THE CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, AND THE ANNIVERSARY OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

MARCH 21, 2012

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C O N T E N T S

THE CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, AND THE ANNIVERSARY OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

WEDNESDAY, MARCH 21, 2012

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:02 a.m., in room 2322 of the Rayburn House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Members present: Representatives Stearns, Terry, Murphy, Burgess, Blackburn, Gingrey, Scalise, Griffith, Barton, DeGette, Schakowsky, Green, Christensen, Dingell, and Waxman (ex officio).

Staff present: Gary Andres, Staff Director; Sean Bonyun, Deputy Communications Director; Paul Edattel, Professional Staff Member, Health; Julie Goon, Health Policy Advisor; Sean Hayes, Counsel, Oversight and Investigations; Debbee Keller, Press Secretary; Katie Novaria, Legislative Clerk; Andrew Powaleny, Deputy Press Secretary; Alan Slobodin, Deputy Chief Counsel, Oversight; Alvin Banks, Democratic Investigator; Phil Barnett, Democratic Staff Director; Brian Cohen, Democratic Investigations Staff Director and Senior Policy Advisor; Elizabeth Letter, Democratic Assistant Press Secretary; Karen Lightfoot, Democratic Communications Director, and Senior Policy Advisor; and Matt Siegler, Democratic Counsel.

OPENING STATEMENT OF HON. CLIFF STEARNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. STEARNS. Good morning, everybody. I call to order this subcommittee's hearing on the Center for Consumer Information Insurance Oversight during the week of the 2-year anniversary of the Patient Protection and Affordable Care Act.

My colleagues, it has been 2 years since the health care law was forced on the American people on a purely partisan basis. As we have done since its initial passage, we continue to evaluate the effect the law has on individuals, the health care industry and the United States government. It is fairly obvious what those effects are: number one, higher cost, higher premiums, and increased government control.

Now, these are not partisan points. These are objective facts. Proponents of the law promised lowered premiums, they promised

lowered costs, and they promised that if you didn't want your coverage to change, it would not. That is simply not the case.

This month, the Congressional Budget Office announced that the 10-year cost for the bill is nearly $2 trillion, substantially higher than the figure used when the law was passed. The CBO also reported that as many as 20 million Americans could lose their current coverage, despite the President's countless promises that if you liked your coverage you could keep it. These are not partisan talking points. This is the analysis of the non-partisan Congressional Budget Office.

Meanwhile, the implementation of the law has failed to inspire confidence in the future of Obamacare. The cost and premium increases for some were so large that a waiver program had to be created to excuse over 1,700 companies, insurers and individuals from the law's effects. For example, one business from my home State of Florida needed a waiver so that 34,000 individuals did not face significant premium increases or the loss of their coverage. Yet, these waivers still expire in 2014, and I fear the premium increases and loss of coverage will become unavoidable for over 3 million Americans.

The Early Retiree Reinsurance Program is practically broke. In fact, we will probably learn from one of the witnesses today whether this program, which was supposed to last until the year 2014, has finally run out of money. As of last month, it had already spent $4.7 billion of its $5 billion budget.

Despite predictions that 375,000 individuals would sign up for the temporary high-risk pools in the first year, only 50,000 have signed up 2 years later.

The countless pages of regulations, rules and requirements for Obamacare have been incredibly confusing. To my constituents and individuals throughout the country, these massive new rules and regulations demonstrate the increasing interference of the Federal Government into their lives, while to the business community, the uncertainty they create makes planning for the future nearly impossible.

Lastly, the creation of the Independent Payment Advisory Board, the IPAB, has been met with universal distain by the medical community and our seniors. Today we are debating on the House Floor a bill to repeal this board of unelected bureaucrats charged with cutting Medicare payments to doctors and hospitals.

Of course, next week the Supreme Court will address the question of whether this unprecedented reach into every American's life is permitted by the Constitution, but today, my colleagues, we want to evaluate the law's effects since its passage.

Today's hearing is unique because we will start off with a member panel featuring both Senator Ron Johnson from Wisconsin and our fellow House Member Donna Edwards. I welcome both of them this morning. I thank them for appearing and contributing their time. We also have Mr. Steven Larsen joining us again today. Mr. Larsen is the Deputy Administrator and Director for CCIIO and has previously been a witness of both this committee and the Subcommittee on Health. So we welcome him back also and thank him for joining us today.

