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4 HEARING ON ``CUTTING THE RED TAPE: SAVING JOBS FROM PPACA'S

5 HARMFUL REGULATIONS''

6 THURSDAY, SEPTEMBER 15, 2011

7 House of Representatives,

8 Subcommittee on Health

9 Committee on Energy and Commerce

10 Washington, D.C.

11 The subcommittee met, pursuant to call, at 10:18 a.m.,  
12 in Room 2322 of the Rayburn House Office Building, Hon. Joe  
13 Pitts [Chairman of the Subcommittee] presiding.

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

17 Staff present: Paul Edattel, Professional Staff Member,  
18 Health; Julie Goon, Health Policy Advisor; Kirby Howard,

19 Legislative Clerk; Debbie Keller, Press Secretary; Ryan Long,  
20 Chief Counsel, Health; Carly McWilliams, Legislative Clerk;  
21 Andrew Powaleny, Press Assistant; Heidi Stirrup, Health  
22 Policy Coordinator; Phil Barnett, Democratic Staff Director;  
23 Alli Corr, Democratic Policy Analyst; Tim Gronniger,  
24 Democratic Senior Professional Staff Member; Ruth Katz,  
25 Democrat Chief Public Health Counsel; and Purvee Kempf,  
26 Democratic Senior Counsel.

|  
27           Mr. {Pitts.} The subcommittee will come to order. The  
28 chair recognizes himself for 5 minutes for an opening  
29 statement.

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

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

44           A May 2011 PricewaterhouseCoopers survey of employers  
45 also echoes the Administration's warnings. Of note, 51  
46 percent of the employers surveyed did not expect to maintain  
47 grandfathered health status, meaning their employees would  
48 forfeit their current coverage and pay higher premiums due to  
49 the health care law's mandates on their new coverage.

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

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

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

66 Supporters of this section claim the medical loss ratio  
67 regulation was designed to protect consumers from  
68 unscrupulous insurance companies. However, it actually  
69 contains perverse incentives for insurance companies to  
70 ignore waste and fraud, which drives up premiums and  
71 copayments for consumers. Under the regulation, investments  
72 in fraud detection, and even quality improvement and care  
73 coordination, fall under administrative expenses, which can

74 only make up 20 percent of a plan's spending. Plans  
75 struggling to make the 80 to 85 percent threshold for medical  
76 costs often can't risk these activities, which could save  
77 consumers money and provide them with a higher quality of  
78 care, for fear of being penalized and having to pay rebates.  
79 Even worse, if a plan does identify fraud, cutting those  
80 fraudulent payments and activities actually reduces their  
81 amount of spending on medical costs, making it even harder  
82 for them to reach the 80 or 85 percent threshold.

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

91 Again, while the medical loss ratio has been billed as a  
92 tool to protect consumers from insurance companies, many  
93 States are clamoring for waivers to exempt their citizens  
94 from these protections. The Secretary of HHS is empowered to  
95 grant MLR waivers to States that can prove that meeting the  
96 80 to 85 percent thresholds will destabilize its insurance  
97 market.

98           Currently, HHS has granted MLR waivers to five states:  
99   Maine, New Hampshire, Nevada, Kentucky and Iowa. With these  
100   waivers, consumers in these States are now protected from one  
101   of the health care law's key consumer protections. Residents  
102   of North Dakota and Delaware are not as lucky. HHS rejected  
103   their waivers. Nine more states--Florida, Georgia,  
104   Louisiana, Kansas, Indiana, Michigan, Texas, Oklahoma and  
105   North Carolina--have determined that their insurance markets  
106   will be destabilized by having to comply with the MLR  
107   regulation and have applied for waivers. They are still  
108   waiting to hear back.

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

119           I strongly support H.R. 2077, introduced by Dr. Tom  
120   Price and Rep. Cathy McMorris Rodgers, which repeals the  
121   section of the Public Health Service Act dealing with MLR

122 requirements, which was added by the new health care law, and  
123 I would urge my colleagues to support.

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

126 [The prepared statement of Mr. Pitts follows:]

127 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|  
128 Mr. {Pitts.} I now recognize the ranking member of the  
129 subcommittee, Mr. Pallone, for 5 minutes.

130 Mr. {Pallone.} Thank you, Mr. Chairman.

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

141 The two bills under discussion today support what I have  
142 been saying all year long. If the Republicans had their way,  
143 insurance companies would have free rein to drop someone's  
144 coverage unexpectedly when they are in an accident or become  
145 sick because of a simple mistake on an application. If the  
146 Republicans had their way, over 1.2 million young adults  
147 would lose their insurance coverage through their parents'  
148 health plan as their children worked to launch their careers.  
149 And if the Republicans had their way, insurance companies  
150 would once again be allowed to deny health coverage to a

151 breast cancer patient who was in remission but now needs to  
152 restart her chemo and to put an annual cap on the amount of  
153 care she will have access to, or even worse, a lifetime limit  
154 on her health coverage so in a desperate time of need she has  
155 to choose between bankruptcy and getting lifesaving care. If  
156 the Republicans had their way, insurance companies would once  
157 again have the ability to freely raise patients' premiums,  
158 likely by double digits, and have no restraints or  
159 accountability on what proportion of these premium dollars  
160 are spent on health care services.

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

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

170         [The prepared statement of Mr. Pallone follows:]

171 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|  
172 Ms. {Schakowsky.} I thank the ranking member very much  
173 for yielding to me.

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

178 The idea of a medical loss ratio says that we are just  
179 not going to let the insurance companies charge whatever they  
180 want. That legislation, that rule, the medical loss ratio,  
181 holds insurance companies accountable and ensures that health  
182 care consumers receive the services for which they are  
183 already paying top dollar. By law, insurance companies have  
184 to spend at least 80 percent of their premium dollars on  
185 medical care and health quality improvement as opposed to  
186 administrative costs, marketing, executive salaries and  
187 bonuses.

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

193 This hearing is also going to focus on legislation to  
194 repeal the grandfathered health plan regulation, and doing so

195 basic consumer protections like ending lifetime coverage  
196 limits and rescission of coverage will be undermined and  
197 employer-sponsored health insurance plans, plans that cover  
198 160 million people. So now we are not just talking about  
199 public plans, we are going to reach into those private plans  
200 and tell these employers what they can do and offer to their  
201 consumers.

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

218         Thank you. I yield back.

219 [The prepared statement of Ms. Schakowsky follows:]

220 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|  
221           Mr. {Pitts.} The chair thanks the gentlelady and  
222 recognizes the vice chairman of the subcommittee, Dr.  
223 Burgess, for 5 minutes.

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

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

232           I have to say, we talked about doing the bidding of  
233 insurance companies. Exhibit A, the Affordable Care Act, why  
234 cannot we get the information from the White House from the  
235 six groups that met down there in May of 2009 that discussed  
236 how we were going to carve up things in health care,  
237 insurance companies to be sure, doctors, hospitals, pharma,  
238 medical device manufacturers and the unions. So what was up  
239 with that? The President came out of that meeting and said  
240 we saved \$2 trillion for health care. Two trillion dollars  
241 for health care, but there are no minutes, there are no  
242 emails. There is not even an envelope with a scratch on the  
243 back about what this \$2 trillion represented, and we are to

244 believe that?

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

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

263           Now, is there a reason for this? Is partly the reason  
264 because since 2008 the government has spent \$54 billion on  
265 regulatory agencies and they are growing at 16 percent--the  
266 only true growth industry in this country is federal  
267 regulation--or that the government regulatory system is the

268 third largest employer in the Nation or because complying  
269 with federal rules and regulations costs \$1.75 trillion per  
270 year? Is it because the Affordable Care Act and the effect  
271 that its regulations are having on our Nation's employers?

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

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

291 Thank you, Mr. Chairman, and--

292 Mr. {Shimkus.} Would you yield?

293 Dr. {Burgess.} Yes, I would be happy to yield to the  
294 gentleman from Illinois.

295 [The prepared statement of Dr. Burgess follows:]

296 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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297           Mr. {Shimkus.} Thank you from my colleagues, and I am  
298 going to take this minute just to do a plug on a bill that we  
299 just dropped yesterday, which was the Medicare common access  
300 card. We all know there is Medicare fraud. Part of this  
301 debate is, how do you stop fraud in billing. In Medicare, we  
302 know there is great fraud. What the Medicare common access  
303 card, which I have a copy of one, it is just using an ID card  
304 like the military does. It is a double identification system  
305 with a chip in the card and then a password. To date, in the  
306 DOD, these cards are out. Twenty million of these cards have  
307 been out. There has been not a single instance of fraud.  
308 And so if you really want to make sure that the person who is  
309 supposed to receive the service is identified and properly  
310 billed for it, then I would encourage all my colleagues on  
311 both sides to look at the bill dropped.

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

317           With that, thank you, Mr. Chairman.

318           [The prepared statement of Mr. Shimkus follows:]

319 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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320           Mr. {Pitts.} The chair thanks the gentleman and  
321 recognizes the ranking member emeritus, Mr. Dingell, for 5  
322 minutes for an opening statement.

323           Mr. {Dingell.} Mr. Chairman, I thank you for your  
324 courtesy and I thank you for recognizing me.

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

332           The bills before us today would strip historic reforms  
333 that protect consumers and it is going to leave us in a  
334 situation where the things that we have done to ensure and  
335 protect the rights of the American public are stripped away  
336 in a most unfortunate way. The intent of the medical loss  
337 requirement is to ensure that consumers know that money  
338 coming out of their paychecks each month for health care is  
339 going to go for quality care, not to line the pockets of the  
340 insurance companies. This provision is going to benefit  
341 countless Americans. It is going to, according to HHS  
342 estimates, see to it that nearly 75 million people are in

343 health plans that will be subject to new requirements and up  
344 to 9 million Americans will be eligible for rebates next  
345 year. Costs to the government that we pay for health care  
346 will go down because of the things under attack in this  
347 committee today. The requirements that we are making are  
348 safe, effective and achievable.

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

358         These two bills are a direct and unfortunate assault on  
359 the sick, the elderly and the disabled who deserve protection  
360 and assurance that they will have the care they need when  
361 they are wheeled into an emergency room, and sadly, it will  
362 let the insurers spend consumers' hard-earned dollars with no  
363 accountability. These things are bad from the standpoint of  
364 the public, the consuming public. They are also bad from the  
365 standpoint of the taxpayers because the loss of these  
366 provisions is going to run up the cost of Medicare, Medicaid,

367 government retirement plans, and it is also going to run up  
368 the cost of plans which are held by private industry for the  
369 benefit of their employees, and the situation is going to  
370 impact on ordinary citizens who buy their own insurance  
371 because they have no one to assure their protection against  
372 the abuses which the legislation before the committee would  
373 strip the consumers of protection in their enactment.

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

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

391 and a wide array of other programs that are necessary to  
392 protect American consumers.

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

399         I thank you for the time, Mr. Chairman.

400         [The prepared statement of Mr. Dingell follows:]

401 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

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402           Mr. {Pitts.} The chair thanks the gentleman.

403           That concludes the members' opening statements. We will

404 call panel one to the table. Our first panel is Steve

405 Larsen, Director of the Center for Consumer Information and

406 Insurance Oversight with the Centers for Medicare and

407 Medicaid Services. Welcome, Mr. Larsen. If you can

408 summarize, your written testimony will be made part of the

409 record, and you have 5 minutes.

|  
410 ^STATEMENT OF STEVE LARSEN, DIRECTOR, CENTER FOR CONSUMER  
411 INFORMATION AND INSURANCE OVERSIGHT, CENTERS FOR MEDICARE AND  
412 MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

413 } Mr. {Larsen.} Thank you, Chairman Pitts, Ranking Member  
414 Pallone and members of the subcommittee, and thank you for  
415 the opportunity to discuss the benefits of the medical loss  
416 ratio and grandfathering provisions of the Affordable Care  
417 Act.

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

424 Since enactment of the ACA, HHS with the Departments of  
425 Labor and Treasury have already implemented many of the  
426 private insurance market reforms including prohibiting  
427 insurance companies from imposing lifetime dollar limits on  
428 coverage, rescinding coverage absent fraud, and enabling many  
429 young people to stay on their parents' health plans up to age  
430 26.

431 The MLR provision in the Affordable Care Act reforms the

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

448 Consumers will begin receiving rebates in 2012 from  
449 plans that don't meet the standard in 2011. However, we are  
450 already seeing indications that the MLR provision is causing  
451 insurance companies to more carefully evaluate their need for  
452 increases, slowing the rate of premium growth. Insurers that  
453 have not met these standards have announced to Wall Street  
454 and in many cases advised State regulators that they are now  
455 setting prices to meet these new standards. One large

456 insurer will reportedly be dropping rates for nearly 10,000  
457 customers in Connecticut by between 5 and 20 percent. The  
458 GAO also found that issuers were moderate rate increases  
459 because of this rule. Repealing this provision will be a  
460 step backward for consumers.

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

474       The grandfathered plans interim final rule is intended  
475 to preserve the ability of Americans to keep the coverage  
476 that they had when the ACA was passed. However, if the terms  
477 of that coverage are changed significantly, the plan could  
478 end up as a very different plan than the one that was in  
479 effect in March of 2010, perhaps with much higher

480 coinsurance, deductibles or with fewer benefits, but if this  
481 modified coverage is still considered to be grandfathered  
482 coverage, it also would not provide some of the key consumer  
483 protections that we just talked about.

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

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

499         Also, based on the feedback we have received through out  
500 process and from formal comments in response to the interim  
501 final rule, HHS and Departments of Labor and Treasury issued  
502 an amendment to the amendment to the grandfathering rule in  
503 November of 2010. The amended final rule allows employers to

504 change carriers and keep their grandfathered status, again,  
505 providing even more flexibility to businesses and insurance  
506 companies in the implementation of this provision.

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

512 Thanks for the opportunity to appear before you, and I  
513 look forward to answering your questions.

514 [The prepared statement of Mr. Larsen follows:]

515 \*\*\*\*\* INSERT 1 \*\*\*\*\*

|  
516           Mr. {Pitts.} The chair thanks the gentleman. We will  
517 now begin the questioning and recognize myself for 5 minutes  
518 for that purpose.

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

533           Mr. {Larsen.} We have spent a substantial amount of  
534 time looking at this impact on agents and brokers. We know,  
535 for example, that the National Association of Insurance  
536 Commissioners on other issues related to the MLR standard  
537 took a pretty close look at the impact on agents and brokers  
538 of the MLR provision. Ultimately, as you may know, the NEIC

539 declined to take further action in terms of recommendations  
540 or endorsements of changes to the MLR provision whether it is  
541 repealing it or other modifications. As I remember, the work  
542 that the NEIC did, they found there was really a spectrum of  
543 activity, that there was certainly some issuers that had  
544 decided to lower commissions. It wasn't always clear whether  
545 that was a direct result. Some issuers in fact had  
546 increased. There wasn't a clear trend across all markets in  
547 all States regarding responses by issuers on the agent and  
548 broker issue. So I think it is certainly the case that in  
549 some instances insurers have limited their commissions to  
550 brokers. We are concerned about that and we will continue  
551 look at it. At this point the NEIC declined to take any  
552 action on that, and I think we have limited legal ability to  
553 do so as well.

554       Mr. {Pitts.} Well, you have the ability to review  
555 regulations. Are you going to review the regs?

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

563 have expressed.

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

574           Mr. {Larsen.} Well, first of all, we certainly support  
575 the role of agents and brokers in connection with the PESA  
576 program. We were very pleased to be able to provide payments  
577 or commissions to them on the PESA program. We certainly  
578 don't view the MLR rule as punishing agents and brokers.  
579 Frankly, it is many of the insurance companies that are  
580 taking this action. There is a very wide range in  
581 commissions that companies pay, and it is very possible that  
582 some of the companies are exploiting the MLR provision to  
583 lower agents' and brokers' commissions when they may not need  
584 to be doing that. I am not sure there is any clear data on  
585 that, but we support the role of agents and brokers both now  
586 and in 2014 in the exchanges, and we look forward to working

587 with them to see if there is a way to get us through that  
588 period between now and then.

