges and tax credits are available?

Mr. LARSEN. Well, we certainly don't think they will and expect—we don't expect that they will. As you have pointed out, I think it was the RAND study that, in fact, predicted that the num-

ber of small businesses and employees of small businesses that would have coverage would increase significantly thanks to the efficiencies of the Affordable Care Act, and I think Mercer, you know, concluded in many respects it was a little early to tell, but ultimately also said that they did not expect plans to stop offering employer-based coverage.

Mr. WAXMAN. On June 2, 2011, Ms. Reichel testified on behalf of the America's Health Insurance Plans, or AHIP, during the first part of the hearing and suggested that HHS adopt a one-size-fits-all for the 3-year transition to the 80 and 85 percent standards for medical loss ratios for all health plans. Currently HHS has in place a State-by-State waiver process set forth in law to respond to situations in specific States where an individual market is highly concentrated and the MLR could destabilize the market. HHS has approved waiver requests from three States for modifications of the MLR standards and is considering several more.

Can you tell us what goes into the decision as to whether to grant a waiver for a State's individual health insurance market from the MLR requirements?

Mr. LARSEN. Sure. And I, you know, will say to start out that, you know, every State is different. And I think that is why this system works well, because some States don't need a waiver. It is obvious that some States haven't requested a waiver.

So the idea of having a national waiver would deprive a lot of consumers of the value of the law when a modification, excuse me, wasn't necessarily needed.

But to answer your question, the basic test is whether a market is likely to be destabilized if the 80 percent were to be applied to the individual market, and really we look at whether it is likely that a small insurance company that might be running substantially below 80 would decide to leave the market. And then we look at whether there are other coverage opportunities if that insurance company were to leave the market. And as you mentioned, we agreed with the application from Maine and made, I think, minor modifications to the other two applications.

Mr. WAXMAN. So these decisions are more nuanced from place to place.

Mr. LARSEN. Yes.

Mr. WAXMAN. Some States will need a transition; some States won't. We shouldn't prejudge the waiver application by instituting a national transition policy.

Mr. LARSEN. That is right.

Mr. BURGESS. The gentleman's time has expired.

I now recognize the gentleman from Michigan. Five minutes for questions, please.

Mr. ROGERS. Thank you, Mr. Chairman.

Although I am not surprised that the gentleman from California makes the argument that people who are grandfathered won't lose their insurance, and, in his words, all this is a little nuanced, but what you will have is you will have millions of Americans who don't get to keep the health plan that they like, as was promised; will get a health plan that is far more expensive and they don't want, courtesy of the Federal Government.

To say that that is nuanced is ridiculous. And to say that we are not going to have companies make the choice not to provide insurance is not based on any reality, and certainly isn't by anybody who actually owns and works and operates a business anywhere in America.

I am just shocked that the conclusion is, oh, they are just going to do it. I just talked to a restaurateur today, a woman who has been in the business for 15 years, who hits the 30-employee threshold not with full-time employees, but because she has so many part-time employees in a restaurant, who said, if this were put into place, my business is gone. I have no choice but to stop health care for the five people that I provide it for today. And you will see that again and again and again. I mean, she was literally in tears talking about what this bill does to her and the people she cares about that she considers her family.

So what you, sir, would call nuanced, I call a disaster, and it is happening today.

And I want to talk about the MLR. It gets my blood pressure up because I know these people, and they are absolutely in a state of panic about how they are going to do this. And their only other real option is to drop health care coverage; say, good luck, go buy it at the Federal exchange. I hope it works out for you. Man, just an incredible outcome that we would be so callous toward these—in this case she is a single woman, business entrepreneur, trying to make it happen. Apparently those people don't count anymore.

Before I get to my questions, I did want to say a couple of things on the MLR and why it has created such a desperate economic situation for health care agents and brokers. And, by the way, these small businesses who count on these brokers to navigate what is already a complicated system now are losing this option on something that will even be more complicated with hundreds of thousands of pages of rules and regulation and law that they don't understand, and that is why they hire brokers and agents to try to get them the best deal that they can.

But what should raise some red flags with every member of this committee, a regulation from President Obama's health care law is single-handedly crippling an entire segment of our economy. And this isn't myth, this isn't speculation, it is happening today.

Let me tell about these people. Most health care agents are small business owners, and their average income is $50,000 a year. I don't know about you, sir, but I don't consider that wealthy. They help other employers navigate complex health insurance markets and essentially serve as the HR department for small business owners. They provide incredible value to our health care system and the employer community, especially the small business community.

These agents are brokers. They are very real people. They are business owners. They are small. They tend to be independently owned. They are in our communities, and they are losing jobs today, today, because of this rule, and HHS knows it, I know it, and thousands of agents and brokers who have had to close their doors certainly know it.

Yet HHS has refused to address this issue. They have ignored the job loss, turned a blind eye to real families who are suffering

under the weight of this regulation. This is unacceptable, and this committee should take action to protect these jobs and protect an industry that provides a service. The fix is simple, and HHS could do it today, and I am baffled they have ignored this problem for so long.

I have a bipartisan bill which would force change in the MLR rule that would protect these agents and brokers from this job-killing regulation. It has 90 cosponsors, including 15 Democrats and 23 members of this committee. I hope we can take action on this legislation soon. It is an immediate jobs crisis in our communities for thousands of hard-working small business owners who are already being crushed by the weight of this new health care law.

I want to thank you, Mr. Chairman, for having this hearing.

I just want to ask you, sir, there was a letter; you mentioned the NAIC and their effort here. One of the provisions—and I have a letter here that was directed to Secretary Sebelius, and I just want to quote from this letter: The role of insurance producers, agents and brokers will be especially important—as we move forward. We encourage HHS to recognize the essential role served by the producers and accommodate producer compensation arrangements in any MLR regulation promulgated.

We have heard again and again that you are going to do something for these people who are getting crushed right now. We see nothing. Can you help me understand where we are at and what you are going to do to protect these jobs and these people who are providing these services?

