

STATEMENT OF

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ON

**“THE CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT
AND THE ANNIVERSARY OF
THE PATIENT PROTECTION AND AFFORDABLE CARE ACT”**

BEFORE THE

**U. S. HOUSE OF REPRESENTATIVES COMMITTEE ON ENERGY & COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS**

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**House of Representatives Committee on Energy & Commerce
Subcommittee on Oversight and Investigations**

**“The Center for Consumer Information and Insurance Oversight and the Anniversary of
the Patient Protection and Affordable Care Act”**

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Chairman Stearns, Ranking Member DeGette, and Members of the Subcommittee, thank you for the opportunity to highlight the efforts made by the Centers for Medicare & Medicaid Services (CMS), and my office, the Center for Consumer Information and Insurance Oversight (CCIIO), in implementing the Affordable Care Act. Nearly two years ago today, Congress passed historic health reform legislation, which will reduce our deficit, control rising health care costs, expand access to affordable, quality health insurance coverage for millions of Americans and strengthen consumer protections to ensure individuals have health insurance coverage when they need it most. Since the Affordable Care Act became law, we have focused on the law’s main goal for private health insurance, to strengthen the private health insurance market in order to make private health insurance coverage more available, affordable, and accountable to Americans.

To achieve this goal, we have improved access to private health insurance coverage for millions of people, and created and enforced new rules making private health insurance fair and more affordable. Over the past two years, we have been focusing on implementing the Affordable Care Act as smoothly as possible, in a way that continues to strengthen the productive partnership between the private sector and the government. We have provided States, employers, and insurance companies the flexibility needed to ensure an easy transition towards a health insurance system that is accessible and affordable for all Americans. Over the next two years, our work continues with the implementation and start of the Affordable Insurance Exchanges, markets where small businesses and people without employer-sponsored coverage and small businesses will be able to easily compare and choose comprehensive health insurance plans that best fit their needs.

Two Years of Increasing Private Health Insurance Options

The Affordable Care Act is strengthening the private health insurance market by making affordable, high-quality private health insurance coverage accessible to millions of Americans. Because of important reforms in the Affordable Care Act, most young adults under 26 can now be covered under their parents' plans, people with costly pre-existing conditions are able to find affordable health coverage, insurance companies are prohibited from denying children with pre-existing conditions coverage, and early retirees have continued to receive quality health insurance from their employers.

Historically, young adults making the transition from school to work have been more likely than any other demographic group to go without health insurance. The Affordable Care Act makes it easier for younger Americans to obtain and maintain health insurance coverage. Before this policy was enacted, insurance companies typically dropped children from their parents' coverage when they turned 18 or graduated from college. Young adults are also more likely to get jobs that do not offer employer-sponsored coverage. The law now allows most young adults without access to employer-sponsored coverage to stay on their parents' health insurance plans until they turn 26. About 2.5 million young adults have already gained health insurance coverage because of this part of the law.

In addition to helping young people find private insurance, CMS established the Pre-Existing Condition Insurance Plan (PCIP). Created under the Affordable Care Act, the PCIP program provides an affordable coverage option for uninsured people with pre-existing conditions, until the broader reforms in the Affordable Care Act take effect. Data shows that the program is helping those Americans in great need of health care who have been locked out of the private insurance market. Already, PCIP is helping 50,000 Americans with pre-existing medical conditions access critical health care services.

CMS recognizes the important role that States play in their administration and support of the PCIP program nationwide and is committed to maintaining that strong partnership throughout the duration of the program. Twenty-seven States operate their own PCIP program, often in

coordination with existing State High Risk Pools, and 23 States and the District of Columbia have opted to have a Federally-operated program.