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

595         Mr. {Larsen.} If I understand your question, yes,  
596 commissions are considered part of the administrative  
597 expense.

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

604         Mr. {Larsen.} No.

605         Mr. {Pitts.} It seems these rules are written in a way  
606 to disadvantage small employers. It also seems as if these  
607 rules will direct people into these new exchange plans. If a  
608 small business wants to use a broker or an agent because  
609 their employees don't want to be dumped into the exchange,  
610 they should be able to without federal rules that tilt the

611 playing field to government entities.

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

614 Mr. {Pallone.} Thank you, Mr. Chairman.

615 Mr. Larsen, the Republicans are portraying the  
616 discussion draft as a means for Americans who like their  
617 health coverage to keep it, and in fact I think this  
618 legislation is much broader. The real intention, I think, is  
619 to eliminate the insurance reforms enacted by the Affordable  
620 Care Act and put insurance companies, not patients, back in  
621 control, and I just wanted to point out just a few of the  
622 consequences of this legislation becoming law. One is, over  
623 1.2 million young adults would lose their insurance coverage  
624 because plans would no longer be required to cover them until  
625 age 26. Over 165 million Americans with private insurance  
626 coverage would be vulnerable again to having lifetime limits  
627 placed on how much insurance companies will spend on their  
628 health care. Fifteen point nine million people in the United  
629 States would be at risk of losing their insurance because  
630 rescissions would once again be legal, and 41 million  
631 Americans would lose guaranteed coverage for preventive  
632 services like mammograms and flu shots without cost sharing.  
633 Up to 43 million people in small business health plans would  
634 lose their medical loss ratio and rate review protections,

635 which would allow insurers to charge them high prices for  
636 low-value plans.

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

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

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

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

656         Mr. {Pallone.} Now, the Republicans have repeatedly  
657 claimed that the grandfathering rule issued by HHS will  
658 result in tens of millions of people losing their health

659 care. Is it accurate to say, as some are, that the  
660 grandfathering rule will result in people with employer-  
661 sponsored coverage being denied or losing their health  
662 insurance coverage because of HHS or because of the  
663 Affordable Care Act?

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

669 Mr. {Pallone.} And so where would Republicans get the  
670 idea that tens of millions of people are losing their health  
671 care? Where is this coming from?

672 Mr. {Larsen.} I don't know exactly where that is coming  
673 from.

674 Mr. {Pallone.} Okay. I mean, it just appears to me as  
675 another case where the Republicans are inventing problems  
676 allegedly caused by the Affordable Care Act, and even if  
677 plans do lose grandfathered status, that doesn't mean a  
678 person loses their health insurance. In fact, they gain some  
679 consumer protections like rights to external appeals and  
680 coverage of preventative services, and in any case, these  
681 requirements will not be prohibitive for employer plans  
682 because they usually already meet the rules. One employer

683 benefits consultant notes, and I quote, that ``large  
684 companies realize that they already comply with many of the  
685 requirements of non-grandfathered plans so the changes they  
686 will need to make aren't likely to add a significant cost or  
687 administrative burden.'' I mean, I just--to me, this is just  
688 a lot of nonsense. It is just another way to repeal patient  
689 protections, and everything that the Republicans are saying  
690 is going to happen, in fact, it is just the opposite.

691 Let me just ask you one more thing. I have got another  
692 minute here. Under the Republican legislation, grandfathered  
693 health plans would not have to report or openly justify  
694 premium increases. Have you seen an impact from rate review  
695 on premiums in any States in which it has been implemented so  
696 far, and is rate review going to be an impossibly onerous  
697 burden for insurance companies to meet?

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

707 important provision.

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

717           Thank you, Mr. Chairman.

718           Mr. {Pitts.} The chair thanks the gentleman and  
719 recognizes the vice chairman of the committee, Dr. Burgess,  
720 for 5 minutes for questions.

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

729           Mr. {Larsen.} Yes, sir. I know that we provided an  
730 initial response to you since our last meeting, and we are

731 working quickly to get the rest of those to you.

732 Dr. {Burgess.} Let me ask you a quick yes or no  
733 question. States have rate review authority and they had  
734 that prior to the passage of the Affordable Care Act. Is  
735 that correct?

736 Mr. {Larsen.} Some did, some didn't.

737 Dr. {Burgess.} Now, in response to a question that Mr.  
738 Pallone asked, you said you didn't know where the figures  
739 came from about people who would lose their plans under  
740 grandfathered status. So June 17, 2010, Department of Health  
741 and Human Services issued an interim final rule imposing  
742 additional restrictions that health plans must comply with in  
743 order to protect their grandfathered status. The  
744 Administration issued an amendment to the interim final rule  
745 17 November 2010. By the Administration's own estimates, 49  
746 to 80 percent of the small employer plans, 34 to 64 percent  
747 of large employer plans and 40 to 67 percent of individual  
748 insurance coverage will not be grandfathered by the end of  
749 2013, so that is from which those figures come, and we will  
750 be glad to provide you the places for those citations so you  
751 can familiarize--

752 Mr. {Larsen.} Perhaps I misunderstood. I thought that  
753 the question was, was there a claim that people were going to  
754 lose their coverage. The answer is no. Those statistics

755 relate to the projected--

756 Dr. {Burgess.} Remember, the big selling point on the  
757 Affordable Care Act was, if you like what you have, you can  
758 keep it.

759 Mr. {Larsen.} Sure.

760 Dr. {Burgess.} And if people like what they have, they  
761 may not be able to keep it. I think that is a fair statement.  
762 Is that not right?

763 Mr. {Larsen.} Well--

764 Dr. {Burgess.} Yes is the answer to the question. Let  
765 us move on.

766 Are you familiar with the Texas benefit pool?

767 Mr. {Larsen.} Say that again.

768 Dr. {Burgess.} The Texas benefit pool. It is not the  
769 high-risk pool, but this is a benefit pool for relatively  
770 small jurisdictions like small towns, and there are a number  
771 of small towns in Texas, to be able to pool together to  
772 purchase health insurance for their municipal employees that  
773 otherwise--and these are frequently cities that have  
774 significantly less than 50 employees under their  
775 jurisdiction. So 40,000 beneficiaries in 750 different  
776 political subdivisions and 90 percent of these numbers have  
777 50 or fewer employees. Under the Affordable Care Act as  
778 currently written, they will go out of business. They cannot

779 be a grandfathered plan. They cannot survive as a health  
780 plan in the exchanges because of the tight definitions, so it  
781 looks like they have got nowhere to go, and this is the  
782 solution that the State of Texas created to a problem well  
783 over 30 years ago. It has worked and it is providing lower-  
784 cost health care today but it is going to end up costing the  
785 Federal Government more because you will need higher  
786 subsidies for low-income workers and higher-priced plans.

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

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

796         Dr. {Burgess.} All right. We will get you some more  
797 information on that, and I have got a number of others, and  
798 clearly I am going to run out of time.

799         As you know, I have been fascinated by your center or  
800 office or whatever we are calling it since I first learned of  
801 it a little over a year ago, and what began as the Office of  
802 Consumer Information and Insurance Oversight last summer is

803 now the Center for Consumer Information and Insurance  
804 Oversight and it is now under the direction of the Centers  
805 for Medicare and Medicaid Services and not a standalone  
806 agency within the agency. Have I basically given a  
807 recapitulation of your brief history correctly?

808 Mr. {Larsen.} Yes.

809 Dr. {Burgess.} But also nowhere in here is your agency  
810 or center authorized. It was not mentioned specifically in  
811 statute in the Affordable Care Act, so it was a mystery to  
812 many of us when we first learned about it in August of last  
813 year that you were up and running and office space off the  
814 Hill and hiring employees, and I remember talking to your  
815 predecessor about well, why in the world could you--you know,  
816 surely these are functions that are already being performed  
817 at HHS, why not just--you are duplicating abilities, and I  
818 was informed that that is not the case because for the first  
819 time the federal government is going to regulate the entire  
820 private insurance market in the country, which historically  
821 has been a function of the States. Is that correct?

822 Mr. {Larsen.} The original office, OCIO, yes, was set  
823 up to implement the new provisions relating to the private  
824 health insurance market.

825 Dr. {Burgess.} And we have a new agency or a new office  
826 or center--

827 Mr. {Larsen.} Center.

828 Dr. {Burgess.} --not authorized under statute. You  
829 have spent now, according to figures you provided me through  
830 the end of August, almost \$3 billion, \$3.2 billion in  
831 implementation funds, correct?

832 Mr. {Larsen.} Well, much of that, as you know, as I  
833 think you know, are the reimbursements under various programs  
834 but we haven't--

835 Dr. {Burgess.} It is fascinating that this could occur--  
836 -

837 Mr. {Larsen.} But we haven't spent that money on the  
838 operations of--

839 Dr. {Burgess.} --under the statute and Congress not be  
840 aware of it. I mean, so I welcome your presence here today.  
841 I think it is good we are finally having this dialog and this  
842 oversight, but it troubles me that it occurred the way it  
843 did. It was seemingly something that was under the radar  
844 screen.

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

847 Mr. {Pitts.} The chair thanks the gentleman and  
848 recognizes the Ranking Member Emeritus, Mr. Dingell, for 5  
849 minutes for questions.

850 Mr. {Dingell.} Mr. Chairman, I thank you for your

851 courtesy.

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

856 Mr. {Larsen.} True.

857 Mr. {Dingell.} Is it also true that 34 States prior to  
858 ACA had a minimum MLR standard or reporting requirements for  
859 certain markets? Yes or no.

860 Mr. {Larsen.} I think that is right, yes.

861 Mr. {Dingell.} As you know, ACA sets a minimum federal  
862 MLR standard. As a former State insurance commissioner, do  
863 you believe that this will simplify regulatory compliance for  
864 insurance companies? Yes or no.

865 Mr. {Larsen.} Yes.

866 Mr. {Dingell.} Further, do you believe that minimum MLR  
867 requirements will encourage greater transparency and  
868 understanding in insurance spending for consumers? Yes or  
869 no.

870 Mr. {Larsen.} Yes, I do.

871 Mr. {Dingell.} Under the Affordable Care Act, the  
872 National Association of Insurance Commissioners was tasked  
873 with coming up with definitions and calculation for MLR  
874 requirements. Were the recommendations from the National

875 Association of Insurance Commissioners taken into  
876 consideration prior to the interim final vote? Yes or no.

877 Mr. {Larsen.} Yes. In fact we adopted them all.

878 Mr. {Dingell.} As a matter of fact, you adopted them  
879 all. That is right, isn't it?

880 Mr. {Larsen.} Yes, sir.

881 Mr. {Dingell.} Is it correct that the NAIC  
882 recommendations were unanimously approved by the insurance  
883 commissioners from all 50 States and the District of  
884 Columbia?

885 Mr. {Larsen.} Yes, that is correct.

886 Mr. {Dingell.} So you had vast unanimity on this  
887 matter, did you not?

888 Mr. {Larsen.} Yes.

889 Mr. {Dingell.} Now, did you separately consult with the  
890 States, the public and other stakeholders prior to issuing  
891 the rule? Yes or no.

892 Mr. {Larsen.} We accepted the public input process that  
893 the NAIC conducted and then we have since taken comments and  
894 plan to look at further modifications to the MLR standard.

895 Mr. {Dingell.} Now, one item that has gotten much  
896 attention recently is the ability of the States to apply for  
897 an adjustment under MLR requirements. The Affordable Care  
898 Act allows the Secretary to adjust the MLR standard for the

899 individual market in a State if it is found that the standard  
900 may destabilize the individual market. Is that correct?

901 Mr. {Larsen.} Yes.

902 Mr. {Dingell.} And have you had applications for this  
903 kind of waiver and have you granted such waivers?

904 Mr. {Larsen.} We have had a number of applications. I  
905 think that we have granted five of the ones that we have  
906 reviewed so far.

907 Mr. {Dingell.} Now, is this adjustment meant to help to  
908 transition the State and the insurance plans will have to  
909 make to comply with the new federal minimum MLR standards?

910 Mr. {Larsen.} Yes, sir, that is exactly what it does.

911 Mr. {Dingell.} How many States have requested  
912 adjustments so far?

913 Mr. {Larsen.} I think it is about 13.

914 Mr. {Dingell.} Of this number, how many States have  
915 received adjustments?

916 Mr. {Larsen.} Five of the ones, but we haven't finished  
917 reviewing many of them. Their applications are not complete  
918 yet from the States.

919 Mr. {Dingell.} Has anybody been turned down?

920 Mr. {Larsen.} Yes, two States.

921 Mr. {Dingell.} In whole or in part?

922 Mr. {Larsen.} In whole.

923           Mr. {Dingell.} This temporary adjustment then maintains  
924 the intent of MLR requirements which is to ensure that the  
925 majority of premium dollars are spent on medical claims and  
926 activities to improve health quality. Is that right or  
927 wrong?

928           Mr. {Larsen.} Correct.

929           Mr. {Dingell.} As a former insurance commissioner, do  
930 you believe that the MLR requirement will help the American  
931 consumer get more value out of their health plans? Yes or  
932 no.

933           Mr. {Larsen.} Yes.

934           Mr. {Dingell.} Now, under the MLR requirement, we are  
935 already starting to see insurance companies either slow or  
936 decrease the growth in premiums. Is that right?

937           Mr. {Larsen.} Yes.

938           Mr. {Dingell.} Do you believe that the repealing of the  
939 MLR requirements will harm or hamper or impede this progress?

940           Mr. {Larsen.} It is a step backward, yes.

941           Mr. {Dingell.} All right. Now, let us take a little  
942 look. Some of the things which will be adversely affected  
943 here that we are concerned with are things like insurance for  
944 young adults to 26, prohibition of rescission of insurance,  
945 prohibition of annual and lifetime limits, prohibition of  
946 preexisting-condition discrimination--I want to note

947 particularly that one--no cost sharing for preventive  
948 benefits, patient's choice of providers, protecting small  
949 businesses, giving them new rights, protecting patients from  
950 medical bankruptcy, and right to appeal from insurance  
951 company denials. All of those new rights will be adversely  
952 affected by this legislation. Is that correct?

953 Mr. {Larsen.} Yes.

954 Mr. {Dingell.} And the rights will be taken away from  
955 the consumers. Is that right?

956 Mr. {Larsen.} Yes.

957 Mr. {Dingell.} Thank you, Mr. Chairman. Bad piece of  
958 legislation. I hope everybody is noting it.

959 Mr. {Pitts.} The chair thanks the gentleman and  
960 recognizes the gentleman from New Jersey, Mr. Lance, for 5  
961 minutes for questions.

962 Mr. {Lance.} Thank you, Mr. Chairman.

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

969 As I understand the MLR regulation, there is an  
970 exclusion of health plan investments and initiatives to

971 prevent fraud from those activities that improve health care  
972 quality. It seems to me that this creates a perverse  
973 incentive to tackle fraud on the pay-and-chase side rather  
974 than the prevention side, and I believe CMS is stepping away  
975 from the pay-and-chase model. Could you give us your views  
976 on why we may be choosing to penalize measures to combat  
977 fraud and abuse in the MLR rule?

978       Mr. {Larsen.} So the way that the MLR rule treats fraud  
979 is, it allows certain fraud recovery expenses to be included  
980 but not all of them, and that was essentially the middle  
981 ground that the NAIC reached when they looked at this issue  
982 and balanced the desire to, you know, encourage companies to  
983 invest in fraud prevention recovery versus the statutory  
984 language. I will say, though, that I don't think that we  
985 agree with the conclusion that this creates a disincentive  
986 for investment in fraud because to the extent that insurers  
987 invest in fraud prevention and fraud recovery and lower their  
988 underlying expenses, they are going to be in a position to  
989 lower their premiums and have a competitive advantage  
990 compared to other companies that don't make those types of  
991 investments. So even though it is not fully recoverable in  
992 the MLR formula, we don't agree that that creates a  
993 disincentive for plans to engage in activities that they  
994 should do that is helpful for their efficiency as well.