Mr. LARSEN. Sure, and I appreciate your concern. And as I indicated earlier, we also believe that agents and brokers play an important role in the health care market today, and they will in the future when we have exchanges in 2014.

The NAIC originally did not make any recommendations to pull the commissions out of the MLR calculation, and we adopted their recommendations, but also adopted recommendations to permit the State modification application for the MLR to flag this issue of diminished access to agents and brokers.

As we sit here today again, the NAIC, I think, is doing what they do best and what they did for the MLR, which is conduct an analysis and a study of the data that is available on agent and broker commissions and look at possible solutions. And we are monitoring that, and we look forward to recommendations that they make—they may make based on the data that they collect.

Mr. ROGERS. Just, lastly, let me just get this last point in, if I may. Seventy percent of health insurance agents and brokers have lost income today. Twenty percent have been forced to lay off workers today. Fifteen percent have closed their doors today.

We don't have time for nuance. We don't have time for looking at it and studying it and being calm about it. We need you to get as upset as the rest of us for real Americans are losing their jobs today.

I would hope that you would take a little urgency here, sir. You are going to have your job tomorrow and at least for the next 18 months. I would encourage you to worry about the rest of Americans who have to get up and innovate their way to their livelihood for their families.

And I would yield back.

Mr. BURGESS. The gentleman's time has expired.

The gentleman from New York is recognized for 5 minutes.

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

Let me begin by saying, first of all, you have talked to the stakeholders, and they have been involved in terms of this process, and I raise that question because of, you know, the comment was made by the gentleman from Michigan. You talked to stakeholders and referenced it as you moved forward; am I correct?

Mr. LARSEN. Yes, absolutely.

Mr. TOWNS. Right. What has HHS done to assist States in the establishment of health insurance exchanges?

Mr. LARSEN. We provided assistance in any number of areas, first of all with different types of implementation grants, for them to do the types of studies they need, whether it is IT, you know, plan qualification. So planning and implementation grants, innovator grants to a small number of States that are particularly progressive on the exchanges.

And then I can't tell you how much technical assistance and dialogue we have back and forth with the States, both individually and collectively, at events like the NAIC and NGA meetings and other forums that we have pulled together. So it is a continual dialogue with the States to help them as they make the decisions that they need to make to implement exchanges by 2014.

Mr. TOWNS. You know, I am still thinking about the comments that were made on the other side. Did you incorporate any of the feedback coming from the stakeholders?

Mr. LARSEN. We did. We do that on a continual basis. We put out, I think, either an RFI or RFC initially to get feedback from the States, and we have incorporated many of the comments that we got from the States in our subsequent guidance, both general guidance and technical guidance. We put out some IT, information technology, guidance as well. So I think it has been a very collaborative and iterative process with the States.

Mr. TOWNS. Mr. Chairman, I am going to yield to the gentlewoman from California because I understand we have a vote, and I just want to share my time with her. I saw the expression on her face.

Mrs. CAPPS. Well, thank you very much. I thank my colleague for yielding me time, and I will try to repay the courtesy one day.

I am going to switch gears just for a minute because there are so many criticisms that we have been hearing which ignored the state of the health insurance market before the Affordable Care Act was passed. I think we need sometimes to remember what it was like.

As you remember, as most of us remember, consumers would think that they were covered for things like emergency room care, prescription drugs or lab tests. But then when they tried to use it, they found they weren't covered. The phenomenon was "I like my health insurance until I have to use it." But what were we paying high premiums and out-of-pocket costs for?

One area that I found particularly appalling is the lack of maternity care coverage to women who need it. Unfortunately maternity coverage was largely unavailable in the individual market. In fact,

in 2009, according to a study conducted by the National Women's Law Center, barely 1 in 10 individual market plans available to 30-year-old women across the country provided maternity coverage. Most people didn't know that until they got pregnant, despite the obvious fact that more than 1 in 10 women are likely to want or need maternity coverage. This is all while women were charged more for their health plans for no reason except for her gender, and most Americans didn't realize that either. They just paid their premiums and didn't realize that women were getting charged more than men because they were women.

To me, this is a perfect example of why we need an essential benefit package, and I am happy to report that thanks to the ACA, starting in 2014, women will be able to get the coverage they need.

So would you use 1–1/2 minutes to explain more about the importance of the essential benefits package, and how will this provision protect consumers?

Mr. LARSEN. It is a very important provision that, as you point out, many people believe that they have coverage. Insurance policies are complicated, they are complex. Many people don't understand them. Transparency is also one of the goals of the ACA. But by providing a basic core set of important protections, including maternity coverage, people, when they are paying money for their coverage, they can know that they are actually going to have coverage for, you know, a range of conditions that they might have to deal with. And it is a very important provision in the Affordable Care Act.

Mrs. CAPPS. I thank my colleague for yielding, and I yield back the balance of my time.

Mr. BURGESS. The gentlelady yields back.

The gentleman from Georgia, Dr. Gingrey, for 5 minutes.

Mr. GINGREY. Mr. Chairman, thank you.

Mr. Larsen, are you aware that Secretary Sebelius told the American people on February 8, 2010, that, quote, "with health reform, premiums will go down between 14 percent and 20 percent just by passing the bills"?

Mr. LARSEN. I am not. I can say I am not familiar with that particular statement.

Mr. GINGREY. Well, let me ask you this: Do you agree with her, Secretary Sebelius, that Obamacare, which, I guess, will passed the next month, March 23, 2010—do you agree with her that Obamacare has, in fact, decreased insurance premiums for Americans between 14 and 20 percent?

Mr. LARSEN. When fully implemented, I believe that it will lower premiums for Americans.

Mr. GINGREY. Well, we are talking about right now, you know, since this became law. You say when fully implemented. Are you talking 2014, 2016, 2018?

Mr. LARSEN. Well, I think as we gradually get to health insurance exchanges, which I think CBO and many others have said will lower administrative costs, create a number of efficiencies for small groups and individuals——

Mr. GINGREY. I understand what your hopes are. I absolutely do. But the reality is something quite different, at least at this point in time. Can you name one instance where an insurance premium

went down between 14 and 20 percent since Obamacare became law?

