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4 HEARING ON ``PPACA'S EFFECTS ON MAINTAINING HEALTH COVERAGE

5 AND JOBS: A REVIEW OF THE HEALTH CARE LAW'S REGULATORY

6 BURDEN''

7 THURSDAY, JUNE 2, 2011

8 House of Representatives,

9 Subcommittee on Health

10 Committee on Energy and Commerce

11 Washington, D.C.

12 The Subcommittee met, pursuant to call, at 12:08 p.m.,

13 in Room 2322 of the Rayburn House Office Building, Hon. Joe

14 Pitts [Chairman of the Subcommittee] presiding.

15 Members present: Representatives Pitts, Burgess,

16 Gingrey, Lance, Cassidy, Pallone, Schakowsky, and Waxman (ex

17 officio).

18 Staff present: Clay Alspach, Counsel, Health; Jim

19 Barnette, General Counsel; Paul Edattel, Professional Staff
20 Member, Health; Debbie Keller, Press Secretary; Ryan Long,
21 Chief Counsel, Health; Katie Novaria, Legislative Clerk;
22 Heidi Stirrup, Health Policy Coordinator; Phil Barnett,
23 Democratic Staff Director; Alli Corr, Democratic Policy
24 Analyst; Tim Gronniger, Democratic Senior Professional Staff
25 Member; Purvee Kempf, Democratic Senior Counsel; Karen
26 Lightfoot, Democratic Communications Director, and Senior
27 Policy Advisor; and Karen Nelson, Democratic Deputy Committee
28 Staff Director for Health.

|
29 Mr. {Pitts.} The committee will now come to order. The
30 Chair will recognize himself for 5 minutes with an opening
31 statement.

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

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

43 ``If you like what you have, you can keep it,'' was the
44 promise that President Obama repeatedly made on the campaign
45 trail and in the months leading up to the passage of PPACA in
46 March 2010. ``If you like your current plan, you will be
47 able to keep it. Let me repeat that: If you like your plan,
48 you will be able to keep it.'' That is President Obama with
49 remarks at White House on July 21, 2009. ``If you like your
50 insurance plan, you will keep it. No one will be able to
51 take that away from you. It hasn't happened yet. It won't

52 happen in the future.'" President Obama remarks in April
53 2010.

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

60 According to the Administration's own estimates of June
61 17, 2010, its regulations will force half of all employers,
62 and as many as 80 percent of small businesses, to give up
63 their coverage in the next two years.

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

68 A May 2011 Price Waterhouse Coopers survey of employers
69 reveals companies' responses to the new health care law and
70 how many are contemplating eliminating coverage as a result.
71 It also echoes the Administration's warnings. Of note, 51
72 percent of employers surveyed did not expect to maintain
73 grandfathered health status, meaning their employees would
74 forfeit their current coverage and pay higher premiums due to
75 the health care law's mandates on their new coverage. The

76 report also found that ``84 percent of companies indicated
77 they would make other changes to their plans, that is,
78 raising premiums and copayments, to offset costs associated
79 with PPACA.''

80 The regulations associated with grandfathering health
81 plans are just one reason Americans will lose the coverage
82 they have, even if they like it. The medical loss ratio is
83 another. Despite the fact that the MLR has been billed as a
84 tool to protect consumers from insurance companies, many
85 States are clamoring for waivers to exempt their citizens
86 from these ``protections.''

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

94 In an October 27, 2010, letter to Secretary Sebelius,
95 the National Association of Insurance Commissioners warned:
96 ``We continue to have concerns about the potential for
97 unintended consequences arising from the medical loss ratio.
98 As we noted in our letter of October 13, consumers will not
99 benefit from higher medical loss ratios if the outcome is

100 destabilized insurance markets where consumer choice is
101 limited and the solvency of insurers is undermined.''

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

108 The December 1, 2010, MLR regulation exempted mini-med
109 plans from the requirement for one year, after which HHS will
110 determine whether or not to extend the waivers for 2012 and
111 2013, meaning employees could still be in danger of losing
112 their current coverage.

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

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

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

123 ***** COMMITTEE INSERT *****

|
124 Mr. {Pitts.} First of all, thank you to our witnesses
125 today. I would especially like to welcome a fellow
126 Pennsylvanian, Dr. Scott Harrington, of the Wharton School at
127 the University of Pennsylvania, and I will yield back my
128 time.

129 The Chair recognizes the Ranking Member of the
130 Subcommittee, Mr. Pallone, for 5 minutes for an opening
131 statement.

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

139 Now, I mentioned to you that because of the fact that we
140 had the Full Committee hearing this morning and then we are
141 going to have votes I understand as early as 12:30, and then
142 were the Democrats and the Republicans yesterday, but the
143 Democrats today are leaving at 1:00 to go over to meet the
144 President at the President's request, that it would be
145 virtually impossible to have a hearing today that members
146 would be able to attend. The fact that only the three of us

147 are here just lends credence to that.

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

160 Now, the second thing is, you know, again, we are
161 talking about repeal or either not the whole of the
162 Affordable Care Act in this case, but provisions of the
163 Affordable Care Act. I don't know how many times, it is now
164 what, June 2, 5 or 6 months of just the same thing over and
165 over again, repeal the Act, the Act is bad, defund the Act,
166 turn it from mandatory to discretionary. I don't know how
167 many times we are going to hear over and over about the same
168 thing. I don't hear really much in the way of any kind of
169 replacement or Republican alternatives that would provide
170 coverage or provide affordable coverage. Again, today our

171 focus is on repealing the provisions that limit what the
172 insurance companies can do, abundantly clear that the
173 Republicans are in the pockets of the insurance companies and
174 will do whatever the insurance companies want them to do,
175 even if it means at the expense of the public.

176 So anyway, I have 2-1/2 minutes left. Let me get to
177 some of my prepared remarks, but I really am very
178 disappointed in the way this was set up today and the fact
179 that we keep dealing with the same thing to no avail.

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

190 Some of the most important reforms made in the
191 Affordable Care Act that are meant to curb the insurance
192 industry bad practices are the same ones my Republican
193 colleagues will attack today. They include the medical loss
194 ratio requirements and rate reviews. Medical loss ratio

195 requirements foster transparency and accountable in how
196 insurance companies spend patients' premiums. They also
197 force insurers to be more efficient in delivering quality
198 healthcare. I believe that American patients deserve a
199 guarantee they are getting good value for their dollar. When
200 that value is not met, insurance companies should be required
201 to refund consumers. In fact, HHS estimates that up to nine
202 million Americans could be eligible for rebates starting in
203 2012 worth up to \$1.4 billion, a clear indication there is a
204 real need to hold insurers accountable.

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

216 Another important critical reform was the process of
217 rate reviews. Let me be clear. This is not a provision that
218 prohibits or restricts an insurance company from raising

219 their rates, but what it does is ensure that any large
220 proposed increases are based on reasonable cost assumptions
221 and solid-based evidence. And this step is meant to hold
222 insurance companies accountable and provide unprecedented
223 transparency to the healthcare market.

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

234 Thank you, Mr. Chairman.

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

236 ***** COMMITTEE INSERT *****

|
237 Mr. {Pitts.} Thank you to the Ranking Member, and I
238 yield to the Vice Chairman of the Subcommittee, Dr. Burgess,
239 for 5 minutes for an opening statement.

240 Dr. {Burgess.} I thank the Chairman for yielding. I
241 thank you for having this hearing today. Goodness knows we
242 could have had this hearing in the last Congress, and we
243 should have had this hearing in the last Congress. It is
244 well into a year since the signing into law of the Affordable
245 Care Act, so it is high time we look at some of these things.
246 Both sides of the dais will talk about jobs and the economy.
247 We talk about it, we demagogue about it, but the big question
248 is, are we going to do anything about it. Unemployment is at
249 9 percent, and it begs the question: Why are American
250 employers hesitant to hire new employees. Part of the reason
251 might be, just might be, that in the first year since the
252 passage of the Affordable Care Act, this is what a small
253 business owner confronts when they want to hire a new
254 employee. Is it any wonder that they would stop and look and
255 say I don't think I can do that at this time? We will make
256 do with what we have.

257 Now, the burdensome regulations delivered by the United
258 States Congress stack up as you can see here to be almost
259 insurmountable by anyone who has ever run a small business

260 that looks at a stack like this, would say I don't think that
261 is for me. But here is the simple truth. You just cannot be
262 anti-employer and claim to be pro jobs. It doesn't equate.