995 Mr. {Lance.} Why not go all the way and permit it and  
996 not have a middle ground?

997 Mr. {Larsen.} Well, again, the statutory language that  
998 we are dealing with talks about two categories, categories  
999 related to clinical services like paying doctors and  
1000 hospitals, and then quality-improving activities, and again,  
1001 I think the NAIC and we came to kind of a middle ground on  
1002 this issue but thought that it would be really stretching the  
1003 envelope to include a wider range of expenditures relating to  
1004 fraud prevention.

1005 Mr. {Lance.} Thank you. I obviously respectfully  
1006 disagree and I hope that you might examine that again.

1007 HHS has issued interim final rules implementing PPACA  
1008 without first issuing proposed rules and receiving comment.  
1009 From my perspective, HHS is acting on an ad hoc basis with no  
1010 clear standards. What is your protocol for deciding when HHS  
1011 will issue a rule on an interim final rule without first  
1012 issuing a proposed rule?

1013 Mr. {Larsen.} Well, in the case of implementing the  
1014 ACA, there were a number of interim final rules, or IFRs,  
1015 that we issued in June right after the bill passed, and those  
1016 were largely a function of the pressing time frame that was  
1017 facing us to get regulations in place so that businesses and  
1018 individuals had guidance as to how the law would be

1019 implementing. In areas where we have had a longer lead time  
1020 to implement the law, we have done proposed rulemaking. So,  
1021 for example, on the rate review reg, we did a proposed rule  
1022 and then we finalized that rule recently, so it has largely  
1023 in the case of ACA been a function of meeting the statutory  
1024 deadlines, and of course, after we issue the IFR, we always  
1025 take comments and some case like the grandfathering reg we  
1026 went back and have amended them.

1027 Mr. {Lance.} When will you be replacing the interim  
1028 final rules such as final rules such as the grandfathering  
1029 and MLR rule?

1030 Mr. {Larsen.} So we continue to evaluate the comments  
1031 that we have gotten in. I can't provide you with a specific  
1032 timeline for that at this point but we continually evaluate  
1033 the status of the interim rules to determine--

1034 Mr. {Lance.} Do you think it might be by the end of the  
1035 year, Mr. Larsen?

1036 Mr. {Larsen.} If I could get back to you on that?

1037 Mr. {Lance.} Certainly, through the distinguished  
1038 chairman.

1039 Thank you, Mr. Chairman, and I yield back the balance of  
1040 my time.

1041 Mr. {Pitts.} The chair thanks the gentleman and  
1042 recognizes the gentleman from Louisiana, Dr. Cassidy, for 5

1043 minutes for questions.

1044 Dr. {Cassidy.} Hello, Mr. Larsen. Now, just to be  
1045 clear, if somebody has a high-deductible health plan with an  
1046 HSA, the contribution to the HSA is not included, so they pay  
1047 out \$2,000 out of their HSA, that is not included in terms of  
1048 the claims payment history of the insurance company, correct?

1049 Mr. {Larsen.} I think that is right.

1050 Dr. {Cassidy.} That is my understanding. Now, it seems  
1051 like there is a clear prejudice here because the insurance  
1052 company has fixed costs. They have rent, they have  
1053 utilities, they have whatever. So that the high-deductible  
1054 health care plan, 95 percent of people who have these have  
1055 less than \$5,000 per annum expenses and their deductible may  
1056 be \$5,000. The insurance company has an absolute amount less  
1057 dollars because of the 15 percent MLR, correct? If you will,  
1058 this is a clear prejudice against a plan which encourages the  
1059 person to be most cost-aware and which studies show gives a  
1060 nice balance of the customer, if you will, the patient,  
1061 looking for value. Is that easily acknowledged?

1062 Mr. {Larsen.} I know that is one of the perceived  
1063 benefits, yes.

1064 Dr. {Cassidy.} That is a perceived benefit of the plan?

1065 Mr. {Larsen.} Yes.

1066 Dr. {Cassidy.} And studies would show that it is true.

1067 Now, that said, this MLR is clearly prejudiced against such  
1068 plans. They have fewer absolute dollars with which to pay  
1069 their administrative fixed costs relative to a gold star plan  
1070 which, you know, my gosh, if you charge \$10,000 for a policy  
1071 versus \$2,000, in absolute dollars there is a lot less. Fair  
1072 statement?

1073 Mr. {Larsen.} Right.

1074 Dr. {Cassidy.} So why would we have a policy which is  
1075 prejudicing against the purchase or the delivery of a plan  
1076 which studies show give you a more cost-effective purchase of  
1077 health insurance?

1078 Mr. {Larsen.} It is a question we can go back, to be  
1079 honest with you, the issue about the applicability of this to  
1080 the higher-deductible plans hasn't come on my radar screen,  
1081 so I would be happy to go back and look at that.

1082 Dr. {Cassidy.} I have to say that surprises me, since  
1083 we see the uptake of HSAs with high-deductible health care  
1084 plans as increasing dramatically, and again, this is a clear  
1085 prejudice towards higher-cost plans because a higher-cost  
1086 plan at a 15 percent MLR has more absolute dollars for the  
1087 insurance company to play with. Again, that is not  
1088 disputable, is it?

1089 Mr. {Larsen.} So we can go back and look at that, as I  
1090 said. We have--you know, there is a number of issues that

1091 are kind of front and center on MLR and there are some  
1092 provisions we may have to modify before the end of the year,  
1093 so I would be happy to look at that.

1094 Dr. {Cassidy.} Yes. When you say ``look at'', I just  
1095 don't know what that means. Does that mean that you can see  
1096 that there is a problem here or that well, we will look at  
1097 it? Do you see what I am saying?

1098 Mr. {Larsen.} Yes, I think it means that I would like  
1099 to, you know, sit down and get a better understanding of how  
1100 the MLR provision applies. Again, and it may just be me, we  
1101 haven't heard a lot about this, at least I haven't. You  
1102 know, I confess, it doesn't mean that my staff has not. So  
1103 ``look at it'' means understand it and see if we need to  
1104 respond to it.

1105 Dr. {Cassidy.} The second thing is, so you are at least  
1106 open to having a different set of rules for high-deductible  
1107 health care plans?

1108 Mr. {Larsen.} Pardon me?

1109 Dr. {Cassidy.} Are you open or is it possible to have a  
1110 different set of rules for catastrophic plans?

1111 Mr. {Larsen.} I don't know whether the statute would  
1112 allow that or not, so--

1113 Dr. {Cassidy.} If the statute does not, would you think  
1114 it would be a reasonable thing to correct that, pass another

1115 law, perhaps?

1116 Mr. {Larsen.} I hesitate to say without having a better  
1117 sense of what I am talking about.

1118 Dr. {Cassidy.} That is a fair statement.

1119 The other thing that disturbs is that the pattern of  
1120 usage by the person with the HSA will greatly influence how  
1121 this applies. If you have a group of people, each with  
1122 \$2,000 HSAs, and each uses \$2,000, you never enter into a  
1123 claim, but if one person has \$10,000 and everybody else has  
1124 zero, you have got five people in the group, everybody else  
1125 has zero but one has \$10,000, and clearly there are going to  
1126 be claims paid, you are more likely to be able to hit the MLR  
1127 requirement even though the claims history for the group is  
1128 no different. Fair statement?

1129 Mr. {Larsen.} Sounds like it.

1130 Dr. {Cassidy.} Yes. So I have to admit that this kind  
1131 of bill, which everybody is endorsing over there as  
1132 sacrosanct gives me great pause just as I think about it.

1133 I have a little bit of time left. My insurance company  
1134 clearly a criticism of our system is that it is a sickness  
1135 treatment system, not a wellness-promoting system. There is  
1136 an insurance company back home, Baton Rouge, Louisiana, which  
1137 goes into a small employer and institutes wellness programs,  
1138 and in so doing, they actually decrease utilization. They

1139 have outcomes data that shows this. But apparently this  
1140 would be included in the MLR. They say they are going to  
1141 have to eliminate the wellness program because it will--  
1142 granted, claims history is down, which in and of itself  
1143 decreases their absolute dollars but a portion of their  
1144 administrative costs is getting the folks over 50 to take an  
1145 aspirin a day. So again, this seems like we are prejudicing  
1146 against--

1147       Mr. {Larsen.} Well, I have to confess, that I don't  
1148 understand because that activity at least that you are  
1149 describing would sound like it would be a quality-improving  
1150 activity. We lay out the categories in the--the statute  
1151 actually lays out the categories for improving health care  
1152 outcomes, lowering hospital readmissions, prevention,  
1153 wellness. Those are all part of the permissible types of  
1154 expenses. So I am not clear why in the situation you are  
1155 describing there is a disincentive to do that. It sounds  
1156 like it would be the opposite.

1157       Dr. {Cassidy.} I am out of time, so let me pursue that  
1158 and we will get back to you.

1159       Mr. {Larsen.} Okay.

1160       Dr. {Cassidy.} Thank you.

1161       Mr. {Pitts.} The chair thanks the gentleman and  
1162 recognizes the gentleman from Georgia, Dr. Gingrey, for 5

1163 minutes of questions.

1164 Dr. {Gingrey.} Mr. Chairman, thank you.

1165 I am going to shift gears just a little bit. I want to  
1166 talk about the CLASS Act. According to an article that ran  
1167 in the Atlanta Journal Constitution yesterday, ``Even as  
1168 leading Democrats offered assurances to the contrary,  
1169 government experts repeatedly warned that a new long-term  
1170 care insurance plan could go belly up, saddling taxpayers  
1171 with another unfunded benefit program according to emails  
1172 disclosed by Congressional investigators,'' and that is a  
1173 quote. Mr. Larsen, that quote was based on a joint report  
1174 produced in part by Energy and Commerce Committee Republicans  
1175 that sheds a bright light on the suspicious inner workings of  
1176 Congressional Democrats and the White House as a push for  
1177 Obamacare. The report finds that after repeated warnings  
1178 from the CMS Chief Actuary and others about the insolvency of  
1179 the CLASS program. HHS and Senate Democrats effectively cut  
1180 the actuary out of the process and turned to CBO to give them  
1181 the numbers they needed, only those numbers were wrong.  
1182 Eighteen months after CBO pronounced the CLASS Act solvent,  
1183 Secretary Sebelius finally admitted to the world what we all  
1184 knew, that the CLASS Act was in fact insolvent. As of today,  
1185 CBO has failed to make public the economic model cited in the  
1186 report that deemed this program solvent. Even worse, CBO

1187 staff now says they do not have the capacity to analyze the  
1188 CLASS Act's long-term solvency.

1189           Mr. Larsen, I believe that the economic modeling used to  
1190 sell PPACA, the Patient Protection and Affordable Care Act,  
1191 to the American people needs to be thoroughly reviewed from  
1192 top to bottom.

1193           Further, I would once again call on this Congress to  
1194 pass H.R. 1173. That is a simple bill that my good friend,  
1195 Dr. Charles Bustani from Louisiana, and I have introduced to  
1196 repeal the CLASS Act. The CLASS Act is just another example  
1197 of how bad policy can threaten the financial health of this  
1198 great Nation. What say you, Director Larsen?

1199           Mr. {Larsen.} Well, I will have to say that I will take  
1200 your comments back to HHS. The CLASS Act does not fall under  
1201 the area that I have responsibility for, and I have to  
1202 confess, I have not kept up with the current situation with  
1203 the CLASS act, so I would be happy to share your concerns,  
1204 but I can't respond--

1205           Dr. {Gingrey.} Fair enough. Fair enough, and I do  
1206 appreciate the fact that you will take that back and continue  
1207 to discuss because clearly it is insolvent and it is a real  
1208 cost driver.

1209           Let me follow up on Dr. Burgess's question for a minute.  
1210 The President promised the American people that if you are

1211 among the hundreds of millions of Americans who already have  
1212 health insurance through your job, Medicare, Medicaid or the  
1213 VA, nothing in this plan will require you or your employer to  
1214 change the coverage or the doctor you have. Let me repeat,  
1215 nothing in our plan requires you to change what you have.  
1216 Now, that is pretty much a direct quote from the President.  
1217 Do you agree with the President that nothing in the Patient  
1218 Protection and Affordable Care Act will make the hundreds of  
1219 millions of Americans who already have health insurance  
1220 through their job to change the insurance that they have  
1221 today?

1222 Mr. {Larsen.} That is the point of the grandfathering  
1223 provision, and I think that is what our regulation permits,  
1224 which is for people to continue to keep the coverage that  
1225 they have.

1226 Dr. {Gingrey.} Well, you know, let me express a  
1227 concern, Mr. Larsen, that I have and maybe turn it into a  
1228 question, and it is not just me as a physician member of the  
1229 committee and of the Congress, having too many, 26 years, 31  
1230 years clinical practice of medicine. But, you know, it just  
1231 seems to me that the way this bill was set up with expansion  
1232 of Medicaid up to 133 percent of the federal poverty level,  
1233 so you force more and more of the uninsured on to the States  
1234 that have to balance their budgets and costs them additional

1235 billions of dollars. You at the same time--not, you, but the  
1236 bill--even though you are talking about the grandfathered  
1237 provision and all that, it really concerns us as you have  
1238 heard from committee members on this side of the aisle and  
1239 MLR and why we feel like that that was just another reason  
1240 why so many of these employers that cover American workers  
1241 are going to drop their health coverage unless of course it  
1242 is provided through a union contract. So you basically force  
1243 a bigger volume of people onto the exchanges and you avoid a  
1244 lot of the premium support because you push the nearly poor  
1245 into Medicaid and therefore you make this program work by  
1246 virtue of volume. Health insurers like that, of course, and  
1247 require individuals to purchase health insurance even if they  
1248 don't want it is all part of that scheme, and you ultimately  
1249 end up with Medicare from cradle to grave, and that is a  
1250 legitimate concern.

1251 I know I have run out of time, but if the chairman will  
1252 indulge me, what say you in regard to those concerns?

1253 Mr. {Larsen.} Well, you covered a lot of ground, but a  
1254 couple comments. One, the ACA expands coverage through a  
1255 number of different mechanisms, certainly through a Medicaid  
1256 expansion, which by the way the newly eligibles are covered  
1257 at 100 percent match through, I think--

1258 Dr. {Gingrey.} For 2 years, yes.

1259 Mr. {Larsen.} For I think longer than that. And then,  
1260 yes, we rely on private market solutions in order to expand  
1261 coverage for those that are not eligible for Medicaid. There  
1262 is a premium subsidy for folks between the 100 and 400  
1263 percent of poverty but those policies are provided in the  
1264 exchanges through private issuers, and I think all the  
1265 studies show that that is going to resolve in a significant  
1266 expansion of coverage for non-Medicaid individuals as well.

1267 Dr. {Gingrey.} Mr. Chairman, thank you, and Mr. Larsen,  
1268 thank you.

1269 Mr. {Pitts.} The chair thanks the gentleman and  
1270 recognizes the ranking member.

1271 Mr. {Pallone.} Mr. Chairman, I would just ask unanimous  
1272 consent to enter four letters into the record: a group  
1273 letter from nearly 50 organizations, HIV Health Care Access  
1274 Working Group letter, American Diabetes Association letter,  
1275 and a Main Street Alliance letter, and these are in  
1276 opposition to the draft, and I believe you have them.

1277 Mr. {Pitts.} We have them. Without objection, so  
1278 ordered.

1279 [The information follows:]

1280 \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|  
1281           Mr. {Pitts.} The chair now recognizes the gentlelady  
1282 from Illinois, Ms. Schakowsky, for 5 minutes for questions.

1283           Ms. {Schakowsky.} Thank you, Mr. Chairman.

1284           I just wanted to correct one item that I think was  
1285 mistaken that was mentioned in questioning. Between July of  
1286 2010 and July of 2011, a number of insurance agents and  
1287 brokers actually went up by 5,500 people. So we were hearing  
1288 about the growing unemployment. In fact, that number is  
1289 actually increased. This is according to the Insurance  
1290 Information Institute, and so we are seeing about a .9  
1291 percent increase in employment, and given the facts today,  
1292 not bad, not great, but not bad and going in the right  
1293 direction.

