STATEMENT OF

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Chairman Gowdy, Ranking Member Davis, and Members of the Subcommittee, thank you for the opportunity to discuss the Department of Health and Human Services' work implementing the Affordable Care Act. I serve as Deputy Administrator and Director of the Center for Consumer Information & Insurance Oversight (CCIIO) within the Centers for Medicare & Medicaid Services (CMS). Since taking on this role, I have been involved in CCIIO's implementation of many of the provisions of the Affordable Care Act, including overseeing private health insurance reforms, assisting States to implement Health Insurance Exchanges (Exchanges), and ensuring that consumers have access to information about their rights and coverage options. Prior to becoming the Director of CCIIO, I served as the Director of the Office of Oversight within CCIIO, which is charged with working with the States to ensure compliance with the new insurance market rules, such as the prohibitions on rescissions and pre-existing condition exclusions for children, as well as ensuring consumer value for premium payments through the medical loss ratio standards and the enforcement of the new restrictions on annual dollar limits on benefits.

As a former State Insurance Commissioner, I understand the key role that States play in the regulation of insurance and insurance markets. I have seen first-hand the importance of holding insurance companies accountable, and understand the need to make quality, affordable coverage more accessible to all health care consumers. I have also served as an executive in a for-profit, publicly-traded managed care company, and understand the need for competitive and robust markets as well reasonable regulations. The Affordable Care Act appropriately balances these objectives.

At this time last year, Congress passed and the President signed into law the Affordable Care Act, which expands access to affordable, quality coverage to over 30 million Americans and strengthens consumer protections to ensure individuals have coverage when they need it most. Immediate reforms include a critical foundation of patients' rights in the private health

insurance market that help put Americans in charge of their own health care. Over the past year, we have already implemented historic private market reforms including eliminating pre-existing condition exclusions of children, prohibiting insurance companies from rescinding coverage absent fraud or intentional misrepresentation of material fact and from imposing lifetime dollar limits on coverage, and enabling many dependent young adult children to stay on their parent's insurance plan up to age 26. The Affordable Care Act also established new programs to expand and support coverage options, including the Pre-Existing Condition Insurance Plan (PCIP) and the Early Retiree Reinsurance Program (ERRP).

Beginning in 2014, State-based health insurance Exchanges will improve access to affordable, quality insurance options for Americans who previously had no health insurance coverage or inadequate coverage. The Exchanges will make purchasing private health insurance coverage easier by providing individuals, families, and small businesses with "one-stop shopping" on a single, easy-to-use website. On the website, American consumers, businesses, and other organizations will be able to compare a range of plans. Eligible individuals will also have new premium tax credits and cost-sharing reductions available to them to make coverage more affordable. By increasing competition between insurance companies and allowing individuals and small businesses to band together to purchase insurance, Exchanges will help to lower health care costs for consumers.

Today, millions of Americans are already benefiting from the Affordable Care Act. Many parents across the country are able to protect their dependent young adult children by allowing them to stay on a parent's plan until they are 26 years old. We estimate that, in 2011, more than 1.2 million young adults will be able to maintain insurance coverage through their parent's health plans because of this new policy. This is an important protection for these young adults and a huge relief for their parents.

We estimate that more than 31 million Americans will benefit from the preventive services provision of the Affordable Care Act, which requires that important early detection

services like mammograms and colonoscopies be available to Americans enrolling in new plans without expensive co-pays or deductibles. Furthermore, insurers are no longer permitted to rescind insurance policies simply because a consumer made an inadvertent error on a form. These changes are putting consumers back in charge of their health care and getting insurers out from between patients and their doctors.

Consumers can also use an important new tool to gain access to an unprecedented amount of information about insurance options and public programs available to them by zip code. In eight months, www.HealthCare.gov has had more than 4 million visitors and the number of insurance options listed continues to grow rapidly. Visitors can get information in plain English – and Spanish – about the coverage options available to them, their protections, and their rights as health care consumers.

As mentioned previously, States play a crucial role in the implementation of the Affordable Care Act. Since enactment, we have worked actively with the Governors, insurance commissioners, Medicaid directors, and other stakeholders to implement programs that are helping consumers and businesses with coverage. It has been our priority to work collaboratively with our State partners as the provisions of the Affordable Care Act go into effect.

States were critical to our efforts to write regulations implementing the new medical loss ratio provisions of the Act. The National Association of Insurance Commissioners (NAIC) worked for nearly six months to develop uniform definitions and methodologies for calculating MLR. Their process included significant input from the public, States, and other key stakeholders, and was approved unanimously by the NAIC Commissioners. HHS certified and adopted the NAIC recommendations and the reaction from consumers and insurers has been very positive. Starting this year, insurers must spend at least 80 or 85 percent of premium dollars, depending on the market, on health care and quality improvement efforts instead of CEO bonuses, profits, or marketing. And those that do not meet this standard will be required to reduce their rates or provide rebates to their customers. In addition, the Department recognizes

State flexibility. The law allows for a temporary adjustment to the individual market MLR standard if the State requests it and demonstrates that the 80 percent MLR standard may destabilize their individual insurance market.