[The prepared statement of Mr. Stearns follows:]

Statement of the Honorable Cliff Stearns
Committee on Energy and Commerce
Chairman, Subcommittee on Oversight and Investigations
Hearing on The Center for Consumer Information and Insurance Oversight and the Anniversary of the Patient Protection and Affordable Care Act
March 21, 2012

(As Prepared for Delivery)

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Mr. STEARNS. I would like to recognize the ranking member, Ms. DeGette.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you very much, Mr. Chairman.

I want to welcome our witnesses today. I am glad to see our favorite friend, Steve Larsen, the Director of the Center for Consumer Information and Insurance Oversight, and of course we are looking forward to hearing from our colleagues, Senator Ron Johnson and Representative Donna Edwards. Representative Edwards, it is nice to see a woman on a panel here to talk about the women's health provisions of the Affordable Health Care Act.

Mr. Chairman, in the spirit of basing today's oversight hearing on the facts, I want to briefly describe some of the benefits of the Affordable Care Act that have or will soon go into effect. Because of this law, 2.5 million young adults who were previously uninsured now have health insurance coverage on their parents' policies. Five point one million seniors have saved an average of more than $600 each on their prescription drugs through Medicare. More than 30 million seniors and more than 80 million Americans overall now have access to preventative care with no copays, coinsurance or deductibles. Over 100 million Americans with private insurance no longer have to worry about the worst abuses of the insurance industry. Their coverage cannot be revoked if they get sick, and they no longer have to fear hitting a lifetime coverage limit because of unexpected medical costs.

Mr. Chairman, this new health reform law does so much good for so many people, and under the mantra of repeal and replace, all the Republican majority has done is vote to repeal it. Now, we have already had two votes in this Congress to repeal the Affordable Care Act in the last year, and yesterday Representative Ryan introduced his budget, which would not only repeal the health care law but would decimate Medicare and Medicaid to boot.

Mr. Chairman, I am wondering when we are going to start having hearings on the second part of repeal and replace, which is the replace part of the Affordable Care Act.

I want to give you a few examples of how the efforts to repeal but not replace health care law would hurt women in particular. In July 2011, the prestigious Institutes of Medicine made recommendations regarding preventative health services for women. These experts recommended insurance companies cover the cost of screening for cervical cancer, counseling and screening for sexually transmitted infections, annual well women preventative care visits, screening and counseling for domestic violence, and services for pregnant women. Using authority granted by the Affordable Care Act, the Department of Health and Human Services issued guidelines ensuring the full range of preventative services outlined by the IOM will be covered by health plans and available to all women without copayments, coinsurance or deductibles. Mr. Chairman, this preventative care will save women's lives and save money, but the proposal to repeal but not replace the law that makes sure women could get this care has not been answered.

That is not all the majority has tried to repeal. Earlier this week, the National Women's Law Center released a report on the pervasive discrimination in the insurance market for women. The report found that the same health insurance policy costs a woman 30, 50 or even 85 percent more than a man of the same age, even if maternity care is not covered. Mr. Chairman, this is simply wrong, and thanks to the Affordable Care Act, it will not continue. But all I have seen are proposals to repeal and not to replace the law that would prevent health insurance discrimination against women.

Mr. Chairman, the facts do not support the drive to repeal this bill, but facts don't seem to matter in this case. Republicans have already decided in advance that the law will not work, and the facts have become irrelevant. Let me give you an example. In fact, Mr. Chairman, you talked about it in your opening statement. Last week, the Congressional Budget Office released new Affordable Care Act estimates. Committee Republicans were quick to claim that the CBO's estimates had changed and this was proof that health care reform had failed. There is only one problem: this is incorrect. Earlier this week, CBO Director Doug Elmendorf spoke out about this misrepresentation and here is what he had to say: "Some of the commentary on these reports has suggested that CBO and the Joint Committee on Taxation have changed their estimates of the ACA to a significant degree. That is not our perspective. For health insurance coverage, the latest estimates are quite similar to the estimates we released when the legislation was being considered. The estimated budgetary impact of the coverage provisions has also changed little."

Mr. Chairman, CBO concluded this year what they concluded 2 years ago when health care reform was passed: the Affordable Care Act will improve health care coverage for hundreds of millions of Americans. It will cover tens of millions of the uninsured. It will improve Medicare and it will cut the deficit. Millions of Americans are seeing the benefits of health care reform already, and these benefits will continue in the future. Thank you.

Mr. STEARNS. I thank my colleague and recognize Dr. Burgess for 2 minutes.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I thank the chairman for the recognition.