1294           In 2010, Mr. Larsen, United Health, WellPoint, Humana,  
1295 Cigna and Aetna made combined profits of \$11.7 billion by  
1296 reducing the share of premiums being spent on the shrinking  
1297 membership in private health plans. Through the recession  
1298 and its aftermath from 2008 to 2010, their combined profits  
1299 increased 51 percent. In 2009, the total private membership  
1300 to these five companies was reduced by 2.7 million people and  
1301 another 839,000 in 2010. That was just 2009. In 2010,  
1302 another 839,000 at a time when 50.7 million people were  
1303 already uninsured. So profits went up. The number of people

1304 that they actually served went down. Despite this decrease  
1305 in membership, in 2010 the five insurers collected \$7.7  
1306 billion more in premiums than in 2009. However, the medical  
1307 loss ratio for four of the five companies decreased from 2009  
1308 to 2010.

1309         So clearly, the money generated by rising premiums was  
1310 not being used for medical or patient care, my point. Health  
1311 insurers are making enormous profits at the expense of their  
1312 customers, and this is not an isolated example. Insurers  
1313 claim that these profits are not large relative to the size  
1314 of their business, but what I see is nearly \$12 billion in  
1315 profits while hardworking families have been asked to pay  
1316 more and more in premiums.

1317         So where does profit fit into the medical loss ratio and  
1318 does a lower medical loss ratio allow insurers to still make  
1319 a decent profit?

1320         Mr. {Larsen.} The answer is yes, that they do still.  
1321 These standards still clearly allow issuers and insurance  
1322 companies to make a very fair, reasonable rate of return in  
1323 profit. The profit is part of the broad administrative  
1324 expense, so everything that isn't paying doctors' bills or  
1325 investing in quality is part of the administrative expense.  
1326 So it is profits, salaries, commissions, overhead, you know,  
1327 rent all of that is part of the administrative expense.

1328 Ms. {Schakowsky.} And when insurance companies talk  
1329 about their profits, they have already subtracted those  
1330 things, have they not?

1331 Mr. {Larsen.} Well, I think they are part of the other  
1332 mix. I guess the point I am trying to make is that there is  
1333 a lot of latitude for the insurers, say, in the individual  
1334 and small group market. They still have 20 percent of the  
1335 premiums to devote to all of the things that I just  
1336 enumerated including profits and so they have the flexibility  
1337 to modify their business model to lower rates in order to hit  
1338 the MLR standard, and it still leaves a lot of room for them  
1339 to make reasonable profits.

1340 Ms. {Schakowsky.} So what I have taken from this panel  
1341 is that a number of insurance companies actually are meeting  
1342 this medical loss ratio standard that you have set. Some  
1343 have actually lowered premiums, making it easier for  
1344 consumers, that the number of insurance agents and brokers,  
1345 which I just learned, has actually gone up, and that  
1346 insurance companies are doing great and that they can well  
1347 afford to meet this sensible and modest standard. That is my  
1348 summary. Am I wrong on any of those points?

1349 Mr. {Larsen.} I agree.

1350 Ms. {Schakowsky.} Thank you.

1351 I yield back.

1352 Mr. {Pitts.} The chair thanks the gentlelady and now  
1353 recognizes the gentleman from Illinois, Mr. Shimkus, for 5  
1354 minutes.

1355 Mr. {Shimkus.} Thank you, Mr. Chairman, and welcome,  
1356 Mr. Larsen. Sorry about being in and out of the hearing  
1357 room. They brought meetings down into the side room so I  
1358 have kind of been in the area but I hope I don't ask  
1359 questions that have already been asked. I was going to  
1360 follow up on what the chairman initially asked but he stole  
1361 my great questions, so I will move to a couple other things,  
1362 and some of this is kind of like Dr. Gingrey and just maybe  
1363 messages to send back to HHS and the like.

1364 This is a great committee, especially on our side. We  
1365 have got practitioners, so I like sitting in. I am not one.  
1366 I am a receiver of their benefits but you have got Dr.  
1367 Cassidy, you have got Dr. Burgess, you have Dr. Gingrey, and  
1368 no one really debates their compassion and concern for the  
1369 health care system because that is their livelihood, so I do  
1370 enjoy sitting in and listening to them as they try to make  
1371 sense of how we can best care for our citizens.

1372 Is there any internal memos going around HHS as to  
1373 different agencies as far as if the Select Joint Committee  
1374 does not meet their goal? You know, the defense budget is  
1375 number one in discretionary budget. Number two and the

1376 biggest cost of the national government is HHS. Have you  
1377 received word as to your office as if there is a  
1378 sequestration, what that might do, and is there some analysis  
1379 going on as to how that may affect the rollout of the Patient  
1380 Protection and Affordable Care Act?

1381 Mr. {Larsen.} I suspect there are but, you know, I am  
1382 really focused on the day-to-day implementation of the  
1383 provisions like the things that we are talking about today,  
1384 so--

1385 Mr. {Shimkus.} So they haven't talked to you about  
1386 that?

1387 Mr. {Larsen.} They have not come and talked to me about  
1388 it.

1389 Mr. {Shimkus.} And obviously, you know, that is my  
1390 concern. I did support the legislation but my really concern  
1391 was for the committee that the savings is on provider  
1392 payments and the hospital payments, physician payments. As  
1393 we know, Medicare pays 70 cents on the dollar. Medicaid  
1394 spends 60 cents on the dollar. I have great concerns.

1395 The other direction I would like to go is on the medical  
1396 loss ratio. We are not a good arbiter on fighting waste,  
1397 fraud and abuse, and do you not believe there is any credible  
1398 support that the ability of the insurance companies to fight  
1399 waste, fraud and abuse should be part of the medical loss

1400 ratio? Obviously, that is why we passed this legislation on  
1401 the Medicare card. We are terrible.

1402 Mr. {Larsen.} A component of it is, up to--they can  
1403 include the amount of expenditures of recovery based on what  
1404 they recover, and again, that was the balancing that the NAIC  
1405 achieved when they looked at this issue. They spent a lot of  
1406 time looking at this, getting input from different groups.  
1407 We adopted that balance. So there a component there but I  
1408 previously testified, we don't agree with the idea that not  
1409 including everything is a disincentive to those expenditures.  
1410 We just don't--

1411 Mr. {Shimkus.} Let me go quickly. I am going to run  
1412 out of time. And to my friend from Illinois, I just had the  
1413 insurance and financial brokers in yesterday. They weren't  
1414 there telling me that times are good. They were in the  
1415 office telling me times are bad, and part of it is because of  
1416 this piece of legislation that is now the land of the land.

1417 And finally, a question on--we did delegate policymaking  
1418 responsibilities to the National Association of Insurance  
1419 Commissioners, but HHS said the association followed a  
1420 thorough and transparent process in which the views of  
1421 regulators and stakeholders were discussed, analyzed,  
1422 addressed and documented in numerous open forums. Were HHS  
1423 comments documented, posted on the Internet with everyone

1424 else's?

1425 Mr. {Larsen.} You mean the comments that we provided to  
1426 NAIC during their process?

1427 Mr. {Shimkus.} Right.

1428 Mr. {Larsen.} Well, I don't know that we actually  
1429 provided kind of formal. We monitored their process so we  
1430 were aware of what they were doing.

1431 Mr. {Shimkus.} Did you attempt to influence their work  
1432 product in any way?

1433 Mr. {Larsen.} I don't recall providing written comments  
1434 to them on any of their issues, so we would listen in to  
1435 their phone calls, but that was largely a delegation to the  
1436 NAIC, and we would talk to their staff from to time.

1437 Mr. {Shimkus.} And I will finish with this. In October  
1438 2010, at the NAIC meeting, over a dozen commissioners  
1439 proposed that NAIC's official MLR submission to HHS remove  
1440 agent commissions from the MLR calculation. The votes were  
1441 there to pass an amendment but it was never called. I  
1442 understand you were in that room that day. Could you tell us  
1443 exactly what discussions you and anyone else at HHS had with  
1444 the NAIC members and staff regarding agent commissions and  
1445 MLR at the meeting in October 2010?

1446 Mr. {Larsen.} Yes. We went down as members of our  
1447 staff have been to all the NAIC meetings. They are a close

1448 partner of ours in the process, so were there to observe the  
1449 process. We were not there to lobby--

1450 Mr. {Shimkus.} So your testimony would be, you didn't  
1451 influence it?

1452 Mr. {Larsen.} No.

1453 Mr. {Shimkus.} Okay. Thank you.

1454 Mr. {Pitts.} The chair thanks the gentleman and  
1455 recognizes the gentleman from Kentucky, Mr. Guthrie, for 5  
1456 minutes for questions.

1457 Mr. {Guthrie.} Thank you, Mr. Larsen, for coming. I do  
1458 appreciate it.

1459 I just want to kind of go a little different path about  
1460 the rebates. Now the rebates are sent back to the employers.  
1461 And my line of questioning with this, the other day I was  
1462 back in our work period, and everywhere we go it seems like  
1463 we walk in--I know the President says there is a headwind on  
1464 the economy but I am telling you, I went to one of the  
1465 smallest banks in Kentucky, the smallest in my district, for  
1466 sure. They said let me introduce you to my new employee,  
1467 that is our new compliance officer, he doesn't make any  
1468 loans, doesn't create anything, all he does is make sure we  
1469 comply with the new law that came down. And so in this, we  
1470 do things here in Washington that sound simple. For  
1471 instance, we are going to rebate back to the employer if the

1472 MLR is breached. And so then I can see myself walking into a  
1473 company, wanting to talk about how we are going to compete  
1474 with China, Brazil, whatever, and they say let me talk to my  
1475 HR person that just got back from a briefing and asking  
1476 questions like if the breach moves forward and an employer-  
1477 sponsored plan isn't corrected, the plan can either pay the  
1478 employer or the employee. They can pay either employer or  
1479 employee, correct?

1480 Mr. {Larsen.} They can do what, sir?

1481 Mr. {Guthrie.} If the health insurance company, if they  
1482 breach the MLR, can rebate, the rebate can go to the employer  
1483 or employee?

1484 Mr. {Larsen.} Well, right, but this is a tricky issue.  
1485 What we said in the reg, and we are looking at possibly  
1486 changing this--

1487 Mr. {Guthrie.} But if it goes to the employee, then the  
1488 employee is responsible for writing a check back to the  
1489 employer for the--

1490 Mr. {Larsen.} The scenario is, so the employee  
1491 contributes to the health care premium.

1492 Mr. {Guthrie.} Like 20 percent. Right.

1493 Mr. {Larsen.} So you have got basically two people  
1494 paying combined the premium to the company, and so if there  
1495 is rebate, yes, we have to figure out, how does the rebate

1496 get back to the people that paid it, and we understand that  
1497 concern. In fact, in the proposed rule, we proposed that the  
1498 insurance company have the obligation to make sure that  
1499 everyone got the right money and--

1500 Mr. {Guthrie.} So the employer is going to have to send  
1501 it to the insurance company?

1502 Mr. {Larsen.} And we said you can enter into an  
1503 agreement with an employer to kind of discharge your  
1504 obligation. The insurance companies have said that is  
1505 tricky, we are not sure how that is going to work.

1506 Mr. {Guthrie.} Yes, that is a problem. They are out  
1507 here trying to make it work when it sounds simple.

1508 Mr. {Larsen.} So we--

1509 Mr. {Guthrie.} But then so the money comes back to the  
1510 employer or the employee, it is now taxable income, correct?

1511 Mr. {Larsen.} That I am not sure about.

1512 Mr. {Guthrie.} I think it would have to be, because  
1513 your premium dollars are pre-tax income, so they would have  
1514 to go back and fix the payroll taxes, correct? If that is  
1515 true. I know that is not your area of expertise.

1516 Mr. {Larsen.} Assuming that is true.

1517 Mr. {Guthrie.} Assuming that is true. Assuming that is  
1518 also true, then at the end of the year the employer is going  
1519 to have to update W-2 forms and redistribute them out to all

1520 their employees. So, I mean, it sounds simple, but we hear  
1521 it everywhere everything that is going on in this town. You  
1522 go to an employer in Kentucky--I haven't had this one yet  
1523 because it is not implemented but that is what they are  
1524 saying. It is reminiscent of the 1099, which created an  
1525 uproar. And that is the problem that we are seeing is, we  
1526 can design something that sounds simple on paper, and all of  
1527 a sudden who does the check go to. That is what they will be  
1528 asking us. Do I have to take out payroll taxes, if have to  
1529 pay payroll taxes, I have to update the W-2 forms. Does the  
1530 income go on this year or does it go on next year?

1531 Mr. {Larsen.} Well, we will work with folks as we are  
1532 in the middle of discussions now to try and figure out how we  
1533 can make it work. We don't want to lose sight of the  
1534 purpose, which is, if folks are in the position to get a  
1535 rebate, it means that they overpaid.

1536 Mr. {Guthrie.} Well, I agree.

1537 Mr. {Larsen.} They are entitled to get money back, so--

1538 Mr. {Guthrie.} And then you have to say, do I have to  
1539 pay--do I have to do an amended tax forms. I mean, it just  
1540 continues.

1541 Mr. {Larsen.} So we want to keep it simple but we don't  
1542 want to lose sight of the fact that we want them to get the  
1543 value for their premium dollar, and if they overpaid, we want

1544 to make sure that they get the money back in their pocket.

1545 Mr. {Guthrie.} We do hope it is simple. It needs to be  
1546 simple.

1547 I want to yield to my friend from Louisiana the rest of  
1548 my time.

1549 Dr. {Cassidy.} Thank you.

1550 Mr. Larsen, briefly reflecting on your remarks, I am  
1551 struck that you all have not considered HSAs. And so I just  
1552 pulled some statistics. I think I have heard in the past  
1553 that all new hires in GM's executive corps have HSAs. I just  
1554 pulled up something. In Lynchburg, Virginia, all the county  
1555 all has HSAs. I then just pulled up something which from  
1556 American Health Insurance Plans which speaks about how 11.4  
1557 million Americans now have HSAs, which increased 14 percent  
1558 in the last year, 26 percent of the growth in the large  
1559 groups but 15 percent in the individual market. I have to  
1560 ask you, why have not you considered HSAs? Because it seems  
1561 that that is the emerging market.

1562 Mr. {Larsen.} Well, when you say ``consider it'',  
1563 meaning consider it as a problem in the context of the  
1564 medical loss ratio regulation, correct?

1565 Dr. {Cassidy.} Correct.

1566 Mr. {Larsen.} And all I am saying to you is, that that  
1567 has not come on our radar screen, at least mine, maybe other

1568 folks in the agency, as an issue that we need to address in  
1569 terms of the imbalance.

1570 Dr. {Cassidy.} Now, to me, that reflects either--and no  
1571 offense, but since to me it just seems so apparent that if  
1572 you have plan which is more parsimonious or at least in terms  
1573 of how much do I have to pay for it, not as much, and this in  
1574 absolute dollars which we are on opposite sides of the issue  
1575 on this bill but we can both agree--

1576 Mr. {Larsen.} I mean, I am not sure the NAIC flagged  
1577 this for us either, so I am not at all adverse to looking at  
1578 it. You know, we have got a lot to do to implement this law  
1579 and when issues are brought to our attention, we take them  
1580 seriously and we will look at it and, you know, we have  
1581 looked at other issues. We amended the grandfathering rule  
1582 based on comments we got. We are looking at possible other  
1583 tweaks to the MLR rule that we have announced previously--I  
1584 am not making news here--you know, how we are going to deal  
1585 with the mini meds going forward and things like that. So we  
1586 will certainly put this on the list.

1587 Dr. {Cassidy.} Thank you.

1588 Mr. {Pitts.} The chair thanks the gentleman, and that  
1589 concludes the questioning for Mr. Larsen. Thank you very  
1590 much, Mr. Larsen, for your testimony and your willingness to  
1591 answer questions and to work with us.