This MLR provision ensures consumers receive value for their premium dollars and encourages insurers to invest in the health of their policyholders, while maintaining insurance market stability. There are signs that this provision has already helped to moderate premium increases.

Rising insurance costs have made it difficult for American employers to provide quality, affordable coverage for their workers and retirees while also remaining competitive in the global economy. The Early Retiree Reinsurance Program serves as one bridge to the new Exchanges that will become available in 2014. Many Americans who retire before they are eligible for Medicare and without employer-sponsored insurance see their life savings disappear because of the high cost of insurance in the individual market. Millions more see their insurance disappear, leaving them vulnerable to high costs and poor quality care. The ERRP provides much-needed financial relief for employers so early retirees and their families can continue to have quality, affordable insurance. More than 5,000 employers – including many State and local governments – have been accepted into the program from all 50 States and the District of Columbia.

The Pre-Existing Condition Insurance Plan program is another bridge to 2014, when all Americans, regardless of health status, will have access to affordable coverage. PCIP provides a lifeline to uninsured Americans who private insurers have refused to insure because of a pre-existing condition. These Americans can now receive health coverage without limitation on benefits or higher premiums because of their condition. Thousands of Americans who were locked out of accessible private insurance coverage before the passage of the law now have this valuable and needed coverage. I'm pleased that enrollment has increased by 50 percent in the last few months, and we expect it to grow. The Department is actively working with States, consumer groups, chronic disease organizations, health care providers, social workers, other

Federal agencies, and the insurance industry to promote the program, including holding meetings with State officials, consumer groups, and others.

Finally, for Americans who receive insurance in the individual and small group markets, the Affordable Care Act should result in more protections from unreasonable rate increases. The law provides $250 million to strengthen States and Territories' ability to review proposals by private health insurance companies to raise their rates for small businesses, individuals, and families. Since enactment, $45 million has been distributed to 44 States and the District of Columbia, and, in February, $205 million in additional funding was made available to States, the District of Columbia, and Territories to continue such efforts. We are committed to working with States, the District of Columbia, and Territories, who are the primary regulator of insurance rates and solvency.

The Bridge to 2014

As Director of CCIIO, I am committed to continued improvement of the health insurance system so that it works for consumers both now and with the additional reforms that start in 2014. It is essential that we make sure that Americans who have insurance today – even if that insurance is highly limited – can keep that coverage until reforms take effect that will increase their ability to choose among comprehensive, affordable insurance options in 2014.

As part of our package of consumer protections called the Patient's Bill of Rights, we began implementing the Affordable Care Act's phase-out of limited benefit insurance products – a subject area that you have asked me to discuss. When consumers are covered under health plans with limited benefits, consumers do not always have access to coverage when they need it. In some cases, policies have "lifetime" dollar limits on benefits, and in some cases, insurers have "annual" limits or dollar-amount caps on what the policies will pay during a single year for the benefits that they cover. In 2009, over 100 million Americans were in private health insurance plans with a lifetime limit, and roughly 18 million Americans were enrolled in a plan with an annual limit.

The Affordable Care Act prohibits lifetime limits in all health insurance plans starting in new plan years on or after September 23, 2010. It also provides that, as of January 1, 2014, no group health plan or any individual market plan that is not a "grandfathered" plan may have annual limits on coverage. However, Congress recognized that there should be a transition period between now and 2014, when the Exchanges will be up and running, during which annual limits would be phased out. Section 2711 of the Public Health Service Act provides that group health plans and issuers may continue to impose a "restricted" annual limit with respect to essential health benefits until the consumer protections take effect in 2014. More importantly, the statute directs the Secretary to define "restricted annual limit" during the interim period in a way that will "ensure that access to needed services is made available with a minimal impact on premiums." This statutory directive recognizes that, for some health plans, an immediate transition to high or no annual limits could significantly raise premiums or reduce coverage with adverse consequences. Therefore, the Secretary must address this concern in implementing the provision during the transition years between passage of the Affordable Care Act and the availability of new quality, affordable options in 2014.

In June of last year, we issued regulations providing that the "restricted annual limit" is $750,000 for group and non-grandfathered individual plans with plan and policy years starting between September 23, 2010 and September 22, 2011. In other words, plans must provide at least $750,000 in coverage for essential benefits such as hospital, physician and pharmacy benefits. The limit will be $1.25 million for plan and policy years starting between September 23, 2011 and September 22, 2012, and $2 million for plan and policy years starting between September 23, 2012 and December 31, 2013. The rising restricted annual limits will increasingly ensure that consumers have coverage when they really need it.

