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PPACA'S EFFECTS ON MAINTAINING HEALTH
COVERAGE AND JOBS: A REVIEW OF THE HEALTH
CARE CLAW'S REGULATORY BURDEN
WEDNESDAY, JUNE 15, 2011
House of Representatives,
Subcommittee on Health,
Committee on Energy and Commerce,
Washington, D.C.

The subcommittee met, pursuant to call, at 3 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; Debbie 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.

Dr. 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.

Dr. Burgess. Thank you, Mr. Larsen, for your testimony.

[The prepared statement of Mr. Larsen follows:]

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Dr. 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.

Dr. 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.

Dr. 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, had 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.

Dr. 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.

Dr. 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 Report's 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.

Dr. 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, okay. 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. -- 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.

Dr. 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 number 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.

Dr. 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.

Dr. Burgess. If 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.

Dr. Burgess. The gentlelady yields back.

The gentleman from Georgia Dr. Gingrey for 5 minutes.

Dr. 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.

Dr. Gingrey. Well, let me ask you this: Do you agree with her, Secretary Sebelius, that Obamacare, which, I guess, will be 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.

Dr. 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 --

Dr. 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.

Dr. 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.

Dr. Gingrey. Yes.

Mr. Larsen. That he said it.

Dr. 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.

Dr. 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. Larsen. 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.

Dr. 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.

Dr. 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.

Dr. Cassidy. Okay. 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.

Dr. 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.

Dr. Burgess. We may very well have another opportunity, but I don't know how long that will be.

Mr. Larsen. Okay. We will do that.

Dr. 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.

[The information follows:]

***** COMMITTEE INSERT *****

Dr. Cassidy. Okay. I yield back.

Dr. Burgess. Does that conclude your time, or do you want additional minutes?

Dr. Cassidy. No. I think we have to vote.

Dr. 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:]

***** COMMITTEE INSERT *****

Dr. 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.

Dr. 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 companies 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.

Dr. 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 --

Dr. 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.

Dr. 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.

Dr. 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.

Dr. 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 complaints 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 4:55 p.m` the subcommittee was adjourned.]