The Affordable Care Act is also making it easier for employers to provide quality, affordable health insurance for their workers and early retirees. In the past, many Americans who retired before becoming eligible for Medicare lost their savings because of the high cost of insurance in the individual market. Millions more saw their insurance disappear, leaving them vulnerable to high costs and unmet health care needs. Under the Affordable Care Act, the Early Retiree Reinsurance Program (ERRP) was created as a temporary program that supports employers that continue to provide private health coverage, helping early retirees keep the private coverage they already have. The ERRP provides financial relief for employers so early retirees and their spouses, surviving spouses, and dependents can continue to have quality, affordable insurance. To date, ERRP has provided \$4.73 billion in reinsurance payments to more than 2,800 employers and other sponsors of retiree plans to help more than 19 million individuals in plans that have received support. ERRP funds are a critical source of support, benefiting retirees, their families, and employees across the country.

The Affordable Care Act created a program to help establish new non-profit health insurers, called a Consumer Operated and Oriented Plan (CO-OP). These insurers are run by their customers. CO-OPs are meant to offer consumer-friendly, affordable health insurance options to individuals and small businesses. Already seven non-profits offering coverage in eight states have been awarded more than \$638 million in loans to get up and running, and more awards will be made in the future,

Two Years of Strengthening Private Health Insurance

Besides ensuring that more people are able to access private health insurance coverage, CMS is working to ensure that private health insurance is working better for current consumers. During the past two years, CMS has implemented important private health insurance reforms that are providing new rights and benefits to put consumers back in charge of their health care.

Specifically:

- Insurance companies cannot deny coverage or specific benefits to children with pre-existing conditions.
- Insurance companies can no longer drop or rescind people's coverage because they made an unintentional mistake on their application. Before the law, about 10,700 people annually lost coverage due to the practice of rescissions, where insurance companies routinely dropped coverage.
- Insurance companies cannot place lifetime limits on the dollar value of essential health benefits. Before the law, cancer patients and individuals suffering from serious and chronic diseases often had limited treatment or went without treatment because they had reached their insurer's lifetime dollar limit on their health insurance coverage. About 105 million Americans, including nearly 28 million children, had lifetime dollar limits on their health benefits before the Affordable Care Act. Now, these Americans enjoy improved coverage without the worry of lifetime dollar limits.
- Insurance companies are transitioning to 2014 when they will no longer be able to place annual dollar limits on essential health benefits.
- About 54 million Americans in new insurance plans are receiving expanded coverage of recommended preventive services without additional out-of-pocket payments, including colonoscopy screenings for colon cancer, Pap smears and mammograms for women, well-child visits, flu shots for all children and adults, and more.
- Americans also have the right to appeal decisions made by their insurance company to an independent third party and use the nearest emergency room without higher cost-sharing, regardless of whether it is in network.
- Starting on or soon after September 23, 2012, health insurers and group health plans will have to provide clear information about health plan benefits and coverage, in a consistent format that can easily be compared by the millions of Americans who have or are shopping for private health coverage. If people are looking to buy private health insurance now, they can compare plans at www.HealthCare.gov, which provides information about more than 10,000 insurance plans from more than 600 insurers.
- The new Consumer Assistance Program grants will help make sure that consumers receive their new rights and benefits under the Affordable Care Act by providing nearly

\$30 million in new resources to help States and Territories. These new grants will allow States, who are in some cases partnering with local non-profits, to help strengthen and enhance ongoing efforts in the States and local communities to protect consumers from some of the worst insurance industry practices. Consumer Assistance Programs will benefit millions of Americans by providing them with information on insurance options and their rights under the new law.

In the two years since the enactment of the Affordable Care Act, CMS has made it easier to find and buy private health insurance, while also ensuring that insurance companies can no longer rescind or limit coverage for arbitrary reasons. These reforms are part of the transition to an improved private health insurance system where consumers are better able to understand what they are buying and can be reassured that they will not lose or be denied benefits if they become sick.

Two Years of Helping to Make Private Health Insurance Coverage More Affordable

The Affordable Care Act helps make coverage more affordable by providing States with resources to improve their review of proposed health insurance premium increases and supporting them as they hold insurance companies accountable for unjustified premium increases. The already-operational rate review program works with States to ensure consumers receive value for their premium dollar. Historically, States have been charged with reviewing rate increases for health insurance. Most States operate effective rate review programs and review proposed rate increases. Many States have the authority to reduce or deny a rate increase. Since the passage of the Affordable Care Act, the number of States with the authority to reject unreasonable rate increases went from 30 to 37.