Mr. LARSEN. Well, I do know that as a result of, for example, I think the rate review law, as well as the medical loss ratio law, that insurers have already said and have reported publicly, some of them publicly traded companies, in their earnings calls that they are moderating their rates based on the MLR standard and the potential for rebates. And I think we know that the rate-review process in a number of instances has resulted in lower premiums for consumers.

Mr. GINGREY. Mr. Larsen, are you aware that President Obama promised the American people on the campaign trail that his health care reform bill would bring down premiums about $2,500 for the typical family when he was campaigning?

Mr. LARSEN. I assume that if you are telling me that, he said it.

Mr. GINGREY. Yes.

Mr. LARSEN. That he said it.

Mr. GINGREY. He did. You assume correctly.

Let me just hold up this poster for you, "Rhetoric Versus Reality on Premiums." Looking at the far right of the chart, 2008, going forward to our current time here in the middle of 2011, the rhetoric in showing these premiums going down from the baseline by $2,500 a year for the average family, just the opposite, in fact, has occurred. The reality is it has increased by $2,500 a family.

So, you know, when we asked you these questions—and I know you have been before the committee a number of times, and we do appreciate that, and I appreciate your responding. But Mr. Rogers from Michigan, in talking about this MLR issue, you know, that would be a pretty easy fix, I think, in regard to the brokers and agents, you know. We want to create jobs, we are about to destroy a segment of the economy and put many of these hard-working men and women out of business. They provide a great service.

Why isn't there an easy fix to that? I don't want to—I am not going to ask you to answer the question. I ask it rhetorically because I did want to yield the balance of my time to the gentleman from Louisiana, and I will do so at this point.

I yield to Mr. Cassidy for the balance of my time.

Mr. CASSIDY. Thank you.

Mr. Larsen, consumer-driven health plans are really cost savings, and people use them. Now, I am concerned that the MLR requirement will be very difficult to achieve if you have a high-deductible health plan with a $5,000 deductible, maybe an HSA beneath, but your MLR is going to be on that amount which is 5K and above. That is really going to be very difficult for these plans to comply with.

Are we just trying—do you have a prejudice against them, or what is the idea about that?

Mr. LARSEN. No, we are not prejudiced against them. I think that, as I indicated before, I will have to go back and kind of check the exact applicability. I think we have gotten comments on the interplay between the MLR standard and the kind of high-deductible policies, and next time I am before the committee, I would be happy to address that.

Mr. CASSIDY. Now, is there a potential for a perverse incentive, because it is my understanding that if these are qualified on the exchange, it will be at the bronze level. But don't I know that the subsidies don't kick in on the bronze level, they only kick in for silver and above?

Mr. LARSEN. I am not sure if that is the case. I would have to double-check.

Mr. CASSIDY. Yes, we are both a little rusty on the details of a complicated bill.

Now, then, let me ask you, would there be interest in giving a different MLR for a book of business which is predominantly consumer-driven health plans?

Mr. LARSEN. I would be happy to look at that. I mean, I know certainly the dynamics are somewhat different for higher-deductible policies, because obviously you are not paying for first-dollar coverage for the types of health care benefits that, you know, the recipient of one of these policies might be getting.

Mr. CASSIDY. So will the rule—do you have latitude within the rule to make this, or will it require a statute?

Mr. LARSEN. I have to look at that.

Mr. CASSIDY. OK. So are we going to have another hearing because there are a lot of kind of unanswered questions about something which is really benefiting people's pocketbooks and their health, but it seems as if we need to have a second hearing on that.

Mr. BURGESS. Well, Mr. Larsen, if I understood you, you are going to get back to me with some detail on the tax implications or the medical loss ratio implications as to the health savings account portion of a high-deductible health plan. And I think the questions, Mr. Cassidy, if we will put those in writing, can we ask you to respond to those questions in writing as well?

Mr. LARSEN. Yes, I will.

Mr. BURGESS. We may very well have another opportunity, but I don't know how long that will be.

Mr. LARSEN. OK. We will do that.

Mr. BURGESS. Bill, if you don't mind getting those in detail for him, there have already been some things that we have asked to have addressed.

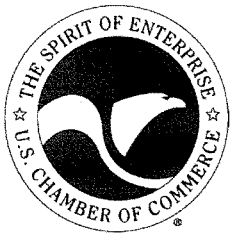
Mr. CASSIDY. OK. I yield back.

Mr. BURGESS. Does that conclude your time, or do you want additional minutes?

Mr. CASSIDY. No. I think we have to vote.

Mr. BURGESS. Just a housekeeping detail. I am going to ask unanimous consent that we insert the statement of the United States Chamber of Commerce into the record. Without objection, so ordered.

[The information follows:]



Statement
of the U.S. Chamber of Commerce

ON: **PPACA's Effects on Maintaining Health Coverage and Jobs: A Review of the Health Care Law's Regulatory Burden**

TO: **The House Energy and Commerce Committee**

FROM: **Randel K. Johnson, Senior Vice President**
Labor, Immigration, & Employee Benefits,
U.S. Chamber of Commerce

DATE: **June 15, 2011**

The Chamber's mission is to advance human progress through an economic, political and social system based on individual freedom, incentive, initiative, opportunity and responsibility.

On behalf of the U.S. Chamber of Commerce (Chamber), the world's largest business federation representing more than three million businesses and organizations of every size, sector, and region, I am pleased to submit this statement for today's hearing: PPACA's Effects on Maintaining Health Coverage and Jobs: A Review of the Health Care Law's Regulatory Burden. I request that this statement be included in the record.