1592 Mr. {Larsen.} Thank you.

1593 Mr. {Pitts.} We will call now panel two, and our second  
1594 panel consists of five witnesses. Our first witness is Mr.  
1595 Edmund Haislmaier, Senior Research Fellow in Health Policy at  
1596 the Heritage Foundation. Next is Ms. Grace-Marie Turner, the  
1597 President of the Galen Institute. Our third witness is Ms.  
1598 Janet Trautwein, who is the CEO of the National Association  
1599 of Health Underwriters. Our fourth witness is Mr. Wendell  
1600 Potter, Senior Analyst at the Center for Public Integrity.  
1601 And finally, Ms. Lynn Quincy, Senior Policy Analyst for the  
1602 Consumers Union.

1603 So we will begin at my left and go down the line. Mr.  
1604 Haislmaier, you may begin your testimony. We ask you to  
1605 summarize your written testimony in 5 minutes and your  
1606 written testimony will be made a matter of the record.

|  
1607 ^STATEMENTS OF EDMUND HAISLMAIER, SENIOR RESEARCH FELLOW,  
1608 HEALTH POLICY STUDIES, THE HERITAGE FOUNDATION; GRACE-MARIE  
1609 TURNER, PRESIDENT, GALEN INSTITUTE; JANET TRAUTWEIN, CHIEF  
1610 EXECUTIVE OFFICER, NATIONAL ASSOCIATION OF HEALTH  
1611 UNDERWRITERS; WENDELL BLAINE POTTER, SENIOR ANALYST, THE  
1612 CENTER FOR PUBLIC INTEGRITY; AND LYNN BATES QUINCY, SENIOR  
1613 POLICY ANALYST, CONSUMERS UNION

|  
1614 ^STATEMENT OF EDMUND HAISLMAIER

1615 } Mr. {Haislmaier.} Thank you, Mr. Chairman and members  
1616 of the committee for inviting me to testify today. A few  
1617 points that I will make out of my written testimony.

1618 I have pointed out in that testimony that there are a  
1619 number of problems, some of which have already been  
1620 discussed, with the medical loss ratio regulations. The  
1621 discussion has already addressed in the previous panel what I  
1622 see as one of the biggest problems, which is the disincentive  
1623 for insurers to spend money on preventing fraud and abuse.  
1624 Mr. Larsen pointed out that there are some provisions that  
1625 allow insurers to get some credit for that. That is true. I  
1626 cover that in my testimony.

1627 The problem that I would point out here is really one of

1628 statute. It is not the fault or the NAIC or Mr. Larsen's  
1629 office. The problem is the statute was badly written and  
1630 this was not accounted for when they wrote the statute. It  
1631 is one of many problems. What Mr. Cassidy was pointing about  
1632 HSAs is another problem, and the problem with rebates and how  
1633 they are paid is another problem. These are things that  
1634 Congress simply did not consider when they drafted the  
1635 statute, and in my reading of the statute, I am afraid that  
1636 NAIC and Mr. Larsen and HHS really have limited ability  
1637 because of the constraints of the statute to actually fix  
1638 what are very real problems, and that is why, Mr. Chairman, I  
1639 am encouraged that you are having a hearing on this because  
1640 it really is Congress that needs to fix the problems that  
1641 they have created here.

1642 Mr. Larsen made the observation, and it is a correct  
1643 one, in my view, and I didn't touch on it in my testimony so  
1644 I would like to expound on it for a minute, that even though  
1645 the MLR provisions disincentivize insurers to pay attention  
1646 to fraud and abuse, he doesn't think that that will be a  
1647 problem because an insurer that neglects those activities  
1648 will result in having higher claims costs and higher premiums  
1649 and thus be competitively disadvantaged, and I would say that  
1650 he is economically correct if you assume--and this is the big  
1651 ``if''--that you still have a robust competitive insurance

1652 market.

1653           Unfortunately, as I outline in my testimony and have in  
1654 other things that I have written, this provision in  
1655 combination with a number of other provisions such as the  
1656 rate review and some of the benefit mandates will lead to a  
1657 dramatic reduction in the number of carriers and thus when  
1658 you move toward an oligopolistic market, if you have only got  
1659 two or three big carriers, then everybody has an incentive to  
1660 just say well, we will ignore it and we will just, you know,  
1661 pass through the costs and pad our profits, particularly  
1662 since they will be operating in a market where many of their  
1663 customers will be subsidized by the government under other  
1664 provisions of PPACA. So while in the short term I think Mr.  
1665 Larsen's economic analysis is correct, in the long term I  
1666 think this is a very serious problem.

1667           Let me make two other--let me make an observation about  
1668 the effects of the medical loss ratio that has not been  
1669 brought up this morning in my oral remarks, and it is covered  
1670 in the testimony that I submitted for the record. One of the  
1671 big problems with this medical loss ratio or minimum loss  
1672 ratio standard is it effectively constrains the amount of  
1673 capital that an insurer can accumulate from their premium  
1674 after paying claims and administrative expenses, and that is  
1675 going to lead, in my view, to a number of insurers simply

1676 exiting the market, particularly smaller ones. I discussed  
1677 that in the testimony. It will very dramatically prevent or  
1678 hinder new insurers from being created because it is not  
1679 possible for an insurer to run a loss and then recoup it in  
1680 the initial startup phase anymore. So the first thing that  
1681 this does is kill off any new insurers entering the market.

1682         Parenthetically, I would say--I didn't cover this in my  
1683 written testimony--but on another subject we have another  
1684 provision of PPACA that is trying to create new co-op  
1685 insurers. This actually works against doing that. There are  
1686 a lot of things that work against doing that.

1687         And then finally, and I think most perversely from the  
1688 perspective of proponents of this legislation, it severely  
1689 disadvantages nonprofit insurers relative to for-profit  
1690 insurers because nonprofit insurers, if you look at a market  
1691 where you want to consolidate to the point that you are too  
1692 big to fail, which is I think where insurers are going to go  
1693 in with PPACA, nonprofit insurers don't have the wherewithal  
1694 to do it. They can't raise the capital other than what they  
1695 retain from premiums whereas for-profit insurers can go into  
1696 the equity market, issue shares and buy up the nonprofits.

1697         So when I look down the road and say well, what does the  
1698 world look like in 15 years or 10 years, if you stay on this  
1699 course, it looks like maybe three national insurance

1700 companies, all for profit, doing everything, and they are  
1701 really going to function like Medicare fiscal intermediaries  
1702 where they just pay the claims and don't care and leave it to  
1703 the government to worry about the legitimacy and the cost of  
1704 it. That I think is very debilitating, and I think is the  
1705 single biggest reason why Congress should repeal this set of  
1706 provisions.

1707           Thank you for your time. I will be happy to answer  
1708 questions.

1709           [The prepared statement of Mr. Haislmaier follows:]

1710 \*\*\*\*\* INSERT 2 \*\*\*\*\*

|  
1711 Mr. {Pitts.} The chair thanks the gentleman.

1712 We are voting on the Floor at this time, so we will try  
1713 to get through another presentation, and if it is all right  
1714 with the ranking member, we will break and come back. Is  
1715 that okay?

1716 Mr. {Pallone.} Yes.

1717 Mr. {Pitts.} We have two votes, unfortunately, so we  
1718 are going to have to go.

1719 Ms. Turner, you are recognized for 5 minutes.

|  
1720 ^STATEMENT OF GRACE-MARIE TURNER

1721 } Ms. {Turner.} I will be quick. Thank you, Mr.  
1722 Chairman. Thank you, Mr. Pallone and members of the  
1723 committee.

1724 Many employers said that the assurances that their  
1725 health plans would be grandfathered was a key reason that  
1726 they supported the legislation, yet independent surveys and  
1727 the Administration's own estimates, as we have heard today,  
1728 indicate that most employers will not be able to maintain  
1729 their grandfathered status and therefore I would argue that  
1730 the rules that were designed to do that therefore are failing  
1731 and are not achieving their goal. The grandfathering rules  
1732 really boxed employers into a corner. They can't make  
1733 changes other than minor modifications to their health plans  
1734 to keep costs down without being forced to comply with  
1735 expensive regulations that increase their health care costs.

1736 Health costs are directly related to creation of jobs,  
1737 as we have talked about a lot today. Higher health care  
1738 costs put additional pressure on the employer's bottom line  
1739 and increase the cost of hiring new workers. This is bad for  
1740 the economy and bad for unemployed workers. Employers do  
1741 work very hard to find the balance between keeping of cost of

1742 health insurance down and also offering benefits that  
1743 employees want and need. Part of the way that they are able  
1744 to do that is by seeking bids from competing insurers and  
1745 adjusting benefits structures on the margin.

1746 But under the grandfathering rules, employers are now  
1747 very limited in what they can do to change benefits. That  
1748 also means they are limited in what they can do to keep costs  
1749 down. Many people argue that the ACA's restrictions are  
1750 needed to keep employers from cutting benefits or imposing  
1751 higher health costs on their employees, and also providing  
1752 these additional consumer protections. But employers or  
1753 really employees are really the ones who are ultimately  
1754 paying the price for these higher health care costs since  
1755 coverage is part of their compensation.

1756 A recent Rand study found that most of the pay increases  
1757 that employees have received over the last 10 years have been  
1758 consumed by health costs. The study found that the typical  
1759 family had just \$95 a month in real dollars more for non-  
1760 health spending in 2009 than it did in 1999. In contrast,  
1761 the authors say that the growth rate of health insurance has  
1762 simply kept pace with the regular cost increase general  
1763 inflation. The family would have had an additional \$5,400 a  
1764 year to spend. So employees are really the ones paying the  
1765 price for higher health care costs. Therefore, it is in the

1766 interest of both to keep health care costs down, and the  
1767 grandfathering regulations issued by HHS restrict their  
1768 ability to do that.

1769         There are many problems that need to be solved in our  
1770 health sector but it is important to follow the medical  
1771 dictum to first do no harm in making changes.

1772         The chairman mentioned that legislation is being drafted  
1773 to reverse the interim final rule, and the Administration  
1774 itself recognizes that companies need relief from burdensome  
1775 and expensive regulations that impact their competitiveness  
1776 and their ability to generate revenues to create new jobs,  
1777 and withdrawing the grandfathering regulations would be a  
1778 very good place to start to achieve those goals.

1779         Thank you, Mr. Chairman. I look forward to questions.

1780         [The prepared statement of Ms. Turner follows:]

1781 \*\*\*\*\* INSERT 3 \*\*\*\*\*

|  
1782           Mr. {Pitts.} Ms. Trautwein, you are recognized for 5  
1783 minutes.

|  
1784 ^STATEMENT OF JANET TRAUTWEIN

1785 } Ms. {Trautwein.} Thank you, Chairman and Ranking Member  
1786 Pallone. I appreciate this very much.

1787 As you know, the leadership of this committee invited me  
1788 here this past June to talk about the desperate economic  
1789 situation that the ACA's medical loss ratio regulation has  
1790 created for the half-million health insurance agents and  
1791 brokers nationwide. Unfortunately, I do not have a positive  
1792 update for the committee today. The economic outlook for  
1793 many health insurance brokers and agents, and I would  
1794 emphasize health insurance agents, which are different from  
1795 general-purpose agents. The MLR specifically applies to  
1796 those who work in the health insurance arena. The market  
1797 continues to be bleak. As health insurance companies renew  
1798 and revise their agent and broker contracts, it is clear that  
1799 the financial situation for many of these people, many of  
1800 whom are business owners themselves, is getting worse.

1801 Clearly, this problem started when the MLR regulation  
1802 was issued in December of 2010. It is very well documented  
1803 that that is when the problem occurred. That regulation  
1804 mandated that health insurance carriers, as you know, treat  
1805 independent agent and broker compensation as a part of health

1806 plan administrative costs in spite of the fact that  
1807 independent agents and brokers are not employed by health  
1808 insurance carriers. They do run their own businesses, hire  
1809 their own employees, pay all of their own office expenses  
1810 including professional liability insurance. Each agent  
1811 decides on their own which health insurance carriers he or  
1812 she will represent and then they are retained by individual  
1813 consumers and employers to assist them with their health  
1814 insurance needs.

1815       Issuance of the HHS regulation on MLR, which categorized  
1816 agent commissions as an insurer administrative expense,  
1817 triggered, as I said, an immediate response for many health  
1818 insurance companies and immediate reduction in agent  
1819 compensation.

1820       In May 2011, a national actuarial study conducted by the  
1821 NAIC taskforce--the professional--not the whole NAIC but the  
1822 professional health insurers advisors taskforce that was  
1823 assigned to address this problem regarding producer  
1824 compensation said that in 2011, a significant number of  
1825 companies have reduced commission levels, particularly in the  
1826 individual market, and this was reinforced by the most recent  
1827 report from the GAO private health insurance early  
1828 experiences implementing new medical loss ratio requirements  
1829 which states, ``Almost all of the insurers we interviewed

1830 were reducing broker commissions and making adjustments to  
1831 premiums in response to the MLR requirements.'' These  
1832 insurers said that they decreased or planned to decrease  
1833 commissions to brokers in an effort to increase their MLRs.  
1834 As a result of these cuts, brokers serving individuals and  
1835 the small business community, as has been said earlier, have  
1836 seen their overall revenues slashed by 20 to 50 percent.  
1837 This means that fewer of them are able to stay in business.  
1838 It also means that those who are able to survive are being  
1839 forced to make service cuts and are no longer able to provide  
1840 the counseling and level of advocacy support to their clients  
1841 that they have in the past.

1842 Now, it may seem to you that what agents and brokers do  
1843 is simple. You may think that all they do is fill out a form  
1844 and sign people up for insurance, and some of you may even  
1845 think it is as easy as buying an airline ticket, but there is  
1846 so much more than that. They meet with each client and  
1847 determine their specific needs covering everything from which  
1848 doctors they use to their preferences for financial risk.  
1849 They have candid conversations with people who are struggling  
1850 to afford coverage and help them find ways to stay insured.  
1851 With employers, they also discuss issues such as the savings  
1852 that can be achieved through wellness and disease management  
1853 programs and the characteristics of a particular company's

1854 workforce, discussing options for structuring their coverage.

1855           This dire situation is why we are looking at all  
1856 possible solutions, whether they are regulatory or  
1857 legislative, to address the problem. This problem needs to  
1858 be addressed both quickly and in a way that is politically  
1859 viable, and there is a solution that we believe meets both of  
1860 these requirements. We believe that if agent commissions,  
1861 since they are not really an insurer expense, removed from  
1862 what is currently defined as premium for MLR calculation  
1863 purposes, either through a legislative act or regulatory  
1864 action, that it would significantly improve the situation  
1865 that exists today.

1866           I am sure that you all are aware of H.R. 1206, which now  
1867 has 120 bipartisan cosponsors, 24 members of this committee.  
1868 It is authored by Mike Rogers and Congressman Barrow, and we  
1869 definitely appreciate them having done this. We endorse this  
1870 as well as do all other national agent professional  
1871 associations as well as, I said, the NAIC broker taskforce,  
1872 and I will stop there.

1873           [The prepared statement of Ms. Trautwein follows:]

1874 \*\*\*\*\* INSERT 4 \*\*\*\*\*

1875           Mr. {Pitts.} The chair thanks the gentlelady.

1876           We are going to recess at this point. We have got about  
1877 4 minutes left. I want to thank the witnesses for their  
1878 patience. We have two votes. We will be right back to  
1879 reconvene after the second vote. The subcommittee is now in  
1880 recess.

1881           [Recess.]

1882           Mr. {Pitts.} The subcommittee will come to order. The  
1883 chairman recognizes Ranking Member Emeritus Mr. Dingell for a  
1884 unanimous consent request.

1885           Mr. {Dingell.} Mr. Chairman, I have a unanimous consent  
1886 request that a letter signed by Charles M. Loveless, Director  
1887 of Legislation for AFSCME, be inserted into the record, and  
1888 also that a statement from Representative Tom Price of  
1889 Georgia be inserted into the record at this point.

