



**STATEMENT OF**

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**ON**

**IMPLEMENTING THE AFFORDABLE CARE ACT**

**BEFORE THE**

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

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

**September 15, 2011**

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

In March 2010, Congress passed and the President signed into law the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), collectively referred to as the Affordable Care Act. The Affordable Care Act expands access to affordable, quality health insurance coverage to over 30 million Americans and strengthens consumer protections to ensure that individuals have coverage when they need it most. Immediate reforms include a critical foundation of patients' rights in the private health insurance market that help put Americans in charge of their own health care. Over the past year, the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury have already implemented historic private insurance market reforms – including eliminating pre-existing condition exclusions for children, prohibiting insurance companies from rescinding coverage absent fraud or intentional misrepresentation of material fact and from imposing lifetime dollar limits on coverage, and enabling many young adult children to stay on their parent's health plan up to age 26.

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

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

### **Medical Loss Ratio**

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

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

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

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

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

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

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<sup>1</sup> Arielle Levin Becker, “As Federal Health Reforms Take Effect, Aetna Proposes Rate Cuts.” [The Connecticut Mirror](#), May 11, 2011, link, [here](#).

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

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

## **Grandfathered Health Plans**

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

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

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

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

### **Transparency and Accountability**

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

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

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

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

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

### **Moving Forward**

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