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

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

275 Document demands were made of these employers, and they
276 produced the documents. The documents were examined, and it
277 turned out that the employers were simply complying with the
278 Securities and Exchange Commission, but some of the
279 information contained within those documents made the then-
280 majority, the Democrats, to side not to hold the hearing
281 after all because what they found was large employers were
282 looking at the data and wondering how in the world it was
283 going to be cost-effective to continue to provide health

284 insurance. No employer wanted to be the first to drop this
285 benefit, but there were many who would likely be second,
286 third or fourth.

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

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

296 The Affordable Care Act really ought to come with a
297 boxed FDA warning that says, Warning: The Affordable Care
298 Act, when used as directed, may be harmful to your health.
299 It may reduce your healthcare and increase your cost.

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

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

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

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

315 ***** COMMITTEE INSERT *****

|
316 Mr. {Pitts.} The Chair thanks to the gentleman and now
317 recognizes the Ranking Member of the Full Committee, Mr.
318 Waxman, for 5 minutes for an opening statement.

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

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

332 Provisions such as rate review and medical loss ratio
333 provide consumers with protections from insurance company
334 rate hikes and help them receive a good value for their
335 premium dollars. Rate review requires transparency so that
336 insurers are required to justify why premiums continue to
337 increase. Premium increases are a hardship for consumers
338 facing a tough job market and a struggling economy, and they

339 are hard to understand given that insurer profits have risen
340 by staggering amounts.

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

351 The Federal Minimum Rate Review provision provides some
352 consistency across the country and offers an easy-to-
353 understand explanation of premium increases and their
354 justification for consumers. The healthcare reform law's new
355 minimum medical loss ratio requirement is aimed at protecting
356 consumers and ensuring that their hard-earned dollars are
357 spent on benefits and quality improvements and less on
358 insurer profits and CEO salaries.

359 A number of States have medical loss ratio rules, and
360 the new federal law standardizes the calculations and sets a
361 minimum of value for consumers wherever they live. The
362 calculation allows for quality improvements, innovation and

363 fraud detection to be counted as medical expenses.

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

375 The Affordable Care Act provides a series of popular
376 insurers' reforms that have already gone into effect, such as
377 allowing adult children up to the age of 26 to stay on their
378 parents' insurance, eliminating lifetime limits and
379 prohibiting rescissions of insurers when someone gets sick.
380 These apply to all plans 6 months after enactment, overriding
381 the grandfathering rules because of their importance to
382 families. The dependents up to 26 policies have been
383 immensely helpful in responding to the downturn in the
384 economy. The prohibition of rescissions is responsive to the
385 insurance company abuses and has received bipartisan support,
386 and the prohibition on lifetime limits of benefits is

387 necessary protection for a person with cancer or hemophilia
388 who has nowhere left to turn when he or she has exhausted
389 lifetime maximums. In 2014, these benefits will be greatly
390 expanded, truly reforming the insurance marketplace in the
391 United States. The market will no longer reward companies
392 that avoid risk and leave some of our sickest with no
393 options. It will be inclusive, accessible, affordable, built
394 on the notion of individual responsibility.

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

400 I yield back my time.

401 [The prepared statement of Mr. Waxman follows:]

402 ***** COMMITTEE INSERT *****

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403 Mr. {Pitts.} The Chair thanks the gentleman. That
404 concludes opening statements. We will go to the first panel.

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

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

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

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

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

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

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

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

425 Your written testimony will be made a part of the

426 official record. We ask that you please summarize your
427 testimony in 5-minute opening statements, and we will go in
428 the order that our witnesses were introduced.

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

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

|
443 ^STATEMENT OF RANDI REICHEL

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

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

460 There likely will be a number of unintended consequences
461 for individuals, families and employers, and there are a
462 number of reasons for this. The first is a lack of a uniform
463 transition period. Most States today either don't have
464 medical loss ratio requirements in the large group, small
465 group or individual markets or the ones that do have medical
466 loss ratio requirements that are crafted to incorporate
467 existing actuarial practices in order specifically to avoid
468 any type of market disruption.

469 Without the time to make the adjustments and the changes
470 that are needed to comply with the MLR provisions, some of
471 the health plans in the marketplace today have no choice but
472 to exit the market. And you know, we know that we are not
473 crying wolf about this, and the reason that we know that is
474 HHS has already acknowledged in its letters to Nevada, in its
475 letters to New Hampshire, when those two States asked for a

476 waiver of the MLR requirements, they conceded that the MLR
477 standard could, in fact, lead to a destabilization of the
478 individual market in those States.

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

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

496 Even more than that, one of the things that we are
497 really concerned about right now is that the MLR requirements
498 do in fact turn back the clock on any kind of efforts to
499 prove quality and prevent fraud and abuse, and they do this

500 for two reasons. One is they only permit dollar recoveries
501 from fraud programs to be counted toward the MLR, but they
502 penalize companies for actually preventing fraud in the first
503 place. And they don't recognize as quality the expenses of
504 transitioning into the ICD-10 coding system that is intended
505 for disease eradication and quality.

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

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

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

524 Mr. {Pitts.} Would you wrap up, please?

525 Ms. {Reichel.} I don't want to repeat what else is in
526 our testimony. We do have some recommendations to mitigate
527 the harmful impact of the medical loss ratio. With that I
528 will thank you for the opportunity to testify and present our
529 perspective.

530 [The prepared statement of Ms. Reichel follows:]

531 ***** INSERT 1 *****

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Mr. {Pitts.} Thank you. Dr. Harrington?

|
533 ^STATEMENT OF SCOTT HARRINGTON

534 } Mr. {Harrington.} Chairman Pitts, Ranking Member
535 Pallone, Mr. Burgess, I am pleased to testify on rate review
536 and minimum medical loss ratio regulation under PPACA.

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

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

552 It is desirable to replace the rate review and medical
553 loss ratio regulations with pro-competitive forms including
554 State option of policies that promote thoroughly informed

555 competition and consumer choice.

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

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

574 These provisions reflect the views that competition and
575 prior State regulation did not adequately discipline health
576 insurers' expenses and profits, but health insurers' expenses
577 and profits are not significant drivers of high and rapidly
578 growing health insurance costs. According to the National

579 Health Expenditure Data, for example, the estimated annual
580 private health insurance medical loss ratio, the ratio of
581 medical cost to premiums, including self-funded plans, has
582 averaged about 88 percent since 1965, ranging from 85 to 90
583 percent with little or no trend over time. Now, there is a
584 lot of variation across companies. Health insurers' profit
585 margins typically average 3 to 5 percent of revenues, lower
586 for not-for-profit insurers. Administrative expenses average
587 11 to 12 percent of premiums.

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

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

600 Research has not provided detailed evidence on health
601 insurance rate regulation, but the adverse consequences of
602 binding rate controls, politicization of insurance pricing,

603 have been aptly documented for automobile insurance, workers'
604 compensation insurance and more recently, homeowners'
605 insurance in catastrophe prone regions. There is no reason
606 to believe that requiring prior regulatory approval or
607 tighter review of health insurance rates will be any
608 different.

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

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

622 Thank you.

623 [The prepared statement of Mr. Harrington follows:]

624 ***** INSERT 2 *****

|
625 Mr. {Pitts.} The Chair thanks the gentleman and
626 recognizes Ms. Trautwein for 5 minutes for her opening
627 statement.

|
628 ^STATEMENT OF JANET TRAUTWEIN

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

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

643 One of the first places that was hit was agent
644 commissions. Now, in reality, agent commissions being
645 considered an insurer expense is really not even accurate.
646 The consumers who purchase health insurance coverage are the
647 ones who hire and can fire their brokers, not insurers.
648 Independent agents pay 100 percent of their own business
649 expenses. Whether accurate or not, the Interim Rule

650 categorizes commissions as an insurance expense largely
651 because these commissions were not specifically listed as an
652 item that could be carved out of the MLR calculation as were
653 taxes, and as a result, our members report that most health
654 insurance carriers changed commission rates as of January 1,
655 2011, the date the MLR rule became effective.

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

669 Now, some of you have probably have never had the good
670 fortune to work with a broker, and you may not understand
671 what this really means or consumers. So I would like to tell
672 you a story that illustrates what I am talking about. This
673 is a story that I know well, and I know it because I

674 personally experienced it. I am here today not just as the
675 head of an association but as someone who knows the people
676 who have been affected. And before I came to NAHU, I was an
677 insurance broker myself for almost 20 years in Texas. And I
678 had a large number of clients that I built up over many
679 years, and I did that by providing them great service and
680 benefits at the lowest possible cost. I promised them that I
681 would help them with any issue that came up relative to their
682 plan, and I am proud to say that during the 20 years that I
683 was in business, not a single one of my clients or a single
684 one of their employees or dependents ever had to go to appeal
685 on a claim and that is because we took care of issues before
686 it required that type of action.

