

STATEMENT OF
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ON
PPACA'S EFFECTS ON MAINTAINING HEALTH COVERAGE AND JOBS: A
REVIEW OF THE HEALTH CARE LAW'S REGULATORY BURDEN
BEFORE THE
U. S. HOUSE COMMITTEE ON ENERGY & COMMERCE,
SUBCOMMITTEE ON HEALTH
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House Committee on Energy & Commerce, Subcommittee on Health

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

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Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee, thank you for the opportunity to discuss the Center for Consumer Information & Insurance Oversight (CCIIO)'s efforts to implement the Patient Protection and Affordable Care Act (P.L.111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), collectively referred to as the Affordable Care Act. I serve as Deputy Administrator and Director of CCIIO within the Centers for Medicare & Medicaid Services (CMS).

The Affordable Care Act expands access to affordable, quality coverage to over 30 million Americans and strengthens consumer protections to ensure that individuals have coverage when they need it most. Immediate reforms include a critical foundation of patients' rights in the private health insurance market that help put Americans in charge of their own health care. Over the past year, the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury have already implemented historic private market reforms including eliminating most pre-existing condition exclusions for children, eliminating lifetime dollar limits on essential health benefits, prohibiting insurance companies from rescinding coverage absent fraud or intentional misrepresentation of material fact and enabling many dependent young adult children to stay on their parent's insurance plan up to age 26.

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

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

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

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

Partnering with States on Rate Review Policies

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

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

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

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

Partnering with States on the Medical Loss Ratio

Many insurance companies spend or allocate a substantial portion of consumers' premium dollars on administrative costs and profits, including executive salaries, overhead, and marketing relative to what they spend on clinical services and quality improvement. To ensure consumers receive value for their premium dollars, the Affordable Care Act establishes minimum standards for spending by health insurance issuers on clinical services and quality improvement activities for their members, known as the MLR provisions. The Affordable Care Act established MLR

standards for issuers of 80 percent for the individual and small group markets and 85 percent for the large group market, which apply beginning in the 2011 reporting year. The Act also requires issuers to provide rebates to policyholders starting in 2012, for premiums paid in the previous year, if these standards are not met.

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

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

Recognizing the need for State flexibility, the Affordable Care Act allows for a temporary adjustment to the individual market MLR standard if a State requests it and demonstrates that the 80 percent MLR standard may destabilize its individual insurance market. The interim final rule established the process and criteria for evaluating State requests for adjustments, based on recommendations made the NAIC.

Partnering with States on Exchanges

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

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

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

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

¹ CBO’s March 2011 Baseline: Health Insurance Exchanges. Link, [here](#).

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

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

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

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

² <http://www.healthcare.gov/news/blog/establishmentgrants05232011.html>

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

“Grandfathered” Health Plans

The Affordable Care Act gives American families and businesses more control over their health care by providing greater benefits and protections for employees and their families. It also provides the stability and flexibility that families and businesses need to make the choices that work best for them. The Grandfathered Health Plans interim final rule with comment period (OCIIO-9991-IFC) that HHS, Labor and the Treasury jointly published on June 17, 2010, and amended on November 17, 2010 (OCIIO-9991-IFC2), is intended to preserve the ability of Americans to keep their current plan if they like it, while providing new benefits and minimizing market disruption.

While the Affordable Care Act requires all health plans to provide important new benefits to consumers, under the law, plans that were in existence on March 23, 2010 are “grandfathered” and exempt from some of the new requirements in the Affordable Care Act. The rule states that these plans can continue to innovate and contain costs by allowing insurers and employers to make routine changes without losing grandfather status, such as cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, or voluntarily adopting new consumer protections under the new law. If a plan loses its grandfathered status, then consumers in these plans will gain additional new benefits including the patient protections provided by the Affordable Care Act, and in the small and individual group markets, review of potentially unreasonable rates and other new protections.

To assist stakeholders in understanding this new rule, CCIIO holds regular technical assistance calls with State regulators and has responded to a number of State inquiries on grandfathering in the last year. The three Departments have also held meetings with issuers and consumer assistance groups about the rule’s standards for grandfather status. Based on feedback we have received through our inquiry process, and from formal comments in response to the interim final rule, HHS, Labor, and the Treasury issued an amendment to the grandfathering rule in November

2010. The three Departments have also published six sets of technical guidance on grandfathered health plans, most recently on April 1, 2011, which are available in question and answer format on the CCIIO website.

Moving Forward

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