You know, I have really been interested in this, what started life as an agency, the Office of Consumer Information and Insurance Oversight, for a long time. It has always been a little bit of a mystery to me. This is the office that is the lead implementation force, the referee on meeting guidance for consumers, States and insurance companies on the Affordable Care Act, but nowhere in the Affordable Care Act is there any reference to the Office of Consumer Information and Insurance Oversight. It was a fabrication by the Secretary of Health and Human Services. Now, when the committee began to look into this in November of 2010 and January of 2011, the agency morphed into the Center for Consumer Information and Insurance Oversight and was drawn back into the Centers for Medicare and Medicaid Services. And it has been tough to get information out of this agency. Yes, sometimes it has come but

it has come in small morsels and it has required an inordinate amount of staff time in order to get the budgetary information, and by the time we receive it, it is frequently months out of date.

Well, the operations of the of the Center for Consumer Information and Insurance Oversight are now under the aegis of the Centers for Medicare and Medicaid Services. This is the most powerful health agency on earth, and indeed that the earth has ever known, certainly within the Federal Government, because they have under their control now Medicare, Medicaid, SCHIP, and for the first time with the passage of the Affordable Care Act 2 years ago, private insurance is now regulated by the Federal Government in the Office of Consumer Information and Insurance Oversight.

So it is essential that we as an oversight body maintain the oversight over this, now this very large and crucial organization. We have a Supreme Court hearing going on, a Supreme Court case being heard next week. It will be interesting to know what the contingency plans are at HHS and CCIIO should the Supreme Court not rule the administration's way.

I will yield back the balance of my time.

Mr. STEARNS. The gentleman yields back.

The gentlelady from Tennessee is recognized for 1 minute.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Mr. Chairman.

I want to welcome our guests. Senator Johnson, great article in the Wall Street Journal today on Obamacare. We appreciate the work you have done. Ms. Edwards, we are so pleased that you are with us, and Mr. Larsen, I want to welcome you back.

As we look at what has happened over the past 2 years, we see that $500 billion has come out of Medicare. Our constituents are aware of this. They are concerned, and they look at this cost of this entire bill. Now, as the chairman said, what we have found out is that the cost has doubled since the original estimates. Those of us from Tennessee who had TennCare, the test cast for HillaryCare back in 1994, indeed reported repeatedly that the cost quadrupled within 5 years. So we are going to want to look at what is happening with this cost.

We are concerned about it. We are concerned about the potential loss of coverage for 5 to 20 million Americans. We hear from a lot of our constituents about the escalation in cost of their private insurance premiums, and indeed, many of my constituents, female business owners, talk about their concern about loss of coverage and access to consistent coverage for elderly relatives, for children with chronic conditions, because they see this insurance market changing and they know that the changes that are in front of them are not going to help them with consistent health care, and we express those concerns and I yield back the balance of my time.

Mr. STEARNS. The gentlelady's time is expired and the gentleman from Louisiana is recognized for 1 minute.

OPENING STATEMENT OF HON. STEVE SCALISE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA

Mr. SCALISE. Thank you, Mr. Chairman. I appreciate you having this hearing. I want to thank our panelists who are going to be testifying later.

You know, I think it is important as we approach the 2-year anniversary of the President's health care law that we look back and see just what has happened, what it is doing to the health care marketplace, and in fact, if many of the promises that were made have been kept or broken, and I think what we have seen so far, I know as I have talked to small businesses throughout my district, the biggest complaint that they give when they talk about the things that are keeping them from hiring people right now, keeping them from creating jobs, is the President's health care law, the cost that it has added, the uncertainty that it has added. If you look at, you know, what it has done to Medicare, $500 billion was raided from Medicare by the President's law, and in fact the President's own health care actuaries confirmed that Medicare will go bankrupt in less than 12 years, and this is the current law of the land.

And so absolutely we want to repeal it, get rid of the higher costs, get rid of the broken promises and the lost health care and the crony capitalism as we will see from these waivers that have been issued by many friends and supporters of the law whereas regular hardworking taxpayers, small businesses weren't able to get those same waivers. I think it is important that we look back at all of that and, you know, hopefully work to address the problems like we will be working to repeal this unelected board of 15 bureaucrats that would have the ability to ration care.

So thanks again for having this hearing and I look forward to our panel. I yield back.

Mr. STEARNS. I thank the gentleman.