1890           Mr. {Pitts.} Without objection, so ordered.

1891           Mr. {Dingell.} Thank you, Mr. Chairman.

1892           [The information follows:]

1893           \*\*\*\*\* COMMITTEE INSERT \*\*\*\*\*

|

1894           Mr. {Pitts.} Thank you.

1895           We will go back to the panel. Mr. Potter, you are

1896 recognized for 5 minutes for testimony summarization.

|  
1897 ^STATEMENT OF WENDELL BLAINE POTTER

1898 } Mr. {Potter.} Mr. Chairman and members of the  
1899 committee, thank you for this opportunity to be here today.  
1900 My name is Wendell Potter. I am Senior Analyst at the Center  
1901 for Public Integrity and former head of corporate  
1902 communications at Cigna Corporation. The views that I  
1903 express today are not necessarily those of either employer.

1904 For 20 years, I worked as a senior executive at health  
1905 insurance companies. During that time, I saw how these  
1906 companies confused their customers and dumped the sick to  
1907 satisfy their Wall Street investors. The top priority of  
1908 for-profit companies is to drive up the value of their stock.  
1909 The stock price of the big for-profit insurers fluctuates  
1910 based on their quarterly reports. Investors and Wall Street  
1911 analysts look for two key figures: earnings per share, which  
1912 is common to all companies, and the medical loss ratio, or  
1913 MLR, which is unique to the health insurance industry. As  
1914 you know, the MLR is the ratio between what an insurer  
1915 actually pays out in claims and what it has leftover to cover  
1916 executive pay, underwriting, lobbying, sales, marketing,  
1917 public relations, other administrative expenses and of course  
1918 profits.

1919            Within the executive offices, there is a single-minded  
1920 focus on being able to show investors and analysts that the  
1921 insurer made more money during the previous quarter than a  
1922 year earlier and that the portion of each policyholder's  
1923 premium devoted to covering medical expenses was less than it  
1924 was a year earlier. Insurers almost always see sharp  
1925 declines in their stock prices when they disclose that they  
1926 spent more money on medical care than investors expected. I  
1927 remember vividly when Aetna's stock price fell more than 20  
1928 percent on the day that it admitted that its first-quarter  
1929 MLR had increased from 77.9 percent to 79.4 percent.

1930            Studies done by the accounting firm  
1931 PricewaterhouseCoopers have shown how successful insurers  
1932 have been in meeting Wall Street's MLR expectations. One  
1933 such study found that the average MLR in the insurance  
1934 industry has fallen from approximately 95 percent in 1993 to  
1935 around 80 percent today. That translates into a difference  
1936 of several billion dollars in favor of insurance companies'  
1937 shareholders and executives and at the expense of health care  
1938 providers and their patients.

1939            The provision of the Affordable Care Act that requires  
1940 insurers to spend at least 80 percent of what we pay in  
1941 premiums on our health care is one of the most important  
1942 provisions of the law and one that must be preserved. Some

1943 have suggested that if the entire MLR provision is not  
1944 repealed, Congress should at least exempt insurance agent and  
1945 broker commissions from the calculation, and a bill  
1946 introduced by Representative Rogers would take that a step  
1947 further by excusing all sales commissions including payments  
1948 to salaried sales staff from the formula. To make it even  
1949 easier for insurers to meet the law's requirements by  
1950 exempting broker commissions is precisely the wrong thing to  
1951 do.

1952         It is important to note that even before the passage of  
1953 the Affordable Care Act, insurers were planning to take steps  
1954 to reduce broker commissions anyway, which they viewed  
1955 already as too high. A recent filing from the State of North  
1956 Carolina revealed that Coventry had reduced its commissions  
1957 on first-year policies from 27 percent to 14 percent and that  
1958 Cigna had cut first-year commissions from 20 percent to 12  
1959 percent. My question to brokers is this: did you really  
1960 deserve 27 percent of your client's premiums?

1961         Another point: Insurers are not being forced by the MLR  
1962 provision to reduce commissions. There are other levers on  
1963 the administrative side or through reducing premiums.  
1964 Basically, insurance companies have been choosing to reduce  
1965 commissions to protect profits. I doubt you have heard of an  
1966 insurers who have reduced the salaries of their CEOs and

1967 other top executives to meet the MLR requirements. You  
1968 haven't, and you won't.

1969 Another thing to keep in mind as you consider  
1970 legislation to exempt commissions from the MLR equation is  
1971 that even if it were to be enacted, it is not likely to be of  
1972 much help to agents and brokers now or in the future.  
1973 Insurers will not restore the commission reductions they have  
1974 already made. Exempting commissions would only help insurers  
1975 by making it easier for them to comply with the MLR  
1976 provisions.

1977 The proposed changes to the grandfathering provision are  
1978 similarly misguided. By denying the Department of Health and  
1979 Human Services the ability to enforce insurance reforms on  
1980 current plans, the bill would take away important consumer  
1981 protections including the prohibition on lifetime limits and  
1982 a ban on rescissions, a practice that lets insurers take away  
1983 your coverage midyear, usually after you have gotten sick.  
1984 It would also prohibit enforcement of the rule that allows  
1985 young people to stay on their parents' insurance plans until  
1986 age 26. This week's census figures show that this provision  
1987 has already helped half a million young people get insurance.  
1988 Why would Congress take away their coverage? HHS carved out  
1989 reasonable limits on what plans could be grandfathered. A  
1990 plan can maintain its grandfathered status until it changes

1991 its benefits or raises its costs too much. This proposal  
1992 would remove those limits so every plan is grandfathered  
1993 forever. This means that people will be locked into the plans  
1994 that don't have the protections they are entitled to under  
1995 the ACA like preventive medicines without copayments.

1996 A final point: If you pass the bill to repeal the  
1997 grandfathering provision, you will be guaranteeing that  
1998 millions of Americans will absolutely be facing the loss of  
1999 the coverage they have. If my insurer is able to cut my  
2000 benefits and hike my premiums and deductibles, actions that  
2001 in the industry are referred to as ``benefit buy-downs'',  
2002 that means that I will not have the same coverage I had or  
2003 was happy with.

2004 Thank you, Mr. Chairman.

2005 [The prepared statement of Mr. Potter follows:]

2006 \*\*\*\*\* INSERT 5 \*\*\*\*\*

|  
2007           Mr. {Pitts.} The chair thanks the gentleman and now  
2008 recognizes Ms. Quincy for 5 minutes for her opening  
2009 statement.

|  
2010 ^STATEMENT OF LYNN BATES QUINCY

2011 } Ms. {Quincy.} Thank you for having me here today.

2012 My name is Lynn Quincy, and I am the Senior Health  
2013 Policy Analyst at Consumers Union, which is the independent  
2014 nonprofit publisher of Consumer Reports magazine, and our  
2015 mission is to provide consumers with unbiased information  
2016 about good services, health and personal finance.

2017 I am here to discuss the changes, the proposed changes  
2018 to the grandfathered regulations and medical loss rules  
2019 called for by the Patient Protection and Affordable Care Act,  
2020 and I am here to ask the committee to take a holistic look at  
2021 the impact of the proposed legislation and to holistically  
2022 look at its impact on consumers.

2023 The proposed legislation addressing grandfathered plans  
2024 would undermine the Affordable Care Act's consumer  
2025 protections in two ways. It broadens the definitions of  
2026 plans that qualify as a grandfathered plan and it calls for a  
2027 blanket exemption of these plans from all Affordable Care Act  
2028 requirements. If enacted, this proposal would leave many  
2029 consumers worse off. You have heard many examples today  
2030 already about, for example, the impact on adult children up  
2031 to age 26 or the current requirement that plans all present a

2032 uniform health insurance disclosure form to consumers so that  
2033 they can better understand their health plan features. If  
2034 enacted, this proposal would create a bifurcated market. In  
2035 2014, consumers wouldn't have the security of knowing that  
2036 all their health insurance choices provide a minimum level of  
2037 coverage and have understandable and uniform caps on out-of-  
2038 pocket spending. Instead, anyone with access to a  
2039 grandfathered plan would have to learn two insurance markets:  
2040 the one featuring the new consumer protections and the one in  
2041 which none of the Affordable Care Act provisions apply.

2042         The proposal expands the definition of what constitutes  
2043 a grandfathered plan, stripping away all requirements for  
2044 maintaining reasonably similar cost-sharing levels, and let  
2045 us be clear about what we are talking about here when we  
2046 discuss an employer's ability to lower cost. What we are  
2047 really referring to is employers' ability to shift costs onto  
2048 employees, and believe me, that is not what consumers want.  
2049 The things that are driving health care premium increases,  
2050 you have to look in other areas besides these new provisions  
2051 and the MLR, and there is nothing more serious that this  
2052 committee should be doing. I just returned from Wyoming,  
2053 where a broker described a 10-person dental office that just  
2054 received a 56 percent premium increase, and he speculated  
2055 that it was due to the fact that someone in that 10-person

2056 group had contracted Grave's disease. These are the problems  
2057 that you need to be addressing.

2058 We regularly hear from consumers about their health  
2059 coverage, and I would like to assure this subcommittee that  
2060 we have not heard a single consumer clamoring to keep their  
2061 health plan as cost sharing rises over 18 percent a year, the  
2062 approximate limit at which they might have to give up their  
2063 grandfathering status.

2064 We also oppose legislation that would repeal the medical  
2065 loss ratio provisions. These provisions are working to  
2066 improve value for consumers as you have already heard today.  
2067 Placing a floor under health insurers, MLR is not new.  
2068 Roughly a third of States have enacted rules that require  
2069 plans to spend a certain percentage of their premium dollar  
2070 on medical care, and that provides us with significant  
2071 credible experience about how MLR regulations affect consumer  
2072 and brokers, and as you have already heard, there is early  
2073 evidence that the federal rule is working to improve value to  
2074 consumers to address those rising premiums that are of such  
2075 great concern.

2076 We note that that the evidence with respect to overall  
2077 broker compensation is mixed. You have already heard about  
2078 the NAIC study and the fact that they declined to support  
2079 legislation that would carve brokers' commissions out of the

2080 MLR.

2081           Today's MLR rules provide needed transparency. Steve  
2082 Larsen talked about this. And this is really important. I  
2083 think this would appeal to both sides of the aisle as we move  
2084 forward. We need to understand what goes into those rising  
2085 premiums so we can better understand how to clamp down on  
2086 them to help consumers.

2087           Finally, today's MLR rule is not a blunt instrument as  
2088 the proposed legislation would be. It provides targeted,  
2089 evidenced-based relief to States. They can apply for an  
2090 adjustment, as we have all discussed, and some of the States  
2091 that have applied for adjustments like Maine already have an  
2092 oligopoly that has nothing to with the proposed MLR rule.  
2093 There are structural problems in the insurance market, to be  
2094 sure, but I am not really expecting the MLR rule to  
2095 contribute greatly to those problems.

2096           My written comments go into greater detail about the  
2097 benefits of our grandfathered rules and MLR rules as they  
2098 exist today.

2099           Thank you for the opportunity to speak to you.

2100           [The prepared statement of Ms. Quincy follows:]

2101 \*\*\*\*\* INSERT 6 \*\*\*\*\*

|  
2102           Mr. {Pitts.} The chair thanks the gentlelady. Thanks  
2103 to all the witnesses for their patience. We will now begin  
2104 the questioning from the members, and I will begin by  
2105 recognizing myself for 5 minutes for that purpose.

2106           Ms. Trautwein, some argue that insurance agents add no  
2107 value to the system are simply overhead in the system that  
2108 can be eliminated at the stroke of a pen or regulation. Can  
2109 you elaborate on the role agents play in our health care  
2110 system?

2111           Ms. {Trautwein.} Absolutely. Well, first of all, it is  
2112 true that agents do help people secure health insurance  
2113 coverage. They counsel their clients on the appropriate  
2114 types of coverage, what is available in the market, what they  
2115 can afford, both individuals and businesses. But where their  
2116 jobs really kick in is after that coverage has been placed  
2117 because if there is a claims issue, if there is a billing  
2118 issue, if there is a question about a regulation, and I can  
2119 tell you right now, our members are very busy advising  
2120 businesses in that area, any of those things go through the  
2121 broker. In fact, I saw a recent study from SHRM, which  
2122 mainly serves larger businesses, that the primary place that  
2123 they are getting their information about health reform comes  
2124 from their broker. And so things like that, advice on

2125 compliance, on regulations, taking care of clients, and I  
2126 mentioned this during the last hearing, but this issue of  
2127 taking care of claims is significant. When I was a broker  
2128 some 20 years ago, I never, ever had any of clients have the  
2129 need to go to the appellate process through their insurer  
2130 because we were able to address it quickly, and that is what  
2131 our members and other brokers do every day.

2132 Mr. {Pitts.} Thank you.

2133 Ms. Turner, can you explain how the grandfathering rule  
2134 diverts the resources of employers towards more expensive  
2135 health coverage and away from capital investment, wage  
2136 increases and job creation?

2137 Ms. {Turner.} Well, as I have mentioned in my  
2138 testimony, if employers are not able to stay within the  
2139 grandfathering provisions and they are required to provide a  
2140 number of other consumer protection such as no out-of-pocket  
2141 costs to employees for preventive care, for example, this is  
2142 going to increase the cost of health insurance and so that is  
2143 why I feel there is really sort of a catch-22 for employers,  
2144 that they find that they need to make changes in order to  
2145 keep their costs down, but if they make those changes, then  
2146 they are subject to another list of rules through PPACA. And  
2147 these do divert capital and I think it really is important,  
2148 as Ms. Quincy was saying, we really do need to take a

2149 holistic look, that employers--and I have been a small  
2150 business owner for 30 years or running small businesses for  
2151 30 years, you don't look at things in silos. You look at the  
2152 bottom line, and if health care costs are rising, then you  
2153 are going to have to figure out what can you do on the other  
2154 side, and sometimes you don't hire that extra worker or you  
2155 don't buy that new piece of equipment. So it really does  
2156 impede employers' ability to make the right decisions for  
2157 their business.

2158 Mr. {Pitts.} Thank you.

2159 Mr. Haislmaier, in December of 2009, the Congressional  
2160 Budget Office released a paper stating that a legislative  
2161 proposal to set an MLR of 90 percent would make health  
2162 insurance an ``essentially governmental program'' in  
2163 combination with PPACA's other provisions. Do you believe  
2164 that a slightly lower MLR of 85 percent like the one included  
2165 in PPACA will give the federal government functional control  
2166 of private health insurance in America?

2167 Mr. {Haislmaier.} I don't know that the percentage  
2168 makes as much difference as the structure of the regulatory  
2169 design. As I pointed out in this regulation for minimum loss  
2170 ratios but also coupled with the other regulations, the  
2171 additional benefit requirements, the rate reviews, etc., do  
2172 shift the industry to a regulated utility model. In fact, it

2173 is interesting that President Clinton's health advisor, Sara  
2174 Rosenbaum, who, you know, is well known in this area, wrote a  
2175 piece in defense of the individual mandate that essentially  
2176 argued that well, yeah, the individual mandate--she was--I am  
2177 not, you know, talking about the legal question about the  
2178 individual mandate but she basically made the point in that  
2179 piece, I think it was for the Journal of the American Medical  
2180 Association or New England Journal, that this design in PPACA  
2181 turns insurers into a regulated public utility, and I agree  
2182 with her on that. What didn't discuss is the economics of a  
2183 regulated public utility and the economics are in that world,  
2184 as a competitor, you either want to be, you know, too big to  
2185 fail. You want to be one of the last two or three left that  
2186 yes, you are going to be regulated but they can never put you  
2187 out of business because they need you to be in business or  
2188 otherwise people don't get the service. That is why people  
2189 scream about, you know, power companies that we had this with  
2190 the storms but they never actually drive them out of  
2191 business. Well, once you get to that kind of a world, you  
2192 don't care what the costs are, you just pass them through  
2193 because your customers have no other choice, and that is the  
2194 world we are headed to with these regulations. So yes, I see  
2195 that happening.