The U.S. Chamber of Commerce has long advocated for meaningful health care reform to expand health insurance coverage, improve appropriate access to the proper health care services, while also realign financial incentives for better quality and efficiencies. Despite our hopes, the legislative negotiations that occurred in 2009 and 2010 did not culminate in the passage of a bipartisan and comprehensive reform bill. The law was drafted and passed by partisan strong-arming tactics, leaving our country to grapple with implementing a convoluted and inconsistent law, which those involved in the negotiations expected to correct and clarify in conference. Now post-enactment, the Chamber continues to work to best serve our members. As you conduct your hearing to review the health care law's regulatory burden and its affect on maintaining health care coverage and jobs, we would like to highlight our experiences with the regulatory process.

Background

Although the Chamber opposed the law and supports its repeal, we are also compelled to engage during implementation by actively participating in the regulatory process, a process which at least preliminarily can be characterized as frantic and chaotic. The Departments began issuing regulatory materials less than one month after the law's enactment and releasing interim final rules with effective dates falling before Agencies' consideration of public comments. The three Departments involved – Health and Human Services, Labor and Treasury - have also issued extensive sub-regulatory guidance in the form of Technical Releases, Notices, Frequently Asked Questions, and Model Notice Language Samples. It has been challenging keeping up with the regulatory materials that have been issued and filing comments to meet the deadlines imposed. This challenge pales in comparison to the difficulties businesses are facing in restructuring plans and educating employees to comply with the new requirements imposed through the regulatory process.

Despite the infamous quote "We have to pass the bill to find out what's in it," it will likely be months before we all know the full meaning of the law. While we may now know the broad provisions outlined by the letter of the law, we will still have to wait months and potentially years for the regulators to flesh out what these provisions will require business and Americans to do to fully comply with the 2,700 page law. In other words, "we will have to see the final regulations to find out what's in them." Even then, a level of uncertainty will remain until regulatory terms are further defined through sub regulatory guidance and enforcement policies.

We have both substantive and procedural complaints regarding the regulations issued to implement the health reform. Our substantive complaints are two-fold: regulations are more prescriptive than the statutory language and run contrary to congressional intent. Our procedural complaints include frustration with the timing and form of the regulatory materials.

Substantive Problems with the Regulations Implementing PPACA

During the legislative process, there were a number of health reform proposals before the members of the House and Senate. Some legislation was more prescriptive than others. In the end, the less

prescriptive bill (the Senate Finance bill) was more palatable to the majority of Congress. However, the regulations implementing the broader, less prescriptive law are now tightening the law's provisions, effectively changing the law that passed into the more prescriptive bill that Congress could not pass.

This point is exemplified in the post-enactment "revision" of the grandfathered plan status provisions by way of the regulations implementing them. The Affordable Care Act contains a very simple grandfathered plan rule essentially legislating the Administration's promise: "[n]othing in the Act shall be construed to require that an individual terminate coverage…in which such individual was enrolled on the date of enactment." The provision specifies that the majority of the health insurance market reforms shall not apply to grandfathered plans and allows new family members and new employees to enroll in grandfathered plans. Neither Section 1251, nor any other provision of the health reform law, discusses the loss of grandfathered plan status.

In previous legislative reforms, when Congress intended grandfathered status to be terminable, that intention was clearly stated in the law. As an example, deferred compensation reform legislation specifically included language describing when a grandfathered plan would lose grandfathered status. Specifically, in October 2004, Internal Revenue Code Section 409A was enacted to reform the tax treatment of nonqualified deferred compensation paid to employees and independent contractors by entities to which they provided services. The statutory language which permitted existing deferred compensation plans to be grandfathered also specifically stated that this grandfathered plan status would continue unless the plan was materially changed. Significantly, before the Affordable Care Act and the Reconciliation Act were passed, ***other health reform legislation considered by Congress included far more prescriptive grandfathering provisions which*** limited the duration of grandfathered plan status to a definitive period of time. This legislation was not passed.

The House bill in Section 202 (a) specifically stated that a plan could only retain grandfathered plan status if there were no changes to "any terms or conditions, including benefits and cost-sharing, from those in effect as of the day before the first day of Y1." And if the issuer does not "vary the percentage increase in the premium for a risk group of enrollees in specific grandfathered health insurance coverage without changing the premium for all enrollees in the same risk group at the same rate, as specified by the Commissioner."

Although ***this legislative approach was specifically rejected by Congress***, it is being incorporated into the law, after enactment, through the promulgation of regulations that bypasses the traditional notice and comment process. These regulations took effect 5 weeks after the comment period ended and may remain binding without any subsequent final regulatory action addressing issues raised by public comments.

Two other examples of regulations that exceed the statutory language are the Interim Final Rule implementing the new Internal Claims and Appeals and External Review Processes and the Proposed Rule implementing Rate Increase Disclosure and Review. First, the appeals rule went far beyond statute in a few areas (ICD code requirement, linguistically appropriate) and the rate review rule essentially sets a federal standard containing a lot more requirements. While the statute says states are to report "unreasonable rates," the proposed rule requires states to submit any rate over 10% with detailed reporting even if the state deems the rate reasonable.

Procedural Problems with the Regulations Implementing PPACA

Following the enactment of the PPACA, the Departments issued seven Interim Final Rules in June and July of 2010, three months after the law's enactment, some of which became effective less than two weeks after comments were due. In choosing not to follow a more traditional informal rulemaking process, very problematic and flawed IFRs were issued without any opportunity for meaningful stakeholder input before mandated compliance. In order to improve the flawed regulations and incorporate valuable stakeholder input, the Departments had to issue sub-regulatory guidance after compliance with the faulty regulations was required, only further complicating the process for business. While we appreciate efforts to improve the flawed rules, more practical problems occurred as a result.

For example, again, we point to the Grandfathered Plan Status regulations. While we recognize the difficult undertaking in remedying the unintended consequences associated with the initial IFR, modifications made to it through the issuance of an Amended IFR created more challenges, uncertainty and unfairness. Because of the interim final rule issued by the Departments in June 2010, many employers were forced to weigh the cost of losing Grandfathered Plan status vs. the additional cost of staying with the same issuer. Many of our members, due to the initial IFR, were essentially forced to forego the opportunity to contract with another carrier (something which would have permitted them to control premium increase) in order to retain Grandfathered Plan Status, a choice which cost them significantly. Additionally, many employers (unable to afford the increase in premiums demanded by their current carrier) were also forced to lose their Grandfathered Plan status.