The Chair recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Mr. Chairman, as we approach the 2-year anniversary of the Affordable Care Act, we have an opportunity to highlight the tremendous benefits that this landmark law has and will provide for millions of Americans, and I am pleased to welcome our first witnesses, Senator Johnson and Representative Edwards, and I know we will be hearing from Steve Larsen from the CCIIO who will be implementing a lot of the legislation.

But House Republicans seem determined to overturn this law regardless of the facts. I find it hard to understand. The Affordable Care Act is giving vital benefits for millions of Americans. We are living up to the promises of this law. Nationwide, the law has provided insurance coverage for over 2 million young adults who were previously uninsured. It saves over 5 million seniors an average of more than $600 each on their prescription drugs. It provided more than 30 million seniors, more than 10 million children and more than 40 million adults new access to preventive care with no

copays, coinsurance or deductibles. Thanks to the Affordable Care Act, over 100 million Americans no longer have to worry about their coverage being revoked if they get sick or by hitting a lifetime coverage limit because of unexpected medical costs.

Last week, my staff prepared reports on the benefits of the Affordable Care Act in all 435 Congressional districts. Mr. Chairman, I would like to enter the reports for the 23 members of the subcommittee into the hearing record.

Mr. STEARNS. By unanimous consent, will do.

[The information follows:]

Early Re ree Reinsurance Program: Reimbursement Update
February 17, 2012

The Early Retiree Reinsurance Program (ERRP) was established by section 1102 of the Affordable Care Act enacted on March 23, 2010. Congress appropriated $5 billion for this temporary program and directed the Secretary of Health and Human Services (HHS) to set up the program within 90 days of enactment. By law, the ERRP is scheduled to end when its resources have been used to pay claims. Due to the significant response among the employer community, the Administration's budget released in February 2011 projected that the funds would be available into fiscal year 2012, which started on October 1, 2011. The program ceased accepting applications for participation in the program on May 6, 2011. On December 9, 2011, CMS notified plan sponsors that $4.5 billion had been paid and issued further guidance informing plan sponsors that claims incurred after December 31, 2011 will not be accepted.

People in the early retiree age group (i.e., ages 55 to 64) often face difficulties obtaining insurance in the individual market because of age or chronic conditions that make coverage unaffordable or inaccessible. The availability of group health insurance coverage for America's retirees age 55 to 64 has declined significantly over the past 20 years, as the percentage of large employers providing workers with retirement health coverage has dropped from 66 percent to 28 percent. The ERRP was designed to provide financial assistance to health plan sponsors that make coverage available to millions of early retirees and their families -- including for-profit companies, schools and educational institutions, unions, State and local governments, religious organizations and other nonprofit plan sponsors.

By law, ERRP payments must be used to reduce plan participants' costs, to reduce plan sponsors' costs of providing coverage, or both. Program payments are thus targeted to encourage plans to continue providing coverage to early retirees and their families.

CMS has taken several steps to promote the integrity of data submitted to, and claims paid by, ERRP. CMS has contracted with a program integrity contractor to conduct audits of a subset of plan sponsors to verify compliance with program rules, including eligibility of early retirees, validity of claims submitted, and use of program funds.

The information below includes all payments made to approved plan sponsors through January 19, 2012. At this time, ERRP has received requests for reimbursement that exceed the $5 billion in funding appropriated. Reimbursement requests which exceed the program's $5 billion will now be held in the order of receipt, pending the availability of funds that may become available as a result of overpayment recoupment activities. CMS will continue to report the status of payments to plan sponsors periodically.

For additional information on program operations and administration, please reference the 2012 ERRP Report on the CMS CCIIO website http://cciio.cms.gov/.

*Kaiser Family Foundation and Health Research and Educational Trust. (2010). Employer Health Benefits, 2010 Annual Survey. Washington, DC.