2196 Mr. {Pitts.} Thank you. My time is expired. The chair

2197 recognizes the Ranking Member Emeritus, Mr. Dingell, for 5  
2198 minutes for questions.

2199       Mr. {Dingell.} First, I would like to compliment you,  
2200 Ms. Quincy and Mr. Potter, for your very fine statements.  
2201 Thank you.

2202       This question is to Mr. Potter. The law requires health  
2203 insurance companies to pay rebates if they spend fewer than  
2204 80 to 85 percent of their customers' dollars on health care  
2205 and quality improvement activity. The Department of Health  
2206 and Human Services estimates that the new minimum MLR law  
2207 will result in consumer rebates to as many as 9 million  
2208 people, up to 1.4 billion in the 2011 plan year and up to  
2209 1.49 billion in the 2011-2013 plan years. Agents and brokers  
2210 are heavily lobbying for special exemption for being included  
2211 into the medical loss ratio calculation. The fact is, some  
2212 agents and brokers are really providing valuable and helpful  
2213 services, and I have to agree with that statement. But they,  
2214 like other costs within the insurance products, they should  
2215 compete and keep costs competitively low as possible for  
2216 consumers. At a time when everybody is being asked to  
2217 tighten their belts and find and create efficiencies, asking  
2218 for an exemption from these pressures, particularly at the  
2219 expense of consumer pocketbooks, is not something that I  
2220 think the consumers will take kindly to.

2221           Mr. Potter, would you please talk to us about the  
2222 dangers of exempting agent and broker commissions from the  
2223 medical loss ratio calculations and what types of commissions  
2224 that they have been getting over the past years?

2225           Mr. {Potter.} Thank you, Congressman. Yes, if they are  
2226 exempted, it will be, as I said in my testimony, really a  
2227 gift to the insurance industry because it will give them just  
2228 one more way that they can meet regulations that they could  
2229 already be meeting if they were to reduce benefits, reduce  
2230 premiums, or if they reduced spending in many other areas of  
2231 spending. McKinsey and Company did a study a few years ago  
2232 showing where most of these companies' administrative costs  
2233 really are, and they are in underwriting, they are in sales  
2234 and marketing and things of that nature. So my own salary,  
2235 for example, was an administrative expense. In fact, I was  
2236 talking to someone in France not long ago who said my job was  
2237 unknown in the French system, and I can understand that.

2238           But there are a lot of other places where cuts can be  
2239 made, and yes, I agree with you, I think agents and brokers  
2240 have indeed provided in many cases good value to the people  
2241 they serve but they do get their income from insurers and  
2242 they have been paid handsomely, and I think that they should  
2243 be expected to give up some--you know, to sacrifice just as  
2244 much as everybody else.

2245 Mr. {Dingell.} Thank you. I have a bunch of questions,  
2246 and I apologize. I don't mean to curtail your testimony.

2247 Ms. Quincy, Consumers Union expanding the consumer  
2248 protections indicates that this has had a negligible impact  
2249 on premiums. My colleagues on the Republican side claim that  
2250 this is an enormous burden to health plans and employers and  
2251 use that as a rationale for repealing key elements of the  
2252 Patient's Bill of Rights for many people. First, and these  
2253 are yes or no, if you can please, do you agree that the new  
2254 consumer protections are imposing a huge burden on health  
2255 plans and employers, or not?

2256 Ms. {Quincy.} I do not.

2257 Mr. {Dingell.} Okay. Do you have any estimates or  
2258 examples of how much these provisions would cost?

2259 Ms. {Quincy.} Yes. I would like to refer the committee  
2260 to my written testimony, if I can find the page. We  
2261 provided, I think, three or four sources that cited some  
2262 actuarial estimates about what the cost of the various  
2263 consumer protections are, and--I think have to go one page  
2264 further to get there. Here we go.

2265 So in the written testimony, I talk about the fact that  
2266 federal agencies have estimated that ending annual lifetime  
2267 limits will increase group premiums by about a half of 1  
2268 percent and will increase non-group premiums by less than 1

2269 percent. Prohibiting preexisting exclusions for children is  
2270 estimated to have a negligible impact on premiums. A recent  
2271 Anthem Blue Cross Blue Shield filing for the individual  
2272 market in Connecticut shows that the new protections from  
2273 unjust rescissions have had no impact on premiums, and ending  
2274 lifetime limits has also benefited consumers without raising  
2275 costs, and for the sources for those statements, I refer you  
2276 to the written testimony.

2277 Mr. {Dingell.} Thank you.

2278 Now, Mr. Potter, very quickly, can you discuss insurance  
2279 company practices with regard to individuals whose  
2280 preexisting conditions prior to the passage of the Affordable  
2281 Care Act and what can we expect since the passage of these  
2282 new protections? In other words, what it is going to do to  
2283 costs, what is it going to do for consumers, what is it going  
2284 to do to industry?

2285 Mr. {Potter.} Insurance companies for many year have  
2286 refused to sell coverage to people with preexisting  
2287 conditions, and it is something that continues to go on right  
2288 now, except for children. That already has gone into effect.  
2289 A Chattanooga newspaper recently disclosed that Blue Cross  
2290 and Blue Shield Tennessee, a nonprofit, supposedly, refused  
2291 to sell coverage to about one-third of applicants, largely  
2292 because of preexisting conditions. It is the leading reason

2293 why we have now more than 50 million Americans without  
2294 coverage, and it doesn't matter whether you are rich or poor.

2295 Mr. {Dingell.} You just don't get insurance if you have  
2296 a preexisting condition.

2297 Mr. {Potter.} Exactly. If you have a preexisting  
2298 condition, you are just out of luck, even if you were born  
2299 with that preexisting condition.

2300 Mr. {Dingell.} Now, I guess my time is expired, Mr.  
2301 Chairman. Thank you.

2302 Mr. {Pitts.} The chair thanks the gentleman and  
2303 recognizes the vice chairman, Dr. Burgess, for 5 minutes for  
2304 questions.

2305 Dr. {Burgess.} Thank you, Mr. Chairman.

2306 You know, I have done a lot of thinking this summer  
2307 about the summer of 2009 when we all went home after this  
2308 committee passed H.R. 3200, which was the House version of  
2309 the health care bill. That version has died a natural death  
2310 and Harry Reid's version is the one that was signed into law  
2311 by the President. But the things I remember being asked at  
2312 those town halls, and they were difficult and they were loud  
2313 and they were long and they were hot, but those town halls,  
2314 people said first off, don't do anything that is going to  
2315 mess up the system that exists and works for arguably, 60,  
2316 65, 70 percent of us. We didn't do that. We screwed it up.

2317 Witness the large number of waivers that are in effect now  
2318 and people concerned about issues like grandfathering. And  
2319 the other thing they asked, and they were really clear on  
2320 this, was can you do something to help us with cost because  
2321 we are concerned about the cost of health insurance.

2322           And then I looked around the country. The one place  
2323 where really cost had been addressed in a very effective way  
2324 was the State of Indiana and Governor Mitch Daniels with his  
2325 Healthy Indiana plan, and for the life of me, I don't know  
2326 why we did not subpoena him and bring him to this committee  
2327 and chain him to the chair until he spilled the beans as to  
2328 how he was able to hold health care costs for his State  
2329 employees down by 11 percent over the previous 2 years.

2330           So Ms. Turner, you are familiar with Governor Daniels'  
2331 plan. Can you very briefly encapsulate what is embodied in  
2332 that?

2333           Ms. {Turner.} Well, Governor Daniels and particularly  
2334 the Healthy Indiana plan, but he also has incentivized State  
2335 employees to enroll in consumer-directed plans, and what he  
2336 has recognized is that if you engage consumers as partners  
2337 and really giving them more information so they have the  
2338 ability to make decisions and to use better information to  
2339 make better decisions, that they really will become partners  
2340 in helping to manage costs, and we have seen it across the

2341 board.

2342 I have a section in my testimony when I talk about a new  
2343 study by the National Business Group on Health and it found  
2344 that companies that offered account-based health plans,  
2345 whether health savings accounts or health reimbursement  
2346 arrangements, had costs that were \$900 lower on average for  
2347 individuals and \$2,885 lower for families. So the reason  
2348 that the number of employees that have joined these plans is  
2349 rising is because they really do help to hold down costs and  
2350 employees become partners. They are more likely actually to  
2351 use preventive services when they have a health savings  
2352 account than they are in regular insurance because, as one  
2353 said, I realized that if I take better care of myself, I will  
2354 save money in the long run. So they provide the right kind  
2355 of incentives and transparency and give employees an  
2356 incentive to be partners in managing costs.

2357 Dr. {Burgess.} Now, as I understand for Governor  
2358 Daniels' plan for State employees, he actually funds the  
2359 health savings account that is associated with that high-  
2360 deductible plan. Is that understanding basically correct?

2361 Ms. {Turner.} Yes, and they put money into the health  
2362 savings account and with the Medicaid expansion, their  
2363 Healthy Indiana plan, both the State and the individuals  
2364 share in funding that account so they really do have a stake.

2365 Dr. {Burgess.} And of course, the phrase I have heard  
2366 associated with that is something magic happens when people  
2367 spend their own money for health care, even if it wasn't  
2368 their own money in the first place.

2369 But perhaps Mr. Haislmaier and Ms. Turner, you can talk  
2370 about how the MLR regs affect consumer-directed health plans  
2371 and perhaps the one place we should have gone that we didn't  
2372 go in the health care law. What is the future ahead for  
2373 consumer-directed health care under the MLR?

2374 Mr. {Haislmaier.} Well, this is one of the areas where  
2375 as your colleague, Representative Cassidy, pointed out, there  
2376 are some problems with the way the statute was drafted  
2377 because it didn't take into account the fact that if you have  
2378 a consumer-directed plan where of the total spending that the  
2379 individual is doing, more of it is going directly from the  
2380 individual to the provider and less through the insurer, then  
2381 the insurer for that portion that they are handling is going  
2382 to have, by necessity, higher administrative costs and are  
2383 going to be penalized for that product design. So it is  
2384 correct that it will favor product designs that are more  
2385 comprehensive, meaning that more of the total spending goes  
2386 through the insurer's hands.

2387 There are other places that practitioners in this area  
2388 have encountered. I remember this from a former colleague

2389 who was a Democratic insurance commissioner and saying that  
2390 one of the problems that they ran into is they are running  
2391 into things like when you have overseas employees and you  
2392 provide them medical care, if you want to send somebody to be  
2393 an oil worker in Nigeria or something, you know, you are not  
2394 only going to have to pay them well but you are going to have  
2395 to make sure--they are going to be worried about, well, hey,  
2396 you are sending me off to work on an oil platform in some  
2397 Third World country, what happens if something happens to me  
2398 medically. Well, these are not administratively cheap plans  
2399 to run because you are going to have to airlift them out of  
2400 there, you are going to have to do this all other stuff. So  
2401 under the MLR, those plans are disadvantaged. The other  
2402 thing--I mean, you just keep compounding this. This fellow  
2403 was pointing out to me, he is in insurance law practice no,  
2404 was another client where it was a church that had  
2405 missionaries who aren't employees but they are providing them  
2406 with health benefits, so how does that get handled. So you  
2407 have got a lot of problems in this.

2408         You know, I could just make one point because I think it  
2409 is really important to understand that disclosing, as I said  
2410 in the testimony, this information is fine, okay. If you  
2411 want to put this information out, States already have the  
2412 data to do that, and I think States should put it out and let

2413 the consumer say, you know, this is one more piece of  
2414 comparative information. It is only when you set a standard  
2415 that says well, you have to do this, you have to do this  
2416 minimum, that you create these problems.

2417         So I would present to you a hypothetical, and let us  
2418 just think about this, if you will indulge me. We have two--  
2419 let us take two insurance plans, two situations. We will  
2420 call them A and B, okay? Under both scenarios, the plans  
2421 cover the same benefits, okay, so there is not a difference  
2422 in lesser benefits or more benefits. Under both scenarios,  
2423 you are going to pay about a thousand bucks for out-of-pocket  
2424 deductible and copays. Plan A charges \$5,000 and has an 80  
2425 percent medical loss ratio, meaning \$1,000 is retained and  
2426 \$4,000 goes to paying claims. Plan B charges \$4,000 and has  
2427 a 75 percent ratio, meaning they keep \$1,000 and \$3,000 goes  
2428 to claims. Which is the better buy? Do you buy the plan  
2429 with the higher loss ratio but \$1,000 lower premium or do you  
2430 buy the plan with the lower loss--I am sorry--the better loss  
2431 ratio under this scenario but is \$5,000 more expensive? You  
2432 see, those are the kinds of decisions a consumer has to make.  
2433 As a piece of information, that is fine, but when you say  
2434 everybody has to fit into this box, you have a problem.

2435         Dr. {Burgess.} Thank you, Mr. Chairman. I will yield  
2436 back.

2437 Mr. {Pitts.} The chair thanks the gentleman and  
2438 recognizes the gentleman from Louisiana, Dr. Cassidy, for 5  
2439 minutes of questioning.

2440 Dr. {Cassidy.} Mr. Potter, if I have been smiling at  
2441 you the whole time, it is nothing inappropriate. I am  
2442 reading Harry Potter to my 10-year-old right now, so we spent  
2443 15 minutes on the phone last night. She would be  
2444 disappointed you don't have a scar on your head.

2445 You know, I read your testimony. It is very compelling.  
2446 But you could want to remove power from insurance companies  
2447 and not necessarily be for the ACA. That is a fair  
2448 statement. And one of the reasons why I like consumer-driven  
2449 health care is because it truly moves the locus of power from  
2450 a bureaucrat, whether it is Washington, D.C., or elsewhere,  
2451 to the consumer. You are the numbers guy. You are the  
2452 fellow who used to help an insurance company look at things.  
2453 Looking at your testimony--and your testimony was almost an  
2454 insurance company as an organic organism which is going to  
2455 move to maximize profits. Let us take Mr. Haislmaier's  
2456 assertion. This MLR seems to reward companies that sell  
2457 higher-priced policies because your 15 percent of a higher-  
2458 priced policy is a greater absolute amount than 15 percent of  
2459 a lower-priced policy, and again, the consumer-driven health  
2460 care plan, you don't start paying claims until someone is

2461 paid their HSA and their out of pocket and then you move into  
2462 it. So just your thoughts on that. I mean, again, looking  
2463 at your testimony, it seems that--I would draw from that that  
2464 they would react in such a way as to preserve their profit  
2465 margin, which means that they would be prejudiced towards a  
2466 higher-priced policy.

2467 Mr. {Potter.} You have to consider the cost of  
2468 insurance including the cost of what you have to pay out of  
2469 pocket. If you just keep premiums in isolation, then it  
2470 skews what is really the obligation of the person who has  
2471 that policy. Another point too is that--

2472 Dr. {Cassidy.} No, but I don't follow how that answers  
2473 my question, and no offense, but I don't see--again, my  
2474 assertion is that if you artificially restrict MLR and not  
2475 account for the absolute, as Mr. Haislmaier's example, we  
2476 have a cheaper policy, \$4,000, but if it is a thousand bucks  
2477 for administrative costs, that is 25 percent MLR. We are  
2478 prejudiced against that policy towards one which is \$5,000  
2479 and now meets this artificial MLR requirement. Would you  
2480 disagree with the example he just gave?