Conclusion

We appreciate your commitment to highlighting the regulatory burdens that the health reform law places on employers and businesses. Anecdotally, the recently released McKinsey Quarterly Report suggests a worst case scenario. Whether the study is precise or not, the Report highlights what we have heard from many of our members: employers are likely to drop employer sponsored health insurance coverage in the years after 2014.[1] If the cost of offering affordable coverage becomes prohibitively expensive or troublesome as a result of insurance coverage mandates, rigid legal requirements, or onerous regulatory burdens, employers will be more likely to stop offering health plan coverage. Particularly, if the level of uncertainty becomes so great and employers come to fear that despite paying for employees' health coverage they will still be penalized with fines, employers will simply stop offering coverage to minimize their risk. This is not in the best interest of anyone.

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1 Scott Womack, Owner and President of Womack Restaurants, a 12 unit IHOP Franchisee in Indiana and Ohio, testified before the House Ways and Means Committee on January 26, 2011, at a hearing titled: Health Care Law's Impact on Jobs, Employers, and the Economy. Bill Feinberg, President of Allied Kitchen and Bath, Inc. located in Fort Lauderdale, Florida testified before the House Committee on Small Business on February 16, 2011, at a hearing titled: "Putting Americans Back to Work: The State of the Small Business Economy." Brett Parker, Vice Chairman and Chief Financial Officer of Bowlmor Lanes, located in New York, NY testified before the House Committee on Education and the Workforce Subcommittee on Health, Employment, Labor and Pensions on March 10, 2011 at a hearing titled: "The Pressures of Rising Costs on Employer Provided Health Care" Phil Kennedy, Owner and President of Comanche Lumber Company located in Lawton Oklahoma testified before the House Committee on Energy and Commerce Subcommittee on Health on March 30, 2011 at a hearing titled: "True Cost of PPACA: Effects on the Budget and Jobs."

Mr. BURGESS. Let me just ask you one quick follow-up while we are getting ready to go vote.

On the issue of fraud—and everyone talks about being able to pay for more health care because we are going to eliminate fraud, waste and abuse. But on the issue of fraud—and this committee has had hearings about antifraud efforts in both Medicare and Medicaid, and you stated fighting fraud in Medicare was a key goal in the Obama administration—but the medical loss ratio regulation excludes health plan investments and initiatives to prevent fraud from those activities that improve health care. So is there a—do you dissect that out to that degree?

Mr. LARSEN. The MLR regulation, I think, strikes a middle ground that we adopted from the NAIC, which permits the inclusion of fraud recovery expenses up to the amount of fraudulent claims that are recovered, and that was the middle ground that, again, that the NAIC struck. And they spent a lot of time looking at this, I think, struggling with the fact that the statute allows for claims expenses and then quality-improving expenses to be included in the formula, but I don't think anyone wanted to provide disincentives for investment in detecting fraud.

Mr. BURGESS. So with all due respect, then a company is going to have to make a decision that, hey, if we go after this money and recover it, that it comes off of our medical loss ratio calculation. But if we are not successful in recovering the money, then it is money that is calculated outside so that it actually works against us.

And we do know that—I mean, I know from my time in the practice of medicine, Medicare and Medicaid, SCHIP functioned under a different system than private insurance in this country. Medicare, Medicaid and SCHIP predominantly pay the bills as they come in, as they are required to do. And then they go—if they find something that looks questionable, then they go after it, so-called pay-and-chase formula; whereas the private companies do run on preauthorization and precertification, which also has its set of problems.

But are you now instructing the private sector that these expenses that are related to precertification will be calculated outside the medical loss ratio, so we really need the private sector to develop a pay-and-chase scenario or a pay-and-chase template? That doesn't seem like the correct direction to go, because we all hear these terrible stories about people getting things they shouldn't have gotten in the health care system, but they are always on the public sector side. They are always on the Medicare and Medicaid side. You rarely hear a news story about one of the private insurance companies bemoaning the fact that they sent a wheelchair to someone who didn't need it.

Mr. LARSEN. Well, I don't think we are creating incentives for pay and chase. I know I was the CEO of a Medicaid HMO in Maryland, and I think we had a pretty good sense of what investment we could make in fraud detection and what the kind of return on investment was going to be. So we had a pretty good sense of that, and it didn't incentivize us to do pay and chase.

Again, I think we have struck a middle ground, as did the NAIC, of trying to encourage that. You know, just nothing prevents com-

panies from doing the right thing, which is investing beyond—investing in fraud-prevention activities beyond where they can actually include in the MLR formula. They still have headroom within the other 20 percent to make that investment, and we would hope they would continue to do that.

Mr. BURGESS. Well, this is something I hope you will continue to look at, because I do believe it needs to be part of the discussion, and we need to keep a focus on it.

Let me ask you one final question on the issues of taxes in the MLR calculation. Section 1001 of the Affordable Care Act states that Federal and State taxes should be excluded from the calculation. Your interim final rule seems to exclude some forms of taxation. Can you give us a little bit of insider direction on that?

Mr. LARSEN. Sure. There was a lot of time and energy spent in the NAIC public process trying to interpret what was meant in the ACA by the reference to——

Mr. BURGESS. With all due respect, it is fairly clear. Congressional intent was abundantly clear State and Federal taxes would be exempt.

Mr. LARSEN. Well, the only thing I can say is I am not sure everyone felt that it had the clarity that you believe is there. And, again, there was a lot of discussion around what that language meant.

Mr. BURGESS. Well, I mean, that is what it says in the—a health insurance insurer offering group/individual health insurance coverage shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss, plus the loss adjustment expense to earned premiums. Such report shall include the percentage of total premium revenue after accounting for collections of receipts, adjustment—paragraph 3—on all known claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.

I mean, that is pretty clear, isn't it?