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

694 He came to me in desperation because his doctors had
695 given him 6 months to live, and he said, look, I have done
696 some research, and I found this one treatment that I really
697 want to try, but he wasn't able to go through with the

698 treatment because it was considered experimental by his plan.

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

704 You might think that this kind of service would be very
705 expensive. The fact is that most agents and brokers just
706 really don't make a lot of money. The Bureau of Labor
707 Statistics says that the average for agents and brokers is
708 \$45,000 to \$62,000 a year. Entry-level agents only make
709 about \$25,000 a year, and this is before the cuts that
710 occurred on January 1.

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

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

720 And I realize that I am out of time, but I would like to
721 ask for your immediate consideration of this legislation. It

722 is a reporting change, but it something that would provide
723 immediate relief to many, many people across this country.

724 Thank you very much.

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

726 ***** INSERT 3 *****

|
727 Mr. {Pitts.} The Chair thanks the gentlelady and
728 recognizes Ms. Hayes for 5 minutes.

|
729 ^STATEMENT OF KATHERINE HAYES

730 } MS. {Hayes.} Thank you, Mr. Chairman, for giving me the
731 opportunity to be here today and also members of the
732 Subcommittee.

733 The last time I was in this room was 20 years ago as a
734 20-something health staffer for a member of the Health
735 Subcommittee, Mickey Leland, from Texas. And knowing that
736 Mickey was first a Texan and second, a Democrat, it is nice
737 to see that Texas is still well-represented on the
738 Subcommittee.

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

744 This Committee and Subcommittee has a really long
745 history of working to protect not only low-income individuals
746 but individuals in the small group and individual non-group
747 health insurance market. Chairman Bilirakis, former
748 Subcommittee chairman, and Chairman Tom Bliley put together
749 the Health Insurance Portability and Accountability Act which
750 laid the foundation for the Accountable Care Act. What it

751 did was preserve McCarran-Ferguson and allowed health
752 insurers or allowed States to regulate health insurance with
753 certain minimum standards. And the reason Congress stepped
754 in and did that, it was after health reform failed back in
755 1993 and 1994, was they saw the burden and the dysfunctional
756 markets in the non-group or individual and small group health
757 insurance markets and wanted to step in to do something. And
758 the Affordable Care Act insurance markets reforms really
759 build on that.

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

765 The problems in the small group market are well-
766 documented. Although health insurance plans are prohibited
767 from denying coverage for small groups, for small businesses,
768 they can charge whatever they want; and quite frankly,
769 although some States have implemented rate bans to limit
770 that, generally, in some States small businesses can pay a
771 100 percent surcharge because of the risk, the high-risk
772 individuals that they employ.

773 The Affordable Care Act was really laid out in two
774 phases if you look at the statute itself. One, there was

775 envisioned a transition period that began with date of
776 enactment, ending in 2014 when most of the insurance market
777 reforms went into place. There were a number of experts,
778 insurance experts and regulations, came before Congress and
779 told Members of Congress that yes, it is very important to
780 reform these markets, but you need to be careful. You need
781 to phase in things slowly. You need to build in protections,
782 and the Affordable Care Act does include that. Some examples
783 of the protections and the transition rules that were put in
784 to the Affordable Care Act include grandfathering of health
785 insurance plans. They include high-risk pools, small
786 business tax credits and the insurance market reforms which
787 include the immediate reforms, annual limits on coverage and
788 coverage of dependent children, as well as medical loss
789 ratios.

790 In a review of the--it is easy to see the Administration
791 is following the pattern that was set out in the Affordable
792 Care Act, which is namely to get through the transition
793 period to full implementation in 2014.

794 Ultimately, small businesses have quite a lot to gain
795 under the Affordable Care Act. They will be able to purchase
796 health insurance coverage through exchanges. They will have
797 options. And they will be able to pool both risk and some of
798 their administrative costs. And finally, even though small

799 businesses that choose not to provide health insurance
800 coverage for their employees, because for the smallest
801 businesses, it isn't a requirement to provide coverage at
802 all, their employees will benefit from the tax credits and in
803 the Affordable Care Act and can purchase through the
804 exchanges. At the end of the day, this will benefit small
805 businesses because their employees will be ensured, they will
806 have less absenteeism, and ultimately, those with health
807 insurance coverage have better health outcomes and better
808 health status.

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

814 Thank you very much.

815 [The prepared statement of Ms. Hayes follows:]

816 ***** INSERT 4 *****

|
817 Mr. {Pitts.} The Chair thanks the gentlelady and
818 recognizes Mr. Rome for 5 minutes for his opening statement.

|
819 ^STATEMENT OF ETHAN ROME

820 } Mr. {Rome.} Mr. Chairman and members of the Committee,
821 thank you for giving me the opportunity to testify today.

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

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

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

834 Thanks to the law, we have a new MLR rule that has been
835 discussed that requires that insurers must spend on actual
836 medical care a specific amount instead of on wasteful
837 overhead, excessive profits and bloated executive
838 compensation. The MLR combats the long-term downward trend
839 and ensures insurers' spending on medical care as a
840 percentage of premiums. While the MLR was about 95 percent

841 back in 1993, it is 80 percent or less among large insurers
842 today. That is thankfully changing already. The new rule is
843 already cutting rates for some consumers like Aetna
844 subscribers in Kansas, an intended consequence of the MLR and
845 it promises up to 2 billion in rebates nationwide if insurers
846 fail to meet the standard.

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

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

859 The big driver is profits. The Wall Street-run health
860 insurance companies, their profits jumped 51 percent from
861 2008 to 2010. In 2010 alone, their combined profits were
862 11.7 billion, up from 9.9 in 2009, despite a 4 percent
863 decline in enrollment. New data indicate they are on their
864 way to record profits in this as well.

865 But reported profits tell only a fraction of the story.
866 Insurers have also amassed a capital surplus that vastly
867 exceeds the Nation's major for-profit and non-profit, what
868 they are required. According to CitiGroup analysis, the
869 Nation's major for-profit and non-profit health insurance
870 companies held an astonishing 90.3 billion in total risk-
871 based capital to cover unexpected medical claims as of
872 December 31, six times more than necessary. And virtually
873 unnoticed by many, the for-profit insurers have steadily
874 moved billions of dollars of cash off their balance sheets to
875 buy back their own shares on the New York Stock Exchange.
876 This increases profits and share prices. It does nothing to
877 improve patient care or the quality of their programs.

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

887 Two final quick things. We should not be spending our
888 time talking about how to undermine the Affordable Care Act.

889 For example, taking broker commissions out of the MLR
890 equation. What that will do is jeopardize 1.4 billion in
891 rebates for consumers, and as rates have gone up 100 percent
892 over the last 10 years, so, too, have the commissions of
893 brokers.

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

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

902 [The prepared statement of Mr. Rome follows:]

903 ***** INSERT 5 *****

|
904 Mr. {Pitts.} The Chair thanks the gentleman and
905 recognizes Mr. Fensholt for 5 minutes' opening statement.

|
906 ^STATEMENT OF EDWARD FENSHOLT

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

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

925 If I could sum up the views of our clients in a couple
926 of words, those words would be frustration and bewilderment.
927 The men and women who run these companies and supply jobs in

928 their communities provide valuable health insurance benefits
929 to their employees, but they struggle to do that. They
930 struggle with the financial aspects of that coverage and with
931 the dazzling array of federal rules and regulations they must
932 navigate in order to provide that coverage.

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

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

946 The health reform law adds a variety of new benefit and
947 coverage mandates that add additional costs and complexities
948 the sponsorship of a group health insurance plan. Our
949 clients understand why Congress would act to supply access to
950 health insurance for those who do not have that access or
951 cannot afford it, but they simply do not understand why, in a

952 time when everyone agrees that health insurance and
953 healthcare is too expensive, why Congress would act to make
954 the provision of employer-sponsored insurance, to which about
955 150 million of us obtain, more costly and particularly more
956 hassle prone.