Most group health plans either already exceeded the new restricted annual limits or could comply with the new restricted annual limits with a negligible or minimal impact on premiums or coverage. However, a very small percentage of the market provides coverage below the new annual limits. It is this small percentage of policies in particular that, without an

accommodation, would sustain more than a "minimal" impact on premiums or coverage if they were required to provide coverage at or above the annual limits provided for in the regulation.

To be sure, limited benefit plans (also known as "mini-med" plans) can leave consumers with unexpected medical bills in the event of hospitalization or chronic disease. Unfortunately they are the only option that some employers offer to their employees and some individuals can afford in some States. In order to protect coverage for these workers, pursuant to the statutory requirement, CCIIO established a process whereby those plans with annual limits below $750,000 could apply for a one-year waiver from the restricted annual limits. The waiver process, which is grounded in our regulation and fleshed out in subsequent guidance, allows employers and insurers to continue offering limited coverage if they can show that complying with the regulation would cause their enrollees to experience a significant increase in premiums or decrease in access to benefits.

The waiver procedure is administered fairly based on each application's merits without regard to the type of applicant or size of business, with the goal of minimizing market disruption and maintaining coverage. Guidance on how to apply for a waiver was posted on our website on September 3, 2010. Applicants must submit: 1) the terms of the plan; 2) the number of enrollees; 3) a description of the annual limits; 4) a narrative describing how compliance would lead to a significant increase in premiums or a significant decrease in access to benefits; and 5) an attestation of the facts of the application by the CEO or plan administrator.

We have posted additional guidance detailing the criteria CCIIO uses to determine if the premium increase or access decrease would be significant. Further guidance also lays out specific disclosure requirements that approved applicants must meet. Approved applicants must notify enrollees and potential enrollees of the plan's annual limits and the fact that the plan does not meet the standards of most plans covered by the Affordable Care Act. This notice is designed to ensure that consumers are aware that their coverage may be inadequate in the event of a catastrophic event or chronic disease.

The annual limit waiver process has been carried out in a way that reflects a commitment to transparency and responsible implementation. CCIIO regularly posts a list of approved annual limit waivers. The list includes the name of the company, the date their application was received, the plan effective date, the number of enrollees covered, the date the application was completed, and the date the waiver was approved.

After we initiated the process in September, applications were received at a relatively steady rate. However, we experienced an expected increase in applications in December, due to the fact that employers and insurers must submit their applications 30 days before the start of their plan year. Many plan years begin on January 1; for that reason we received a large number of applications at the beginning of December. CCIIO worked very hard to ensure that we could process those applications and make timely decisions with respect to these applicants.

As of late February, CCIIO has approved 94 percent of waiver applications received from employers, insurers, and other applicants. The vast majority of waivers, more than 95 percent, were granted to health plans that are job-related. These include self-insured employer health plans, health reimbursement arrangements, collectively-bargained multiemployer plans, and health plans sold by issuers to fully-insured employers.

It is important to note that these limited benefit plans that have received waivers cover an extremely small proportion of the people covered by private health plans in the United States. Since setting up this program, CCIIO has granted waivers to plans covering approximately 2.6 million people, out of the 160 million people who have employer-sponsored health coverage.[1] This figure is less than 2 percent of all covered lives in the private insurance market.

Moving Forward

Until now, very little data were available about these limited benefit plans. We are now analyzing the data we have received through the waiver process and have begun determining what approach we should take for plan years beginning September 23, 2011 and beyond to 2014.

[1] Kaiser Family Foundation - Kaiser's "Employer Health Benefits 2010 Annual Survey," September 2010.

We will continue to work in a manner that minimizes market disruption and ensures Americans have health coverage. The overriding purpose of this waiver program is to ensure that Americans do not lose their health coverage before better health insurance options become available in 2014.

As we lay the groundwork for 2014, it is our intention to continue implementing vital consumer protections while offering enough flexibility to ensure that the market is not disrupted. We are proud of all that we have accomplished over the past year and look forward to 2014 when Americans will have access to more affordable, comprehensive health insurance plans without annual limits that cap their benefits. When the insurance market reforms in the Affordable Care Act are fully implemented, limited benefit plans will be a thing of the past.

In the meantime, I look forward to continuing to work on our bridge toward 2014, year after year, strengthening CCIIO's partnership with Congress, the States, consumers, and other stakeholders across the country. Thank you for the opportunity to discuss the work that CCIIO has been doing to implement the Affordable Care Act.