The Affordable Care Act strengthens these State activities and provides \$250 million in grant resources for States to build and upgrade their rate review infrastructure, hire new staff, and improve the circulation of rate review information to consumers. CMS has awarded \$157 million to date and plans to continue to award grants to States that gain effective rate review programs or further strengthen their programs. For States that do not operate an effective rate review program, insurance companies are now required to provide information to CMS if their

rate increases by 10 percent or more, and to provide CMS and their customers with a justification for rate increases CMS determines to be unreasonable.

States are already using this authority to save money for families and small businesses:

- In New Mexico, the State insurance division denied a request from Presbyterian Healthcare for a 9.7 percent rate hike, lowering it to 4.7 percent.
- In Connecticut, the State stopped Anthem Blue Cross Blue Shield, the State's largest insurer, from hiking rates by a proposed 12.9 percent, instead limiting it to a 3.9 percent increase.
- In Oregon, the State denied a proposed 22.1 percent rate hike by Regence, limiting it to 12.8 percent.
- In New York, the State denied rate increases from Emblem, Oxford, and Aetna that averaged 12.7 percent, instead holding them to an 8.2 percent increase.
- In Rhode Island, the State denied rate hikes from United Healthcare of New England ranging from 18 to 20.1 percent, instead seeing them cut to 9.6 to 10.6 percent.

Working alongside the rate review provision, the medical loss ratio (MLR) provision ensures that insurance companies generally use at least 80 or 85 percent of premium revenue, depending on the market, to either provide or improve the quality of health care for their customers. Starting in 2012, consumers may receive rebates if their insurance companies did not spend at least 80 or 85 percent of premium dollars on medical care and health care quality improvement in 2011. Consumers will receive a notice explaining their carrier's MLR if their carrier owes them a rebate on their premium payments. Insurers will issue the first round of rebates in August 2012, based on their MLR from 2011.

If insurers' practices in 2011 were like 2010, up to 9 million Americans could be eligible for rebates in 2012 that are worth up to \$1.4 billion. Average rebates per person could be \$164 in the individual market. We are already seeing signs that insurers are lowering their prices for consumers before customers pay premiums in order to meet the MLR standard required by the law, indicating the provision has already positively influenced insurer-pricing methods. For example, the Government Accountability Office found that in a survey of seven insurers, most of

the insurers were adjusting premiums and making changes to other business practices in response to the MLR requirements.¹

In the regulations implementing the MLR provision, CMS adopted the recommendations of the National Association of Insurance Commissioners. The regulations recognize the importance of State flexibility and allow States to request adjustment to the MLR rule for the individual market in order to transition more smoothly to the improved private health insurance market. CMS has considered MLR adjustment requests from 17 States² and one U.S. Territory in the past year. Through a transparent and data-driven process, we determined that no adjustment was necessary in ten States, approved an alternative adjustment in six States, and approved the request sought by one State. By balancing the need for flexibility within the private health insurance market with the American people's need for affordable private health insurance coverage, we have successfully implemented new tools that will make private health insurance more affordable.

Moving Towards the Affordable Insurance Exchanges

Over the last two years, CMS has partnered with private insurance companies and the States to improve the availability, affordability, and accountability of private insurance. To continue our goal of supporting and improving the private health insurance market, we have steadily worked towards establishing the Affordable Insurance Exchanges. Beginning in 2014, the Exchanges will provide improved access to insurance coverage choices for an estimated 20 million Americans by 2016. Individuals will be able to access qualified health plan insurance options through the Exchange market, including when they do not receive insurance through their employers, are self-employed, or are currently unemployed. We expect a robust employer-sponsored insurance market to continue, with the additional protections and benefits described earlier that make private insurance more fair and affordable for consumers.