957 We recently finished a 12-question survey of our clients
958 on the impact of healthcare reform on them and the plans they
959 sponsor. Over and over we received the same responses we
960 have been hearing literally from them for the last year,
961 comments such as these, taken verbatim from our survey
962 results. We currently provide healthcare coverage to our
963 employees. The reform Act will do nothing but add cost and
964 add administrative requirements. The law is burdensome with
965 little benefit to employer or employee. In the long run, the
966 law will reduce access to healthcare services and
967 dramatically increase the cost to both the employer and the
968 employee. What they, meaning the Congress, are planning is
969 only going to penalize the employers and employees who
970 actually are hard workers and are trying to make a living for
971 themselves and not relying on the government to take care of
972 them.

973 The law includes a grandfather clause ostensibly
974 intended to shield existing group plans from the law's costly
975 mandates and other provisions. But it is a poor shield

976 indeed. It supplies no protection from several requirements
977 such as the obligation to eliminate lifetime and annual
978 dollar maximums the plans have used for years as--cost
979 containment measures or the obligation to supply coverage to
980 adult children, even if married, even if non-dependent upon
981 the employer or living apart from the employee and spouse or
982 even if the child is gainfully employed himself or herself.

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

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

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

1000 Thank you, sir.

1001 [The prepared statement of Mr. Fensholt follows:]

1002 ***** INSERT 6 *****

|
1003 Mr. {Pitts.} The Chair thanks the gentleman and
1004 recognizes Mr. Gardiner for 5 minutes for an opening
1005 statement.

|
1006 ^STATEMENT OF TERRY GARDINER

1007 } Mr. {Gardiner.} Thank you, Mr. Chairman. Good
1008 afternoon, Chairman Pitts, and Ranking Member Pallone and
1009 members of the Subcommittee. My name is Terry Gardiner. I
1010 am working with the Small Business Majority, and we are a
1011 non-profit national group advocating for small business
1012 owners out there. We represent the 28 million small
1013 businesses which many of those are self-employed and
1014 businesses from 1 to 100 employees. We do scientific opinion
1015 polls and economic research to try to understand what the
1016 problems and the solutions that small businesses need.

1017 I myself started as a self-employed commercial fisherman
1018 for many years in Alaska until I got one of those
1019 entrepreneurial ideas to--a bigger company called Silver
1020 Lining Seafoods in 1981 and spent the next couple decades as
1021 an owner and CEO of that company growing it from start-up to
1022 \$100 million with a thousand employees selling globally in 22
1023 countries. So I have been through this as many of the other
1024 people in Small Business Majority have been of being out
1025 there and dealing with healthcare and access to capital and
1026 all these issues that all small business owners have to
1027 navigate to survive and be successful and create jobs.

1028 So we are well aware that many times there are
1029 regulatory burdens, lots of reports to fill out there. I
1030 think with healthcare, we have also watched for decades and
1031 endured while it only got worse. And so we felt that
1032 something has to be done, and there is a legitimate role for
1033 government to step in when things are only getting worse, as
1034 we have seen over the decades with costs going up and less
1035 availability, and over half our small businesses don't even
1036 offer anymore.

1037 So when we survey small business owners, what we find is
1038 that cost is really the biggest concern. Our research showed
1039 an average of 86 percent of small business owners cite cost
1040 as their biggest barrier. A major economic study we did
1041 found that small employers would pay \$2.4 trillion in
1042 increased healthcare costs through the next decade if nothing
1043 changes. And in fact, we would lose 178,000 jobs and \$52
1044 billion in profits with no reform. This is why we have the
1045 Affordable Care Act, because that was the status quo. We
1046 needed to do something.

1047 One aspect that we are here to talk about today is the
1048 medical loss provision, and certainly insurance companies and
1049 brokers have a stake in this. You have heard about that, but
1050 I think you need remember that employers are paying the bill.
1051 Small employers are paying the bill in the small group

1052 market. Self-employed people are generally purchasing in the
1053 individual market, and all of these dollars and costs we are
1054 talking about passed through. And so whether the MLR is
1055 effective or not is really going to come out of the bottom
1056 line of small businesses, and whatever small businesses pay
1057 and more and more cost is really going to reduce their
1058 ability to expand their company and create jobs, and if we
1059 want small business to continue to create 70 percent of the
1060 jobs, then we need to be thinking about this.

1061 So we need to, you know, work out some of these
1062 problems. We need to make sure that the MLR is protecting
1063 the small businesses because what we hear in meeting after
1064 meeting is small business owners standing up saying I got a
1065 double-digit increase this year on top of one last year.
1066 That should really be our focus. What are we doing about
1067 that? You know, in general, these small business owners are
1068 paying 18 percent more than the larger business owners. So I
1069 think the other thing we are here to talk about today is the
1070 rate review, and really what we are talking about here is
1071 transparency. As has been pointed out, there is no real
1072 hammer of the Federal Government to do anything about it, but
1073 again, this is something that, as a small business owner, you
1074 never get an explanation of why the premiums have gone up
1075 double-digit. You are just told this is the way it is by

1076 your broker, and we certainly support brokers. I always used
1077 the broker. Everybody I know used brokers. They are an
1078 integral part, and we believe they will be a very important
1079 part in the exchanges going forward.

1080 But again, somebody has to pay the bill, and if we just
1081 continue to shrink and shrink the number of small business
1082 owners because of double-digit inflation, that will be a
1083 reason, you know, that insurance companies' business shrinks
1084 and brokers' business shrinks.

1085 So I would just like to conclude by saying I think these
1086 are important parts of overall health reform. We need to get
1087 on with the show and implement the exchanges and the tax
1088 credits, and if anything expands those tax credits along with
1089 these regulatory reforms so we can bring the cost down of
1090 health insurance for small businesses.

1091 [The prepared statement of Mr. Gardiner follows:]

1092 ***** INSERT 7 *****

|
1093 Mr. {Pitts.} The Chair thanks the gentleman. That
1094 concludes the openings statements. We are presently in a
1095 vote on the floor. There are seven votes scheduled, so with
1096 the appointment at the White House at 2:00 for the Democratic
1097 members, we will recess for questions of this panel until
1098 4:00. If you can stay, we would like to ask that you can do
1099 that, and we will recognize the Ranking Member who wants to
1100 express himself.

1101 Mr. {Pallone.} Well, Mr. Chairman, I mean, you know,
1102 this is the same thing that I said at the beginning. I told
1103 you so, I think the way we are proceeding is just not good.
1104 I mean, there is almost nobody here other than, you know, the
1105 three of us and I see that we were joined by one colleague on
1106 either side of the aisle, but I just think that most of the
1107 members have been discouraged from being here because the
1108 panel has now spoken, the questions are going to come later,
1109 we are going to have a second panel after that. I don't know
1110 what time. And I don't know what you are supposed to do now.
1111 I guess you have no choice.

1112 But I just want to again object to the fact that we are
1113 proceeding this way. I think it is not good for the
1114 witnesses because they have to wait around for us to come
1115 back 4 hours later, and the result is that the members are

1116 not here to participate. So I don't know what to say. I
1117 mean, I keep saying the same thing over and over again. I
1118 just hope this is the last time that we proceed in this way
1119 because it is just not conducive to a good debate, frankly.

1120 Mr. {Pitts.} I regret it is unfortunate we have to
1121 postpone the hearing. We will make a call to all the members
1122 to be back in 3 hours at 4:00 and ask the indulgence of the
1123 witnesses if they can return at that time.

1124 Mr. {Pallone.} Mr. Chairman, can I ask what we are
1125 going to do about the second panel?

1126 Mr. {Pitts.} I think perhaps on the second panel we are
1127 going to have to delay the second panel for another day.

1128 Mr. {Pallone.} Well, again, I don't see why if he--

1129 Mr. {Pitts.} He is limited on his time constraints at
1130 the end of the day.

1131 Mr. {Pallone.} I understand that, but we knew that from
1132 the beginning and now we are going to end up having the
1133 hearing when we come back after recess. My original request
1134 was that we postpone it until then anyway. So now we are
1135 going to have to postpone it. It just seems like the whole
1136 thing could have been handled better. We could have just had
1137 it when we came back, and everything would have been straight
1138 through and members would have been here. Now we are going
1139 to have a second hearing when we come back. I just, you

1140 know--it just seems like--let us just hope that this doesn't
1141 happen again.

1142 Mr. {Pitts.} Unfortunately, we have got to work around
1143 the President's schedule, and I regret that. But we will
1144 reconvene. We will recess until 4:00.

1145 [Recess.]