Mr. LARSEN. Well, I think the issue for us was when we were read that in combination with a couple of the other sections, not necessarily—I am not sure the one that you cited. So, yes I realize it said Federal.

Mr. BURGESS. Would further legislation help clarify that for you? Do you need—I mean, congressional intent—and I didn't even vote for this thing. This is a Senate bill. I didn't write it. The Senate Finance Committee staff wrote this bill, as you are well aware. But I think even their intent was pretty clear. Do you need additional legislation to give you direction on this?

Mr. LARSEN. Well, again, I think we tried to make a reasonable interpretation of what we saw. So if Congress doesn't believe that we have interpreted this appropriately, then I guess it would be up to you to make changes if you felt that we had not done what was intended.

Mr. BURGESS. Well, we are up against a hard deadline with votes, and I know you are up against a hard deadline with your time here. I appreciate, again, your coming back. You heard from Dr. Cassidy that there may be the need for further opportunity to discuss, because a lot of this is complicated stuff, and people are having a hard time understanding it. When Mr. Waxman's com-

plaints notwithstanding, the overall popularity of this law is sort of stuck in neutral. It is about the same place where it was a year and 2 months ago. So it seems like this committee could do the country a favor by at least talking about this stuff that is included in the bill.

But this will conclude today's hearing, and I will remind Members on both sides that they have 10 business days for questions for the record, and I will ask all witnesses appearing over the course of this hearing to respond promptly to those questions.

This committee now stands in adjournment.

[Whereupon, at 3:55 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
"PPACA's Effects on Maintaining Health Coverage and Jobs: A Review of the Health Care Law's Regulatory Burden"
June 02, 2011

Thank you, Mr. Chairman for holding this hearing. Our discussion today and testimony from our witnesses should bring to light a story that will play out to be very offensive to republicans and democrats alike, and all other parties that it touches.

The Minimum Medical Loss Ratio (MLR) provision of the Patient Protection and Affordable Care Act (PPACA) and rate review, further deteriorate the states regulatory authorities. MLR will further decrease patient CHOICE in coverage, and accessibility. It will increase costs to insurers, and our suffering economy will lose yet MORE jobs.

Section 1001 of PPACA is written where health plans are required to spend at least 80 percent of the premium revenue or up to 85 percent for a large group on clinical expenses as determined by Health and Human Services (HHS). Additional employer mandated and insurer rules will run costs up so high there will be no choice for employers to drop coverage, drop employees, and insurers to drop coverage in certain areas decreasing access and increasing premiums.

It does not take a rocket scientist to see that these provision which have exclusive final determination authority by HHS, will mean that HHS, NOT consumers, will have complete control over all private-sector health plans.

Within the language of the plan, the even MORE important provider credentialing, utilization review, extension of network coverage, and other quality improvement measures are discouraged. The new regulations also increase administrative burdens by requiring that plans calculate MLRs for EACH market on a state-by-state basis. Insurers and employers must calculate and issue premium rebates based on the Medical Loss Ratio. This WILL destabilize the individual insurance market, create even MORE uncertainty, due to Governmental Federal overreach, decrease access to CONSUMER chosen healthcare plans and create an administrative nightmare to employers and insurers, thus increasing premiums costs yet again.

Local state regulators could build policy that would promote competition based on consumer needs and economic conditions within their state. With this, and allowing health insurers to be licensed in additional states, promotes the competition to keep premiums low for consumers and more available.

The protection the President promised in his statement "if you like your current insurance plan, you can keep it", is NOT the truth! If any changes, even routine ones, are made under the plan, the grandfather protection is lost. Once that protection is lost, the insurer is then subject to a mirage of additional mandates costing the insurers employers and thus the consumers.

If we do not stop this out of control PPACA snowball, employers who supply coverage to over 160 million people will be forced to eliminate full time jobs and eliminate group coverage. With this, I welcome the testimony of our witnesses, and I yield back.

Statement for the Record
PPACA's Effects on Maintaining Health Coverage and Jobs:
A Review of the Health Care Law's Regulatory Burden
June 2, 2011

Chairman Pitts and Ranking Member Pallone, thank you for calling today's hearing on the regulatory impact of the Affordable Care Act (ACA). I hope that as we consider this topic, we are reminded of the crucial reforms provided by the ACA that protect consumers and small businesses.

One of the essential reforms provided for consumers is a grandfathered status for certain plans, ensuring that if consumers like the plan that they have, they can keep it. Plans only lose grandfathered status if they significantly increase premiums or cut benefits – thereby changing two of the fundamental aspects of a plan that consumers care most about. If a plan chooses to significantly change, the plan loses status, however the consumer is promised continuous health coverage under provisions of the ACA. These are reforms that are essential to ensuring a higher level of accountability to consumers in our health system.

In the development of regulation pertaining to the ACA, much input and feedback has been solicited from stakeholders. The Department of Health and Human Services (HHS), for example, certified and adopted recommendations on medical loss ratios provided by the National Association of Insurance Commissioners (NAIC), producing positive reaction from consumers and insurers. National surveys conducted by the Small Business Majority indicate that many small businesses support key provisions in the law, specifically those that help them better afford insurance, such as tax credits and insurance exchanges, and those that help to contain costs. Consequently, 31% of small business respondents that currently provide insurance said that tax credits and exchanges are incentives to continue providing coverage. Without a doubt, these provisions save small businesses large sums in health care costs.

Repeal of the Affordable Care Act, in contrast will likely lead to increased health costs and hinder small businesses' ability to invest in and expand their business. Currently, small businesses pay 18% more on average than large businesses for health coverage. In the absence of the ACA, it is projected that in the next ten years, small businesses would pay nearly $2.4 trillion in healthcare costs for their workers. Such heightened health costs would ultimately lead to the loss of 178,000 small business jobs and $834 billion in small business wages. Nearly 1.6 million small business workers however would suffer from "job lock," where they are locked to their current jobs because they cannot find alternative jobs with comparable health benefits.