2481 Mr. {Potter.} I would.

2482 Dr. {Cassidy.} I don't follow why.

2483 Mr. {Potter.} Because again, you have to consider the  
2484 value that the person has in the policy. If you are paying a

2485 certain premium, yes, there is no doubt, the account-based  
2486 plans typically have a lower premium but there is great cost  
2487 shifting from the employee or the insurer to the--

2488 Dr. {Cassidy.} Now, there is a Kaiser Family Foundation  
2489 study either there or CRS or GAO, I forget which, which shows  
2490 that those who have consumer-driven health care plans with an  
2491 HSA have \$500 extra out of pocket relative to a traditional  
2492 policy, but because their premiums are 25 to 30 percent  
2493 cheaper, net they are \$2,000 ahead. So they also found that  
2494 those patients with HSA and a high deductible accessed  
2495 preventive services as frequently as do those who have a  
2496 traditional policy. They also found that 50 percent of those  
2497 in this particular survey--I am remembering, so I may have it  
2498 a little wrong--were previously uninsured, costs lower by 25  
2499 to 30 percent. Previously uninsured people now have the  
2500 ability to purchase insurance and they are accessing  
2501 preventive services as frequently as those who have  
2502 traditional policies. That sounds like a good value to me.

2503 Mr. {Potter.} It is for some people but some of the  
2504 other studies you might have seen too show that many people  
2505 who are in these kinds of accounts don't have the money to  
2506 meet that deductible. A lot of employers are benevolent and  
2507 they do provide some money to pay that deductible. People  
2508 who are in the individual market like my son don't have that

2509 ability. He had to buy--he was forced to buy a high-  
2510 deductible plan--

2511 Dr. {Cassidy.} How old is your son?

2512 Mr. {Potter.} He is 28.

2513 Dr. {Cassidy.} Now, reasonably speaking, a 28-year-old  
2514 without a chronic medical condition made a wise financial  
2515 decision, correct?

2516 Mr. {Potter.} Here is what happened. He was told that  
2517 he would have to be moved out of his plan, which had a \$500  
2518 deductible, to one that had a \$5,000 deductible or his  
2519 premium would go up 67 percent, and my son has asthma and so  
2520 yes, he is going to be paying quite a bit out of his own  
2521 pocket. He doesn't have a very--

2522 Dr. {Cassidy.} But what was his savings on his  
2523 insurance policy? Because net, if he paying \$3,000 less--

2524 Mr. {Potter.} Two dollars and 12 cents a month was his  
2525 savings, but he is facing a deductible that is 10 times as  
2526 much.

2527 Dr. {Cassidy.} No, I am sorry. That is \$2,000 relative  
2528 to his previous savings but it is more than \$2.20 to what his  
2529 premium would be. I guess that is my point.

2530 Mr. {Potter.} The math is that by moving out of the  
2531 plan that he was in to the one that he moved into, yes, his  
2532 premiums were about the same, actually maybe \$2 less, but his

2533 deductible, his total out-of-pocket expenses over the year is  
2534 considerably more.

2535 Dr. {Cassidy.} I guess I am a little confused, because  
2536 if he had stayed in his previous policy, his premiums would  
2537 have been substantially more.

2538 Mr. {Potter.} That was not available to him. He was  
2539 forced out of that plan, just as I was a few years ago,  
2540 Congressman. I worked at Cigna for quite a few years, and I  
2541 had a plan that I liked. It was a PPO. Cigna decided,  
2542 didn't ask me, Cigna decided that it would move me and every  
2543 other employee out of the PPO or the HMOs into an account-  
2544 based plan. For me and for the CEO and for the executive  
2545 board of GE, that is perfectly fine, but most of the  
2546 employees of Cigna make far, far less than--

2547 Dr. {Cassidy.} We are almost out of time and we are  
2548 about to start getting the clunk on us, but let me just  
2549 respond again. The Kaiser Family Foundation study suggested  
2550 that most people with HSAs have modest incomes, \$75,000 or  
2551 less, and that their out-of-pocket, their global costs  
2552 decrease over the year by a couple thousand dollars, and  
2553 again, they are accessing preventive services as well. I  
2554 would be interested if you have data which shows--and this  
2555 will have to be an off-the-record answer--that shows there is  
2556 any difference in incomes, because people point to the

2557 anecdotes but I don't find that there is any data on  
2558 difference in outcomes.

2559       Mr. {Potter.} Yes, you are right. We could take a look  
2560 at that more closely, but I think people who are healthier do  
2561 gravitate toward these plans.

2562       Dr. {Cassidy.} I think the data shows that even people  
2563 now who are not as healthy or doing as well--

2564       Mr. {Potter.} Because they are being forced into these  
2565 plans against their own--

2566       Dr. {Cassidy.} No, but I am talking about outcomes and  
2567 their pocketbook.

2568       Anyway, I think we are out of time. Thank you.

2569       Dr. {Burgess.} [Presiding] The gentleman's time has  
2570 expired. The chair recognizes the Chairman Emeritus for a  
2571 follow-up.

2572       Mr. {Dingell.} You are most kind, Mr. Chairman. Thank  
2573 you.

2574       This goes to Mr. Potter and Ms. Quincy. Our colleagues  
2575 on the other side of the aisle are portraying the discussion  
2576 draft as a means for Americans who like their health coverage  
2577 to keep it. In fact, the legislation is much broader. The  
2578 real intention appears to be to eliminate the insurance  
2579 reforms enacted by the Affordable Care Act and to put  
2580 insurance companies, not patients, back into control. Would

2581 it be accurate to say that this legislation is another way to  
2582 repeal health reform, and am I correct in my first  
2583 assumption? Yes or no.

2584 Mr. {Potter.} Yes.

2585 Mr. {Dingell.} Ms. Quincy?

2586 Ms. {Quincy.} It would greatly undermine the various  
2587 provisions of the Affordable Care Act that are expected to  
2588 work together.

2589 Mr. {Dingell.} Good. Now, does the legislation that we  
2590 are discussing here allow patients to keep their insurance if  
2591 they like it, as claimed by my Republican colleagues, or are  
2592 the insurers really in charge of being allowed to cut  
2593 benefits, increase cost sharing and make other changes?  
2594 Which is the case?

2595 Ms. {Quincy.} If the discussion draft were enacted, it  
2596 would permit tremendous latitude with respect to self-insured  
2597 employer plans and insurers to make changes in benefits, some  
2598 of which would certainly include cost shifting to employees.

2599 Mr. {Dingell.} Mr. Potter?

2600 Mr. {Potter.} Absolutely. As I said in my testimony,  
2601 if you pass the repeal, the grandfathering, you can  
2602 absolutely guarantee that people who have coverage now, their  
2603 coverage will change significantly in the near future, if not  
2604 the long term.

2605 Mr. {Dingell.} Now, as I understand this, what we are  
2606 essentially doing is setting up two categories of insurance  
2607 carriers. The first category would be those who are  
2608 grandfathered. The grandfathered plans would be able to do  
2609 most anything they want and achieve strong competitive  
2610 advantage over the latecomers, who would not have that  
2611 privilege. Am I correct?

2612 Mr. {Potter.} Yes.

2613 Mr. {Dingell.} Is that right, Ms. Quincy?

2614 Ms. {Quincy.} Yes.

2615 Mr. {Dingell.} And that would lead then to very  
2616 significant advantages to the first category and a strong  
2617 discouragement to the second category going into this  
2618 business. Is that right?

2619 Ms. {Quincy.} Well, my greatest fear would be the  
2620 segmentation of risks since this hugely different--since two  
2621 different insurance markets exist side by side. I think that  
2622 is the greatest danger.

2623 Mr. {Dingell.} And you would tend to see all the bad  
2624 business being shoved into the second category that weren't  
2625 grandfathered. Is that right?

2626 Ms. {Quincy.} Yes.

2627 Mr. {Potter.} Yes. You are correct.

2628 Mr. {Dingell.} Now, if you have got a plan that is

2629 grandfathered, it would then be able to charge lower prices  
2630 for its product and give less benefits at the same time.

2631 Isn't that right?

2632 Ms. {Quincy.} Yes.

2633 Mr. {Potter.} Yes.

2634 Mr. {Dingell.} Let us raise one of the more problematic  
2635 issues with this legislation. Consumers in grandfathered  
2636 health plans including those that have raised premiums, cut  
2637 benefits or increased cost sharing would not have any  
2638 federally guaranteed rights to internal and external appeals.

2639 Is that right?

2640 Ms. {Quincy.} Yes.

2641 Mr. {Potter.} That is correct.

2642 Mr. {Dingell.} So they could kick them all around the  
2643 block and they couldn't complain. All right. This creates  
2644 an environment then where insurers, not health professionals,  
2645 will be making treatment decisions without opportunity for  
2646 outside review bottomed only on the situation where some  
2647 green eye-shaded actuary in an insurance company would be  
2648 defining what treatments the guy could get. Is that right?

2649 Ms. {Quincy.} Particularly in self-insured plans.

2650 Mr. {Dingell.} Okay. Now, my Republicans have said all  
2651 along that the Affordable Care Act is turning the doctor-  
2652 patient relationship into a patient-government relationship.

2653 First of all, is that true? Yes or no.

2654 Ms. {Quincy.} I am sorry. The question, does that  
2655 interfere with that doctor-patient relationship when you  
2656 can't have--

2657 Mr. {Dingell.} Yes. Does this bill interfere with the  
2658 doctor-patient relationship? I am talking about the  
2659 Affordable Care Act. Does it interfere with the doctor-  
2660 patient relationship?

2661 Ms. {Quincy.} I think that you could say that, because  
2662 around 50 percent of--

2663 Mr. {Dingell.} All it really does, Ms. Quincy, is to  
2664 define the rights of the patient and within that new  
2665 definitions the patients and the doctors decide what they  
2666 want to do, and one of the noteworthy things is that the  
2667 medical profession supported this particular thing after  
2668 years of having complained about the need to protect us  
2669 against interference in that relationship. Is that right?

2670 Mr. {Potter.} Yes, Congressman.

2671 Mr. {Dingell.} I am going to ask unanimous consent to  
2672 ask one more question, Mr. Chairman.

2673 Dr. {Burgess.} Seeing no objection, the gentleman is  
2674 given an additional minute, but I caution you about  
2675 statements about the AMA. I am a member. I yield to the  
2676 gentleman.

2677 Mr. {Dingell.} I am not a member, but I am a good  
2678 friend of the AMA, and all I am doing is defining what it is  
2679 they had to say and do.

2680 Dr. {Burgess.} I appreciate you doing that. We are  
2681 going to have an opportunity to talk about that a great deal  
2682 more in the future.

2683 Mr. {Dingell.} And I say this with great respect for my  
2684 friend from Texas.

2685 Now, what I want to know is, is it important that we  
2686 give guaranteed internal and external appeals rights to the  
2687 patients who would have benefits under the plan and were  
2688 being treated in a way they didn't like by the insurance  
2689 company?

2690 Ms. {Quincy.} It is critically important. A GAO report  
2691 shows that roughly 50 percent of coverage decisions that are  
2692 disputed using the appeals process are reversed, so that  
2693 means a mistake was made by the insurance company. So it is  
2694 a critically important right.

2695 Mr. {Dingell.} Mr. Potter?

2696 Mr. {Potter.} It is, and it is an essential benefit of  
2697 the Patient's Bill of Rights that Congress considered many  
2698 years ago, and it is about time the Congress enacted it.

2699 Mr. {Dingell.} Mr. Chairman, I thank you for your  
2700 kindness.

2701 Dr. {Burgess.} I thank the Chairman Emeritus for his  
2702 walk down memory line. I need to remind the Chairman  
2703 Emeritus that it was an amendment that he and I put into H.R.  
2704 3200 that would enshrine the rights of internal and external  
2705 review. The Speaker of the House stripped that provision out  
2706 of the bill that went from this committee on July 30th to the  
2707 House Floor to vote on November 9, 2009. The Senate did  
2708 provide some coverage but it was pretty watered down and  
2709 nowhere near as expansive as the brilliant amendment offered  
2710 by the Chairman Emeritus and the Vice Chair, and it was a  
2711 shame because Texas has led the way on this.

2712 Mr. {Dingell.} If the gentleman would yield?

2713 Dr. {Burgess.} Yes, I would be happy to yield.

2714 Mr. {Dingell.} My good friend is just indicating how  
2715 well we have worked together.

2716 Dr. {Burgess.} There you go.

2717 Mr. {Dingell.} And the fine consequences of that kind  
2718 of effort. I am here to say, I am anxious to work with the  
2719 gentleman if he will stop pushing this kind of nonsense  
2720 legislation. If we work together, we can come up with  
2721 something much better.

2722 Dr. {Burgess.} It was our opponents on the Senate that  
2723 prevented us carrying the day on that as well as the  
2724 Speaker's office and the White House probably had some

2725 interference, but nevertheless, we are where we are.

2726 Let me just ask you, Mr. Potter. I think you testified  
2727 or provided in your written testimony that Congress has  
2728 exempted all taxes from the MLR calculation. Is that  
2729 correct?

2730 Mr. {Potter.} I don't think it is in my written  
2731 testimony, but there is much that has been exempted in the  
2732 MLR calculation. That is correct.

2733 Dr. {Burgess.} But by regulation, working the MLR  
2734 regulation at HHS, they decided to sort of pick and choose  
2735 which taxes are exempt from the calculation. Do you feel  
2736 that that is inconsistent with the intent of the law?

2737 Mr. {Potter.} I think that the statute was pretty clear  
2738 that certain taxes are exempt from the equation. I can't  
2739 tell you which ones in particular would qualify for that.  
2740 That was the intent of Congress, as I understand it.

2741 Dr. {Burgess.} I don't have the page number, but in  
2742 your testimony, the statement is, ``In addition, Congress  
2743 exempted all taxes from the MLR calculation, a huge  
2744 artificial boost to insurers' MLRs.''

2745 Mr. {Potter.} Exempting taxes is a boost to MLRs.

2746 Dr. {Burgess.} Well, again, the impression given that  
2747 all taxes, but HHS did not see it that way.

2748 Ms. Trautwein, let me just ask you, one of the things

2749 that concerns a lot of us, and there are obviously a lot of  
2750 things that concern us in the Affordable Care Act, but the  
2751 cost is a big one, and we had estimates of costs all over the  
2752 place but I think no one now believes those figures that were  
2753 originally delivered to us by the CBO and even the Chief  
2754 Actuary for CMS has said the cost is going to be some \$450  
2755 billion over 10 years higher than what was advertised in  
2756 March of 2010, and in fact, those numbers are probably higher  
2757 still, and the difficulty is, of course, the CBO having to  
2758 estimate how many people would leave their employer-sponsored  
2759 insurance or how many employers would drop employer-sponsored  
2760 insurance and push their employees into the exchange.

2761         So do you think that the number of people ending up in  
2762 the exchange will be greater than currently estimated? Has  
2763 your organization done any looking at this?

2764         Ms. {Trautwein.} Well, thank you very much for this  
2765 question. I am very glad you asked that. This is actually  
2766 one of our primary concerns, not so much whether they end up  
2767 in the exchange or somewhere else. We are very worried about  
2768 what we are seeing in terms of some employer decision-making  
2769 process. So if we calculated the cost of this legislation  
2770 being whatever the final number was modified three times over  
2771 by CBO or whomever, if that is all based on some assumptions  
2772 that frankly we are very worried are not correct. What we

2773 are seeing is many employers saying look, the burden is too  
2774 heavy, and I have talked to them personally. This is not  
2775 anecdotal. Now, if too many of them do this, of course, all  
2776 the estimates that we made relative to the cost of providing  
2777 subsidies for a group of people that did not have employer-  
2778 sponsored coverage is going to mushroom dramatically. And so  
2779 what we are thinking is that many of them are not going to be  
2780 providing coverage far more than were estimated to be dropped  
2781 in the additional calculations, and this is based on massive  
2782 input from our members and their clients.

2783         Dr. {Burgess.} I want to thank everyone for attending.  
2784 That appears to be the conclusion of all the questions, and I  
2785 want to thank the witnesses for participating in today's  
2786 hearing. I thank them for their indulgence while the Floor  
2787 did votes.

2788         I remind the members that they have 10 business days to  
2789 submit questions for the record, and I ask the witnesses to  
2790 respond promptly to these questions. Members should submit  
2791 their questions by the close of business on September 29th.

2792         The subcommittee hearing stands adjourned.

2793         [Whereupon, at 2:22 p.m., the Subcommittee was  
2794 adjourned.]