1146 Mr. {Pitts.} The Subcommittee will come to order, and I
1147 will now begin questioning and recognize myself for 5 minutes
1148 for that purpose.

1149 Let me start with Ms. Trautwein. You talked about the
1150 dire situation facing brokers across the country. Do you
1151 believe the reduction in income and employment for agents and
1152 brokers as a result of the MLR rule will make more Americans
1153 dependent on Medicaid and the health coverage subsidies from
1154 PPACA? If so, would you elaborate?

1155 Ms. {Trautwein.} Yes, thank you. Well, certainly as I
1156 testified earlier, if you look at what the average income of
1157 agents and brokers are today already, it is easy to see that
1158 many of them would be in the category where they would, if
1159 they were not insured through an employer-sponsored plan,
1160 already be eligible for subsidies and certainly with a
1161 reduction of 20 to 50 percent, that absolutely would put many
1162 of them down into the Medicaid levels, particularly when you
1163 consider the expansion of Medicaid that is associated with

1164 the law.

1165 So yes, I would say that many of them probably, no doubt
1166 would definitely qualify for subsidies, and many of them
1167 would also qualify for Medicaid if this is not turned around.

1168 Mr. {Pitts.} Now, some argue that insurance agents add
1169 no value to the system and are simply overhead in the system
1170 that can be eliminated at the stroke of a pen or regulation.
1171 Elaborate a little bit on the role agents play in the
1172 healthcare system please.

1173 Ms. {Trautwein.} Well, the first thing I would like to
1174 say there is that, you know, agents and brokers have been
1175 used for 100 years to help people purchase health insurance
1176 coverage, and they have been used by insurance carriers for a
1177 reason, and it is because it is efficient. And from time to
1178 time, and I have been in the industry 30 years, I have seen
1179 carriers say look, we are going to try to get lean and mean
1180 here, and we are going to use our own people. And invariably
1181 it doesn't last very long. Usually it is a year or less, and
1182 they are back to using agents and brokers because it is more
1183 efficient, because they get a larger number of people
1184 enrolled, and they are able to do it at a lower cost.

1185 Then you have the service aspect which I talked about
1186 earlier, and I gave you one example. But those types of
1187 things happen all the time, every sort of claims situation

1188 that you can imagine. And this is all at a time when it is
1189 taking much more time for them to do their jobs because they
1190 have so many questions about the new law, particularly from
1191 their employer clients, and for their small employers, they
1192 often serve as their HR department. You would be surprised
1193 all the things that they actually do.

1194 Mr. {Pitts.} Thank you. On the issue of fraud, Ms.
1195 Reichel, a 60 Minutes episode last year pegged the amount of
1196 fraud and abuse in the Medicare program at more than \$60
1197 billion a year. Some have estimated that it might be closer
1198 to 100 billion. Do you agree? Does anyone disagree that the
1199 amount of fraud and abuse in the Medicare program could be as
1200 high as \$60 billion as 60 Minutes reported?

1201 Ms. {Reichel.} I have seen that number on the 60 Minute
1202 report, yes, and I know that that is accurately what they
1203 have reported.

1204 Mr. {Pitts.} Now using that small number of 60 billion
1205 that is about 12 percent of Medicare spending per year.
1206 Using the higher number of 100 billion, the percentage is
1207 about 21 percent. Would a private plan be able to stand--12
1208 percent or 21 percent of its claims were a result of fraud
1209 and abuse?

1210 Ms. {Reichel.} I think it would be quite difficult for
1211 them.

1212 Mr. {Pitts.} Will the MLR rule hinder Plans' ability to
1213 stop fraud before it happens and if Plans are forced to pay
1214 more fraudulent payments, will premiums increase?

1215 Ms. {Reichel.} You know, that is really an excellent
1216 question. The way the MLR is structured, Plans are not going
1217 to be able to get credit for preventing fraud. Fraud
1218 prevention activities are categorically excluded from the
1219 medical loss ratio, and the only thing that Plans can get
1220 credit for is the dollar amount that they have actually
1221 recovered after the payments have already been made and
1222 services that are potentially fraudulent have already been
1223 rendered.

1224 Mr. {Pitts.} I only have 30 seconds left, but Dr.
1225 Harrington, I watched your reaction when someone else was
1226 testifying about the excess profits. Would you care to
1227 comment on your reaction to the testimony of the excess
1228 profits insurance companies make?

1229 Mr. {Harrington.} Two quick things, I think. Whenever
1230 I look at profits, I tend to look at profit margins because
1231 this is a big country with a big industry, and if you look at
1232 dollar amounts, they can be big dollars on a small percentage
1233 of total premiums.

1234 I apologize for my reaction. My reaction was really to
1235 the issue of insurance companies' allegedly holding all this

1236 capital in excess of what is required by regulation. I have
1237 done a lot of work on insurance company capital requirements,
1238 regulatory requirements are the very bare minimum to keep
1239 regulators from taking over the company, and to me it really
1240 makes no sense to start comparing the amount of capital the
1241 company holds compared to that regulatory requirement as some
1242 measure of how much money it could disperse to--the leadings
1243 health insurers typically have financial strength ratings
1244 from rating agencies in the neighborhood of A to A-minus.
1245 They are not A-plus, they are not A-plus-plus. So certainly
1246 the rating agencies that are evaluating their solvency do not
1247 regard the amount of capital they are holding as excessive
1248 relative to their responsibility to meet unforeseen
1249 contingencies to their policyholders.

1250 Mr. {Pitts.} Thank you. My time is expired. The Chair
1251 recognizes the Ranking Member, Mr. Pallone, for 5 minutes for
1252 questions.

1253 Mr. {Pallone.} Thank you, Mr. Chairman. I want to ask
1254 Mr. Rome, your testimony notes that from 1999 to 2009 health
1255 insurance companies raised premiums 131 percent, three times
1256 the growth of wages and four times the rate of overall
1257 inflation. One of the regulations that Republicans are
1258 attacking here today is the so-called rate review regulation,
1259 which I think requires very little of health insurers. It

1260 only asks that they provide a justification to HHS for any
1261 premium increase of 10 percent more. Insurance companies
1262 with that amount of rate increase will be identified on a
1263 public website. It seems to me that this is the least we can
1264 do to try to stop excessive premium increases. So I just
1265 wanted to ask you, what more can you tell us about the state
1266 of profitability of the insurance industry today? Is rate
1267 review going to be an impossibly onerous burden for the
1268 insurance companies to meet? Have you seen an impact from
1269 rate review on premiums in any States in which it has been
1270 implemented so far?

1271 Mr. {Rome.} Rate review does a couple of very important
1272 things. One is it brings transparency to this process, and
1273 if insurance companies are selling a good product with good
1274 rates--there ought to be no problem taking a close look at.
1275 Rate review, which just today the California Assembly passed
1276 and it--Senate, the good example there is auto insurance.
1277 They have had rate reviews since--prior rate approval, there
1278 is a robust and competitive market. But it has brought down
1279 rates. In just the last year-and-a-half, aggressive
1280 intervention by regulators has reduced rates in multiple
1281 places with health insurance. And so anytime you see rates
1282 getting reduced in Massachusetts from 18 to 10 percent, et
1283 cetera, you know that those rates have some room, and

1284 regulation helps find it.

1285 Mr. {Pallone.} The second question was mentioned I
1286 think or someone said that Aetna recently announced in
1287 Connecticut they will reduce premiums in the individual
1288 market there by 5 to 20 percent or 10 percent on average
1289 beginning in September. That is certain a welcome change to
1290 hear premiums go down instead of up.

1291 But are you aware of why Aetna of Connecticut reduced
1292 its premium? And I know your testimony talks about large
1293 insurers having a significant amount of built-up reserves, so
1294 they should be able to afford some premium reductions. Is
1295 that what is happening with Aetna of Connecticut or is there
1296 some similar actions in the near future that we might see
1297 form other insurers?

1298 Mr. {Rome.} Aetna is an example of the MLR in action.
1299 In order to avoid paying the rebate that they would have been
1300 required to pay as a consequence of not meeting their MLR
1301 target, they lowered rates. And they wouldn't have lowered
1302 rates if they weren't in a position to do so.

1303 Mr. {Pallone.} Okay, and are we likely to see that with
1304 other insurers?

1305 Mr. {Rome.} I think so, and I think what is important
1306 is that while we along with others point out the importance,
1307 \$2 billion in rebates could come to consumers. The fact is

1308 that the MLR is not designed to produce rebates. It is
1309 designed to more--industry and lower premiums.