Prior to the Affordable Care Act, our health system was broken. Thankfully, the law provides for a place for a number of meaningful reforms that protect consumers, small businesses, and the stability of insurance markets. Though we have a long way to go, I am certain that the ACA provides us with a solid starting point. Let us continue to work together to continue to improve our nation's healthcare system for all.

Thank you, Mr. Chairman.

Steve Larsen's
Additional Written Questions for the Record
"PPACA's Effects on Maintaining Health Coverage and Jobs:
A Review of the Health Care Law's Regulatory Burden"
House Energy & Health Committee
Subcommittee on Health

June 2, 2011

The Honorable Bill Cassidy

The MLR regulations discriminate against high deductible plans in favor or more expensive low-deductible plans. Here's how this happens:

a. Under the MLR regulations, plans may only count claims paid by the insurance carrier towards meeting the 80% minimum loss ratio standard. This requirement penalizes plans with higher deductibles because the plan does not pay for claims below the deductible. Historical experience indicates that about 95% of individuals enrolled in high deductible plans will not incur more than $5,000 in claims in a given year, meaning that many of them will not meet their annual deductible, so the insurance carrier pays zero medical claims on their behalf. Thus, for about 95% of those individuals enrolled in a plan with a $5,000 or higher deductible, very few claims will actually count towards meeting the minimum loss ratio standard.

b. High deductible plans must still incur the expenses associated with processing claims even when claims are not paid by the plan due to the high deductible to ensure that they are properly credited towards satisfying the deductible and limits on out-of-pocket expenses, as well as member payment responsibility. This means that under the MLR regulation, high deductible plans must still incur the cost of processing claims that they cannot count as "paid" for purposes of trying to meet the minimum loss ratio standard.

c. Fixed costs represent a higher share of expenses for plans with higher deductibles because they have lower premiums. Every insurance carrier has fixed costs that it must allocate across the products it sells. All things being equal, fixed costs represent a higher share of premium costs for lower premium products (i.e., higher deductible plans) relative to higher premium products (i.e., lower deductible plans).

1. **Don't these factors make it harder for high deductible plans to meet the minimum loss ratio standards relative to plans with low deductibles? Don't the MLR regulations therefore discriminate against high deductible plans? Will insurance carriers selling high deductible products be able to count all claims they process (including claims paid by members while satisfying their deductible) towards meeting the minimum loss ratio**

standard? If not, will you be proposing a more appropriate standard for high deductible plans?

Answer: The Affordable Care Act required the National Association of Insurance Commissioners (NAIC) to develop uniform definitions and methodologies for calculating insurance companies' medical loss ratio (MLR). The NAIC model regulation was approved unanimously by representatives from every State and the District of Columbia and is the product of months of public hearings and consultation with consumers, employers, insurers, and other stakeholders. The NAIC has a long history of developing model regulations through a transparent process with stakeholder input, and this process was no exception.

The MLR adjustment factors recommended by the NAIC were based upon the extensive actuarial analysis it commissioned to address the potential for statistical unreliability of issuers' experience. In fact, the study specifically examined an adjustment "distinction by product type or actuarial value ranges (e.g. high deductible plans vs. low deductible plans)."[1] The MLR Interim Final Rule (codified at 45 C.F.R. § 101, *et. seq.*) (IFR) certifies and adopts the recommendations submitted to the Secretary of Health and Human Services (HHS) on October 27, 2010, by the NAIC, and incorporates recommendations from a letter sent to the Secretary by the NAIC on October 13, 2010.

Relying on the reasoned and thoughtful recommendation of the NAIC, the MLR IFR takes into account the average deductible for an issuer's book of business in each market in each State for purposes of determining the credibility adjustment. The higher the average deductible, the higher the adjustment provided to issuers below a certain size (between 1,000 and 75,000 life-years in a given State's individual, small group or large group market).[2] For instance, the largest adjustment based upon the deductible is for an average deductible of $10,000 or more. Second, under the IFR, issuers are required to aggregate the total market experience for each of the individual, small group, and large group markets within a State. Consequently, while every issuer has fixed costs, for the purposes of the MLR, those costs are allocated across all insurance products (including high deductible plans) sold in each State and in each market.

In order to eliminate any potential disincentive for new market entrants, the MLR IFR also adopted the NAIC recommendations relating to the special circumstances of newer plans by adjusting when newer plans' experience is to be reported. Specifically, an issuer may defer to the next MLR reporting year the premium and claims experience, as well as the life-years, associated with policies first issued after the start of the MLR reporting period if these policies account for more than half of the issuer's experience in a market segment for an individual State.

The IFR also adopts the NAIC recommendations with respect to reimbursement for clinical services provided to enrollees, also known as incurred claims. As recommended by the NAIC, claims paid by the issuer are included in incurred claims, but an issuer's costs for processing

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[1] Millman NAIC Report, "Credibility Adjustment Factors for use in PPACA MLR Refund Calculations," Millman Inc. (August 31, 2010).

[2] The MLR IFR adopts the approach taken by the NAIC, by designating as "noncredible" any reported MLR that is based on experience from fewer than 1,000 life-years.

claims are an administrative cost and are not included. This is consistent with the MLR statutory provision, section 2718 of the Public Health Service Act, which provides that "reimbursement for clinical services provided to enrollees" shall be included in the numerator of an issuer's MLR.

2. **The regulation includes a "cost-sharing adjustment factor" that appears to make it somewhat easier for insurance carriers with small enrollment to meet the minimum loss ratio standard. However, the adjustment for cost-sharing (i.e., deductibles) is minimized and ultimately rendered useless because of the mathematical formula for the MLR. The reason is that the cost-sharing adjustment factor must be multiplied by the credibility adjustment factor, which declines and ultimately becomes zero as a plan's enrollment grows. Therefore any positive adjustment the carrier gains for selling products with higher deductibles is negated as enrollment in these plans grows. That does not encourage carriers to sell these plans. Yet these are just the kind of plans that need to be available in the future insurance exchanges to provide affordable options that will also keep the cost of the subsidies down. How will you address this perverse incentive?**

Answer: The NAIC commissioned an extensive analysis by a well-known national actuarial consulting firm, and relied on these findings to develop its credibility and deductible adjustment calculation. Consistent with NAIC recommendations, the regulation establishes a "credibility adjustment" when the insurer's MLR for a market within a State is based on less than 75,000 life-years enrolled for an entire calendar year. Issuers with less than 1,000 life years for a given market within a State are not credible, are presumed to meet or exceed the MLR standard, and are not subject to rebates. The credibility adjustment recommended by the NAIC and adopted in the regulation addresses the statistical unreliability of experience based on a small number of people covered and a smaller number of claims.