Exchanges will make purchasing private health insurance easier by providing eligible individuals and small businesses with one-stop shopping where they can choose qualified health plans that

¹ Dicken, John. *Early Experiences Implementing New Medical Loss Ratio Requirements*. GAO-11-711. July 29, 2011. <http://www.gao.gov/new.items/d11711.pdf>

² The 17 States considered for a MLR adjustment were Maine, New Hampshire, Nevada, Kentucky, Florida, Georgia, North Dakota, Iowa, Louisiana, Kansas, Delaware, Indiana, Michigan, Texas, Oklahoma, North Carolina, and Wisconsin.

best fit their needs, while also guaranteeing access to a comprehensive package of items and services, known as “essential health benefits.”³ New premium tax credits and reductions in cost sharing will help ensure that eligible individuals can afford to pay for the cost of private coverage purchased through the Exchanges. The Exchanges will also allow States to pool together small businesses to help lower premium rates, while the insurance reforms provided in the Affordable Care Act will protect these people and others who receive their insurance through their employer.

Although the Exchanges are not required to be operational until 2014, the research and planning necessary to build them is underway. CMS’ CCIIO has been steadily working with States through Exchange planning grants to support their infrastructure, and gathering feedback as we develop our rulemaking. This year will be critical for building Exchange infrastructure and initiating the many business operations needed to meet the 2014 deadline.

Earlier this month, we continued our progress towards 2014 by releasing new rules to help States design and develop their Exchanges. The Final Rule, released on March 12, 2012 (CMS-9989-F), offers a framework to assist States in setting up their Exchanges. The framework preserves and, in some cases, expands the significant flexibility in the proposed rules that enables States to build Exchanges that work for their residents. For example, the final rule allows States to decide whether their Exchanges should be operated by a non-profit organization or a public agency, how to select plans to participate, and whether to partner with the Department of Health and Human Services for some key functions. The final rule offers significant additional flexibility regarding eligibility determinations for Exchanges and affordability programs. It also makes it easier for small businesses to get coverage through the Small Business Health Options Program (SHOP), strengthens consumer protections, and keeps it simple for health plans interested in participating in the Exchanges.

³ Essential health benefits must include items and services within at least 10 categories -- ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

CMS starts with the basic premise that we want States to establish their own Exchanges, and we are working to get them the guidance, regulations, and resources they need to do so. States are already making progress towards establishing their own Exchanges:

- 44 States have initiated an information technology gap analysis to assess what information technology capabilities they need to run a State-based Exchange, and 37 States have completed that analysis;
- 33 States, including DC, are working toward establishing an Exchange with Establishment or Early Innovator funding;
- 17 States have authority to establish an Exchange either through State laws that support their ability to establish or operate an Exchange or through an Executive Order granting that authority;
- 15 States have issued a Request for Proposals or are in the process of issuing a Request for Proposals for a System Integrator; and
- 12 States have issued a Request for Proposals or are in the process of issuing a Request for Proposals for an Exchange Platform.

Establishing the Exchanges continues our mission to support and improve the private health insurance system by making comprehensive, affordable private insurance options available to all Americans.

In the Years Ahead

CMS is proud of all that we have accomplished and implemented since enactment of the Affordable Care Act two years ago. The Affordable Care Act will reduce our deficit, control health care costs, and make health care more affordable, available, and accountable. Over the past two years, we have made significant progress. Already, millions of Americans are receiving new preventive benefits without cost sharing, 2.5 million young adults are covered on their parents' policies, the ERRP has helped support 19 million early retirees, their families and their former co-workers, and the PCIP has provided sometimes life-saving care and coverage for over 50,000 Americans who were previously shut out of the market due to a pre-existing condition. I am looking forward to 2014 when even more Americans will have access to affordable, comprehensive health insurance plans through the Exchanges, tax credits, and expanded

Medicaid coverage. In the meantime, I look forward to partnering with Congress, the States, consumers, and other stakeholders across the country in order to strengthen health insurance options. Thank you for the opportunity to discuss the work that CMS has been doing to implement the Affordable Care Act.