1310 Mr. {Pallone.} All right. Mr. Gardiner, I think I have
1311 time to ask you a question. As you know, the experience of
1312 small business with unrelenting health insurance rate
1313 increases is not surprising nor uncommon. Since 2000,
1314 premiums from employer-sponsored insurance have grown three
1315 times as fast as wages. These increases are crippling
1316 America's small businesses in my opinion, not health reform.

1317 Over half of the small businesses in the country can't
1318 afford to offer health benefits to their employees which
1319 means the majority of uninsured Americans are small business
1320 owners, their employees or their families. In your testimony
1321 you talk about a small business owner who was quoted 160
1322 percent premium increase from his carrier last year forcing
1323 him to change plans. So my question is can you talk about
1324 how different insurance reforms and the exchanges, you know,
1325 in the Affordable Care Act, will help lower premium increases
1326 over time, with regard to small businesses?

1327 Mr. {Gardiner.} I think that one of the special
1328 problems that small businesses have faced, while everybody
1329 sees medical costs, premium costs, going up in the country
1330 and it is very well documented--small businesses are much
1331 more subject to a very much annual volatility. You know,

1332 every time we have a meeting, there is always somebody
1333 standing up talking about what their premium went up and
1334 other people chiming in. And a lot of times they can't even
1335 find out why their premium went up. And you know, we talk
1336 about people in the small group market. It is even more
1337 volatile if you are self-employed. If you are one of 22
1338 million self-employed, you experience even more premium
1339 volatility. And I think we are not really going to see that
1340 premium volatility come down until the exchanges are up--and
1341 combined with the insurance reforms. At that point we are
1342 going to see an ability to level them out.

1343 So I think the main thing we hear from small business
1344 owners, can we get these exchanges going sooner because, you
1345 know, we are going to have to bring those elements together
1346 of the exchanges and the insurance reforms before we will
1347 decrease that volatility on a year-to-year basis.

1348 Mr. {Pallone.} Thank you very much. Thank you, Mr.
1349 Chairman.

1350 Mr. {Pitts.} The Chair thanks the gentleman and
1351 recognizes the gentleman from Louisiana, Dr. Cassidy, for 5
1352 minutes for questions.

1353 Dr. {Cassidy.} By the way, I enjoyed all the time we
1354 had together. Now I am intrigued that you brought up
1355 Massachusetts, because frankly, Massachusetts concerns me.

1356 If you will, that appears to be the prequel, as someone
1357 described it, the beta version of Obamacare. Massachusetts
1358 appears to be the prequel or beta version of Obamacare. And
1359 their small group market has the highest premiums in the
1360 Nation. Now, they started off with an uninsured rate of
1361 about 10 percent. Now it is about 4 percent. And the
1362 economic drag or something has been incredible. Maybe it is
1363 not this, but they have actually had a negative--I did see
1364 that they had a crackdown on their MLR, but those are non-
1365 profit insurance companies. If you talk to the providers and
1366 the insurance companies, they say effectively, this is like
1367 the Soviet Union, that they are being ignored in terms of
1368 their true expenses. It is just arbitrarily being decreased.
1369 Clearly you disagree with that, so I just would like your
1370 response to those kind of ascertations.

1371 Mr. {Rome.} I mean, I don't want to spend a lot of time
1372 on Massachusetts itself because I was citing it as an example
1373 of rate reductions that have come about because of prior rate
1374 approval or because of insurance regulators stepping in.

1375 And so you see that in multiple cases. Certainly
1376 California had very large rate increases, 39 percent that
1377 went to 14 percent in 2009, looking at North Dakota recently,
1378 27--

1379 Dr. {Cassidy.} Can I ask you then, knowing that those

1380 exist but obviously we may differ in terms of it, I am also
1381 concerned, I am still a practicing physician in a public
1382 hospital, and it has always been my observation that
1383 politicians overpromise and underfund. And there is this
1384 populace pressure to do something about climbing premiums.
1385 Do you see any risk that in the future some DHH secretary,
1386 whatever she is secretary, will say no, thou shalt not
1387 increase your premium. We are going to disregard this cost
1388 structure because frankly, it is a political pressure. It is
1389 the year before presidential reelection, for example, and
1390 there is--increase. Do you see no risk in that?

1391 Mr. {Rome.} I don't see any risk in that because there
1392 isn't any demonstrate that that has occurred to date. There
1393 is 22 States that have prior rate approval. I mentioned the
1394 California example of auto--

1395 Dr. {Cassidy.} Now, wait a second. I think we can look
1396 at property and casualty rates in Florida and see that there
1397 was a political response to something which, you know, people
1398 objected. You are raising our premiums. The actuaries for
1399 the P&C companies said no, this is reasonable. We have huge
1400 exposure here.

1401 Now, you may argue whether Citizens in Florida was a
1402 good thing or a bad thing, but clearly, that was a political
1403 response to an outcry which actuaries say is fiscally

1404 unsound. So there does seem to be precedent for this.

1405 Mr. {Rome.} Again, I don't think that there is any
1406 significant precedent. What there is is a substantial
1407 history of regulators taking, whether it is on both sides of
1408 the aisle, taking a cool look at rate hike requests and
1409 making judgments based on the merits.

1410 Dr. {Cassidy.} Let me ask you--

1411 Mr. {Rome.} It is an important--

1412 Dr. {Cassidy.} I have limited time, so I am sorry to be
1413 rude. Dr. Harrington, you see where I am going with my line
1414 of questioning. What are your observations?

1415 Mr. {Harrington.} We haven't had detailed statistical
1416 analyses of the relationship between regulation and health
1417 insurance and performance metrics like--and the like.

1418 There have been dozens of studies of the impact of rate
1419 regulation and workers' compensation insurance and automobile
1420 insurance. You can have environments where an insurance
1421 company is in an environment of rapid claim cost growth will
1422 ask for 10 or 15 percent in a politicized environment. Maybe
1423 they can negotiate a rate increase of 8 or 9 percent. That
1424 can go on for a period of time. It reduces the company's
1425 incentive to write new business. It reduces their incentive
1426 to provide good quality. It reduces their financial
1427 strength. But it cannot persist.

1428 The studies that have looked at long periods of time
1429 show that basically there is no difference by type of
1430 regulation in these markets, automobile and homeowners'
1431 insurance. Now, I can't attest to that in health insurance
1432 because people haven't looked at the data, but I don't think
1433 you can look at anecdotes for what happened in Massachusetts,
1434 for example, because in the short run, companies will take a
1435 rate increase less than the actuarial projection if the
1436 alternative is enormous legal fees--or having to leave a
1437 marketplace.

1438 I would also just like to say we need to keep our facts
1439 straight. The California situation was highly publicized.
1440 Thirty-nine percent was touted all over. The weighted
1441 average increase was 25 percent. It eventually was only 14
1442 percent, and there was--dispute about the numbers and so on.
1443 But it is not right to compare 39 percent to 14 percent, and
1444 it is also not right to assume as I said in a particular year
1445 if you get a lower rate increase because of some regulatory
1446 action, that that is really consistent with the underlying
1447 cost of the business in the long run viability of the
1448 company.

1449 Dr. {Cassidy.} Thank you very much. I am out of time
1450 almost. I yield back.

1451 Mr. {Pitts.} The Chair thanks the gentleman and

1452 recognizes the gentleman from California, Mr. Waxman, for 5
1453 minutes for questions.

1454 Mr. {Waxman.} Thank you, Mr. Chairman. Ms. Hayes,
1455 Republicans have repeatedly claimed that the Administration's
1456 rule on grandfathering plans will lead to people losing their
1457 plans. Is that true?

1458 Ms. {Hayes.} Is it true that Republicans have claimed
1459 that? Is that the question? I am sorry.

1460 Mr. {Waxman.} No.

1461 Ms. {Hayes.} Is it true that they will actually lose
1462 their plans? No, Mr. Chairman. I am sorry, Mr. Chairman.
1463 That was a slip.

1464 Mr. {Waxman.} I won't hold it against you.

1465 Ms. {Hayes.} Okay. And I apologize, Mr. Pitts, for
1466 that slip. No, the grandfather rules were established to
1467 provide a transition for health insurance, and first of all,
1468 you know, starting with the premise that an individual can
1469 keep their health insurance, with all due respect to the
1470 Administration, is a false premise to begin with because any
1471 day an insurance plan could decide that they are no longer
1472 going to offer it in that market. And it is not so much that
1473 an individual I believe is so much attached to an insurance
1474 policy to begin with or an insurance carrier in particular,
1475 they are worried about whether or not they can continue to

1476 see their healthcare providers, they are worried about
1477 whether or not it is affordable, they are worried about what
1478 benefits are covered.