The adjustment factor applied to high deductible products was developed to recognize that the variability of the claims experience is greater under health insurance policies with higher deductibles. HHS codified the NAIC-recommended deductible adjustment factors in the IFR. Issuers may take the average deductible level sold to consumers and adjust their MLRs accordingly. The NAIC-recommended actuarial analysis determined that an issuer reaches full credibility at ≥75,000 life years, meaning that a statistical adjustment for unreliability of experience is no longer needed.

3. **Please explain the rationale for the cost-sharing adjustment factor being based only on the annual policy deductible instead of the plan's annual limit on out-of-pocket expenses. Please explain why a plan with a $2,000 annual deductible and a $5,000 annual limit on out-of-pocket expenses receives no cost-sharing adjustment (factor = 1.0) while a plan with a $5,000 annual deductible and a $5,000 annual limit on out-of-pocket expenses receives a cost-sharing adjustment of 1.402.**

Answer: The adjustment factors in the IFR are consistent with the NAIC recommendations to address the potential for statistical unreliability of issuers' experience. Although the total cost-sharing limit for out-of-pocket costs is the same for the two product designs discussed in the

example above, these products are not the same from a statistical variability perspective,(even though the total cost-sharing limit for out-of-pocket costs are the same) assuming all other things being equal. Statistical variability in claims is a function of the expected number of claims. A policy with a higher deductible is expected to have fewer claims and higher random statistical variability than a policy with a lower deductible. Similarly, a policy with fewer covered lives is expected to have fewer claims and higher random statistical variability than a policy with more covered lives. This is true because claims will not be covered until more claims have been incurred and, all other things being equal, a product with a $2,000 deductible is likely to attract higher users of health care who submit more claims than a product with a $5,000 deductible.

Once the deductible has been met, cost-sharing for covered claims is not likely to affect the number of claims filed in the same way that the amount of the deductible does. Under the scenario presented in the question, the plan with a $2,000 deductible and $3,000 in additional cost-sharing would be paying claims as soon as the $2,000 deductible had been met and thus have more claims experience, whereas the plan with a $5,000 deductible would not be paying claims until the $5,000 deductible had been met.

4. **Please explain how you can assure the Congress and the American people that the MLR regulation will preserve high deductible plan options in the future insurance market.**

Answer: The MLR IFR acknowledges the need to preserve flexibility in the health insurance market. As discussed above, the MLR IFR contains several adjustments to address the special circumstances of certain types of issuers, and encourage market entry (reporting timeframes for newer experience) and retention of various sizes of issuers (credibility adjustment). As noted in question 1, the IFR specifically addresses deductibles in the credibility adjustment. These provisions work together to preserve high-deductible health plans as meaningful options in the market.

5. **Please explain how you can assure the Congress and the American people that the regulation will not encourage smaller companies to self-insure so they can avoid the impact of these regulations.**

Answer: The choice to self-insure or to purchase a fully-insured product is a business decision that rests with the employer group. This choice depends on a number of factors outside the scope of the MLR IFR.

6. **Please explain whether you are willing to exempt high deductible plans from the MLR regulations.**

Answer: The MLR statute does not allow HHS to exempt certain types of plans. As explained in question 1, the MLR IFR does allow adjustments that are designed to take into account the special circumstances of smaller plans, including plans with higher deductibles.

7. **Please explain whether you are willing to set a lower MLR standard for high deductible plans.**

Answer: The MLR standard is set forth in statute as 80 percent for the individual and small group market. The standard is 85 percent for the large group market. CMS does not have the authority to change the standard in the group markets. However, the statute does allow CMS to adjust the MLR standard in a State's individual market if a State requests it and demonstrates that application of the 80 percent MLR standard may destabilize its individual insurance market. As of June 2, 2011, CMS has received MLR adjustment applications from 12 States and 1 Territory, and granted 3 States an MLR adjustment (ME, NH, and NV).

8. Please explain whether you are willing to count claims processed below the deductible as "paid claims" for purposes of the MLR calculation for high deductible plans.

Answer: Section 2718(a)(1) of the PHS Act defines incurred claims as the amount an issuer spends "...on reimbursement for clinical services provided to enrollees under such coverage." As explained in question 1, insurer claims processing is not a reimbursement for clinical services and is classified as a non-claims cost.

9. Please explain whether you are willing to modify the MLR formula so that the cost-sharing adjustment factor is not negated by the credibility adjustment factor.

Answer: The MLR IFR definitions and methodologies for calculating the components of the MLR follow the NAIC's recommendations, which were approved unanimously by representatives from every State and the District of Columbia, following months of public hearings and consultation with consumers, employers, insurers, and other stakeholders. The adjustments for smaller plans, including those with higher deductibles, and newer plans were all part of the NAIC's recommendations. In addition, the adjustments for smaller plans, including those with higher deductibles, were adopted following an extensive actuarial analysis by a well-known national actuarial consulting firm. The actuarial study commissioned by the NAIC looked at high deductible plans versus low deductible plans, as well as a variety of coinsurance arrangements and out-of-pocket limits. Based upon this study, as well as input from a variety of stakeholders, the NAIC recommended that the credibility adjustment be based on the size of the population covered by the issuer and the average deductible of the covered population. It is important to note that the deductible factor was developed to recognize that the variability of the claims experience is greater under health insurance policies with higher deductibles. HHS adopted NAIC's recommendation that the deductible factor be multiplied by the base credibility factor in order to determine the overall credibility adjustment.

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