1479 And under the grandfather rules, plans are required to
1480 meet--but frankly, if the plans change their policy so that
1481 they no longer meet the grandfather provisions, that is not
1482 the same policy anymore, either, because if they are losing
1483 grandfather status, they have made a significant change in
1484 their benefits. There has been a significant increase in
1485 cost sharing for beneficiaries, there has been a reduction in
1486 benefit coverage generally.

1487 So the grandfather rule protects individuals and they
1488 can continue to keep the plans they have so long as the
1489 carriers keep the same--

1490 Mr. {Waxman.} Right. Would you say employers won't
1491 drop coverage just because they may not qualify as for the
1492 grandfather?

1493 Ms. {Hayes.} Oh, absolutely not. I think clearly every
1494 employer group that I have heard has said that they want to
1495 continue to offer healthcare benefits because it is an
1496 important tool for recruiting and retaining personnel. At
1497 the same time, there are provisions in the Affordable Care
1498 Act.

1499 Mr. {Waxman.} Let me move on to some others in the

1500 limited time I have--

1501 Ms. {Hayes.} Sure.

1502 Mr. {Waxman.} --because I wanted to ask Mr. Gardiner,
1503 Republicans continue to say, and this isn't a question of
1504 whether they continue to say it, I am asserting that they
1505 have said over and over again that the Affordable Care Act
1506 will cost small employers too much. However, we know this is
1507 not the case. The ACA contains multiple provisions in
1508 directly at reducing healthcare costs for small businesses
1509 and ensuring the small businesses, their employees will have
1510 access to affordable and quality health insurance. In your
1511 testimony you discuss some very important provisions that are
1512 already helping millions of small businesses. For example,
1513 you talked about the small business tax credit that offers a
1514 credit of up to 35 percent of their health insurance costs.
1515 Four million small businesses--with the small business tax
1516 credit, and early evidence suggests that many are already
1517 benefitting from it. According to a survey by the Kaiser
1518 Family Foundation, the percentage of small employers offering
1519 health coverage has risen from 46 percent in 2009 to 59
1520 percent in 2010, in part due to the reform's new tax credit.
1521 Can you please elaborate on how the healthcare tax credit for
1522 small business is helping create jobs and health security?

1523 Mr. {Gardiner.} The direct linkage between the

1524 healthcare tax credit and any tax credit is that the more
1525 money is flung into the treasury of a small business, then
1526 they have more money to invest--for jobs is the fact that
1527 over the last decade 70 percent of the net new jobs have come
1528 from small business, and you know, there is a lot of other
1529 industries out there, and they invest in a lot of mergers and
1530 acquisitions and increased dividends and go offshore and
1531 everything. But really, you know, small businesses are there
1532 because somebody was an entrepreneur--that, and they pour
1533 their lives and their money back into growing their business.

1534 So when we say that they can get a 35 percent tax credit
1535 that is going to reduce their cost, that is going to stay,
1536 you know, in the treasury of their company, and they are
1537 going to be looking at how to expand their business. And
1538 very much like this is last year Congress provided the tax
1539 equity for self-employed, the 22 million self-employed, which
1540 reduced their cost when they purchase healthcare by 15.3
1541 percent. And we should keep that in mind as one of the
1542 benefits of the overall health reform that needs to be
1543 retained also.

1544 Mr. {Waxman.} I see my time is expired.

1545 Mr. {Pitts.} The Chair thanks the gentleman and
1546 recognizes the gentleman from New Jersey, Mr. Lance, for 5
1547 minutes for questions.

1548 Mr. {Lance.} Thank you, Mr. Chairman, and good
1549 afternoon to the panel. A similar vein of questioning as
1550 suggested by Mr. Waxman, Mr. Fensholt, in your testimony you
1551 state that many of your clients may lose their grandfathered
1552 status, due even to modest or routine changes, and I would
1553 like to suggest several examples and if you would comment on
1554 them please, sir.

1555 Mr. {Fensholt.} Sure.

1556 Mr. {Lance.} A plan increases co-insurance from 5
1557 percent to 6 percent, and a family believes the plan still
1558 provides good value for the family. In your judgment, would
1559 the plan remain grandfathered and could the family keep that
1560 type of plan?

1561 Mr. {Fensholt.} Well, the plan loses grandfathered
1562 status, and the issue in my space, in the middle market,
1563 large market, is that when a plan loses that grandfathered
1564 protection, additional benefit mandates and requirements drop
1565 down on top of that plan, and those carry costs. And so the
1566 problem as we see it with the grandfathered rule, it is--
1567 grandfathered rule, very modest changes. I think here is
1568 where Ms. Hayes and I part company. It does not take a
1569 significant change in plan design.

1570 Mr. {Lance.} So for example, another situation, a co-
1571 pay is increased for prescription drugs from \$5 to \$10 or

1572 perhaps an owner asks her employees to increase their share
1573 of health premiums from 2 percent to 8 percent. In your
1574 judgment, what would happen in those situations?

1575 Mr. {Fensholt.} In those situations, the plan loses
1576 grandfathered protection. The additional mandate dropped
1577 down the plan. The plan incurs the additional cost.

1578 Mr. {Lance.} Thank you very much. Ms. Reichel, in your
1579 testimony you mentioned that the administrative and
1580 regulatory burdens of the medical loss ratio requirements
1581 will put significant challenges to employers and health
1582 plans.

1583 In New Jersey where I live, there is a history of
1584 administering MLRs and overseeing administrative rebates,
1585 although one--PPACA, we have the situation but not as strict
1586 as PPACA. I would be interested in your thoughts on what
1587 effects the stricter MLR and would a State like New Jersey's
1588 insurance market be challenged in this regard, recognizing
1589 that what we have in New Jersey is not as strict as what is
1590 in PPACA.

1591 Ms. {Reichel.} What is in the ACA now I think is going
1592 to be a real burden on small businesses, and here is why we
1593 think that. Assume if you will that there is going to be a
1594 rebate owed to a small business. The insurance company has
1595 to do much more than simply determine that a rebate is owed

1596 to the employer and provide that back to the employer. What
1597 the small employer now, and large employer, too, needs to do
1598 in order to get that is to provide data to the insurance
1599 company that all the premiums that the employer has paid, he
1600 needs to determine what the premiums are that the individuals
1601 he employs pays. He also has to determine what the
1602 percentage of the rebate is coming back to the employee, and
1603 he has to provide documentation to the insurance company that
1604 he actually gave--so the reporting requirements on small
1605 employers is much greater than it ever was before.

1606 Mr. {Lance.} And as a follow-up to that, what if a
1607 State has never had to deal with the MLR? It seems to me it
1608 might face an even more significant effect on this market?

1609 Ms. {Reichel.} I would think that that would be
1610 absolutely true, not only from the small employer but also
1611 from the carrier point of view where a State that has no MLR
1612 currently in effect, effectively what the companies are
1613 doing, he is going from zero to 60 immediately, or I guess
1614 zero to 80 or 85 overnight.

1615 If the State has no medical loss ratio now, then it, in
1616 effect at the federal level for policies that were in effect
1617 before the statute was effectively signed. So there is a
1618 retroactive application of the medical loss ratio. In a
1619 State where there hasn't been an MLR, I think that that climb

1620 is really steep for the carriers.

1621 Mr. {Lance.} Thank you. I conclude from the
1622 questioning and from the testimony that it is unlikely that
1623 the President's promise that Americans can keep their health
1624 plan if they like it is not accurate, and I think we have to
1625 move in the direction to making that possible in the greatest
1626 number of situations.

1627 Thank you, Mr. Chairman.

1628 Mr. {Pitts.} The Chair thanks the gentleman. We will
1629 begin a second round of questioning here. Mr. Fensholt, in
1630 your testimony you state that employers' biggest concern
1631 about PPACA is the massive administrative burden imposed by
1632 the law. Do you believe that the healthcare law's
1633 administrative burden is merely a short-term issue for
1634 employers as the law's implementation has begun or will the
1635 law present additional administrative headaches for job
1636 creators down the road?

1637 Mr. {Fensholt.} Oh, it will definitely be the latter,
1638 Mr. Chairman. This is an ongoing trend at the federal level
1639 with regard to health insurance and the administrative
1640 burdens. There are federal rules put on plan sponsors, and I
1641 might add, by 2014, for example, employers are not only going
1642 to have to comply with the panoply of existing obligations
1643 but they will begin reporting to the insurance exchanges the

1644 various levels of coverage they are offering their employees,
1645 what they are charging for it, who is eligible for it, who is
1646 enrolled in it and do this on a regular basis, along with a
1647 variety of other reports and obligations.

1648 The irony about these reporting and disclosure
1649 obligations is that if you look at any one of them
1650 individually, they may not appear all that onerous. But in
1651 the aggregate, none of these obligations is a sword thrust to
1652 the heart. But in the aggregate, you are asking an employer
1653 to supply more than 50 disclosures, notices and reports to
1654 the Federal Government. I mean, over time this is death by
1655 1,000 cuts to employers. And I will tell you, sir, that we
1656 have clients who are at the end of their rope. Their view is
1657 this is just becoming too hard, too complicated. The--of the
1658 axe hanging over our head is too severe. We are not going to
1659 want to do this much longer. And rather than making that
1660 burden easier, health reform makes it harder, more
1661 complicated and more cumbersome.

1662 Mr. {Pitts.} Thank you. Ms. Hayes, in a December 14
1663 editorial, Secretary Sebelius and Attorney General Holder
1664 wrote, ``It is essential that everyone have coverage.
1665 Imagine what would happen if everyone waited to buy car
1666 insurance until after they got in an accident. Premiums
1667 would skyrocket, coverage would be unaffordable and

1668 responsible drivers would be priced out the market.' ' Yes or
1669 no, do you agree with Secretary Sebelius and the Attorney
1670 General that if the individual mandate is unconstitutional,
1671 would premiums skyrocket?

1672 Ms. {Hayes.} If it is struck down, would premiums
1673 skyrocket? I believe that if the individual mandate were not
1674 a part of this law, it would be more difficult for insurers
1675 to continue to operate, yes.

1676 Mr. {Pitts.} So it is fair to say that you believe that
1677 if the individual mandate were not in the bill, that would
1678 impact other parts of the law?

1679 Ms. {Hayes.} Yes.

1680 Mr. {Pitts.} Anyone. Medicare's plan to prevent fraud
1681 and abuse has often been described as a pay-and-chase model.
1682 Can anyone describe how pay-and-chase anti-fraud efforts
1683 work? Ms. Reichel?

1684 Ms. {Reichel.} I have seen people looking down at my
1685 end of the table. What pay-and-chase means is that once a
1686 service has been provided, the bill has been sent to the
1687 insurance company, the insurance company has paid it, there
1688 is a retroactive application if you would or an attempt to
1689 get the money back that somebody finds out after the fact has
1690 been provided fraudulently for a service that didn't occur,
1691 for a service that shouldn't have occurred, so somebody who

1692 wasn't there. That is pretty much what a pay-and-chase is as
1693 opposed to preventing the fraud from occurring in the first
1694 instance.

1695 Mr. {Pitts.} All right. I am going to at this time
1696 yield 5 minutes to the Ranking Member for his questions
1697 because we are voting.

1698 Mr. {Pallone.} Thank you. Have we started the vote?

1699 Mr. {Pitts.} Yeah.

1700 Mr. {Pallone.} Okay. I will try to be quick. I wanted
1701 to ask Ms. Hayes about the waivers. You know, Republicans,
1702 they spend a lot of time complaining about the inequities in
1703 the waiver process for annual limit requirements. They have
1704 made allegations that favored political allies of the
1705 democratic party, particularly unions who were being exempted
1706 from all the health reform bills, consumer protections and
1707 insurance regulations. And I think these claims have been
1708 wildly--they need a lot of consideration here, but for
1709 instance, union plans were more than five times more likely
1710 to be rejected for annual limit waivers than were other kinds
1711 of applicants--for annual limits of policies affect only a
1712 small number of people and are just one consumer protection
1713 of the law.

1714 Your testimony describes the waivers as a kind of
1715 transitional policy from today's world to a much more

1716 rational insurance regime in 2014. Would you just elaborate
1717 on that a little bit?

1718 Ms. {Hayes.} Yes, sir. I have seen no evidence to
1719 suggest that the Administration is granting favors to anyone
1720 when it comes to waivers. Clearly, Congress anticipated and
1721 were warned during debate that there were going to be
1722 transitional issues, and that is built into the law itself.
1723 So I don't find it particularly surprising that waivers have
1724 had to be granted and particularly in the area of some of the
1725 mini-med plans that you have seen out there which I don't
1726 think anyone would argue are allies of the current
1727 Administration.

1728 Mr. {Pallone.} All right. Thank you. I want to ask
1729 Mr. Gardiner and Mr. Rome, this is about the Affordable Care
1730 Act creating jobs because I obviously believe that it creates
1731 hundreds of thousands of jobs. But the opponents make strong
1732 claims that the law will kill jobs. They argue that
1733 requiring employers to offer health insurance and to improve
1734 their benefits will increase cost of labor. I don't think
1735 that is true because I think the ACA is in fact helping to
1736 create thousands of jobs in the public and private healthcare
1737 sectors.

1738 In June 2010 funds were allocated to train more than
1739 16,000 new primary care providers including physicians,

1740 nurses. It seems logical that the newly insured 30 million
1741 people will need doctors, nurses and other healthcare
1742 personnel to meet their medical needs. I know that the
1743 Republicans have said that the country may not have enough
1744 doctors and hospitals to serve these people, but the answer
1745 to that is to grow the workforce to create more jobs.

1746 So I just wanted you to comment, one or both of you.
1747 Can you describe for us how the ACA is a job creator, not a
1748 job killer, and talk about some of the other factors, just to
1749 comment on that. I will start with Mr. Rome, I guess.

1750 Mr. {Rome.} Okay. I would just say two things before
1751 Mr. Gardiner. I mean, one is that one of the best things
1752 that we can do to help create jobs is reduce the expenses
1753 that employers face, and reducing healthcare costs is an
1754 important and significant part of that. And that is why the
1755 MLR, for example, which makes insurance more efficient and
1756 more affordable is an incredibly important part of job
1757 creation.

1758 The second thing is when we do talk about medical
1759 personnel, simple example. Over the next 10 years, community
1760 health centers are going to go from treating 20 to 40 million
1761 people, and that is a substantial change in treatment, and
1762 that will obviously create jobs in the health sector, as just
1763 one example.

1764 Mr. {Pallone.} Mr. Gardiner?

1765 Mr. {Gardiner.} Where we start from is what if we don't
1766 have healthcare reform? That is what we see as the job
1767 killer, and that was the study that we had done by MIT to
1768 start with. So we start from the premise if we don't do
1769 something about the ever-escalating, we are going to lose
1770 jobs. And we documented that as 178,000 jobs, but I think
1771 that is a very conservative number. But if we go forward
1772 with health reform and reduce costs, then firms can invest
1773 that money. And in fact, the other part that we have to look
1774 at is job loss. You have got 42 million employees at small
1775 firms under 100 employees, and it has been well-documented in
1776 the literature out there that people can't leave because they
1777 are worried about getting the benefit. Of course, this would
1778 be any size firm because they don't know if they are going to
1779 have healthcare where they go, especially when we have half
1780 of the small employers not providing it, and that is a
1781 shrinking base.

1782 So employees can't move. They are unhappy. Everybody
1783 who has been an employer knows that that is not a good thing,
1784 that when an employee wants to move, they ought to be able to
1785 move. But it also applies to people starting companies,
1786 entrepreneurs. Why is somebody going to take the risk to
1787 leave a good job with good benefits and go out there and be a

1788 self-employed person, a start-up company, and then find out
1789 how expensive and how unattainable healthcare might be for
1790 them. So there are several ways that having healthcare
1791 available and having it more affordable and less volatile is
1792 going to help small businesses grow and make it easier for
1793 people to start companies.

1794 Mr. {Pallone.} Thank you. Thank you, Mr. Chairman.

1795 Mr. {Pitts.} The Chair thanks the gentleman. That
1796 concludes our first panel. The Chair thanks the witnesses
1797 for their testimony, for their patience. Despite the
1798 interruption, it was an excellent panel, excellent testimony.

1799 The subcommittee will take testimony from the second
1800 panel at a date to be determined. The subcommittee is now in
1801 recess.

1802 [Whereupon, at 12:08 p.m., the subcommittee was
1803 adjourned.]