The Sherwin-Williams Company	1,208,513.56
The Timken Company	5,378,873.42
The Western and Southern Life Insurance Company	1,581,553.64
Tilden Mining Company L.C.	222,799.76
UFCW Local Unions & Employers Benefit Plan of SW Ohio Area	1,016,661.70
UFCW Unions' and Employers' Health and Welfare Plan of Central Ohio	708,198.15
Union Construction Workers Health Plan	752,942.58
United Food & Commercial Workers Union-Employer Health & Welfare Fund	180,414.52
United Taconite LLC	53,368.91
White Castle System, Inc.	86,307.96
Wittenberg University	27,330.85
Oklahoma	
Advantage Health Plans Trust	35,012.60
ConocoPhillips Company	9,400,356.84
Indian Electric Cooperative, Inc.	58,128.71
OGE Energy Corp.	695,927.41

General Electric Company	38,588,700.79
General Re Corporation	268,408.33
Glastonbury Public Schools	85,277.73
Hamden Public Schools	441,936.49
IBT Local 191 Health Service & Insurance Plan	13,338.17
International Brotherhood of Electrical Workers Local	65,943.32
International Union of Bricklayers and Allied Craftworkers	4,400.22
International Union of Operating Engineers Welfare Fund 478	270,756.00
IUPAT District Council No. 11 Health Fund	24,661.60
Knights of Columbus	19,824.94
Legrand Holding, Inc.	94,487.81
Local 443 Transportation Health Service & Insurance Plan	751.00
Madison Board of Education	4,081.96
NECA - IBEW Local 35 Health Fund	28,521.90
New England Electrical Workers Benefits Fund	364,608.67
Newtown Board of Education	1,482.11

Electrical Workers Insurance Fund	908,030.60
Flint Area Sheet Metal Workers Health & Welfare Fund	20,737.72
Ford Motor Company	17,290,035.77
General Motors LLC	31,282,423.69
Genesee County Community Health	81,570.34
Genesee County Road Commission	176,953.54
Genesee County Water and Waste Services	107,356.19
Genesys Regional Medical Center	4,846.86
Gkn North America Services, Inc.	466,848.55
Guardian Industries Corp	291,119.41
Haworth International, Ltd.	35,155.18
Henniges Automotive Holdings, Inc.	202,468.13
HLI Operating Company, Inc.	213,829.26
Hurley Medical Center	194,873.95
Huron-Clinton Metropolitan Authority	130,425.21
Ingham County, MI	294,272.74

Waterloo Central School District	61,219.29
Wayland-Cohocton Central School District	1,288.77
Wayne Central School District	13,007.19
Wayne County Health Care Plan Trust	80,630.40
Welfare Fund of Local No. One, IATSE	181,749.22
Westchester Community College	318,648.24
White & Case LLP	16,270.50
William Floyd Union Free School District	268,146.77
Williamson Central School District	11,737.36
York Central School District	1,184.29
North Carolina	
Alex Lee, Inc.	391,998.21
Alexander County	6,500.87
American Kennel Club	48,205.14
Arrowood Indemnity Company	152,669.12
Bank of America Corporation	4,610,027.20

Electrical Workers Insurance Fund	908,030.60
Flint Area Sheet Metal Workers Health & Welfare Fund	20,737.72
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Ingham County, MI	294,272.74

Harris County	3,089,168.13
Hendrick Medical Center	124,363.38
Hewlett-Packard Company	10,192,806.40
Holly Corporation	261,844.21
Houston Refining LP	294,214.16
Hunt Consolidated Inc.	110,006.88
Huntsman International LLC	1,076,681.57
Interstate Brands Corporation	704,647.51
Joint Board of Trustees of U.A.P.P. Local 142 Bene	17,596.12
Kinder Morgan, Inc.	1,088,638.11
Lehigh Hanson, Inc.	287,417.32
Lennox International Inc.	93,319.59
Lyondell Chemical Company	772,792.74
Maverick Tube Corporation	2,546.98
Metropolitan Transit Authority of Harris County, TX	706,531.09
Millennium America Holdings Inc.	28,985.14

Texas	
Alcon Laboratories, Inc.	2,206,097.44
Allied Pilots Association	45,866.93
Alon USA Energy, Inc.	112,339.32
American Airlines Inc.	24,260,057.92
American Heart Association	298,069.21
Anadarko Petroleum Corporation	859,791.74
AT&T Inc	213,785,782.47
Atmos Energy Corporation	431,824.80
Basell North America, Inc.	176,839.10
BHP Copper, Inc.	33,071.22
BJ Services Company, U.S.A.	214,759.36
Boy Scouts of America	887,735.24
Brazoria County	245,489.80
Broken Hill Proprietary USA Inc.	825,458.17
Burlington Northern Santa Fe, LLC	2,749,230.73

JPMorgan Chase & Co.	8,568,059.48
Katonah-Lewisboro School District	520,418.91
Kendall Central School	13,055.44
Kenmore Town of Tonawanda Union Free School District	180,812.65
KeySpan Corporation	2,197,691.20
King Kullen Grocery Co., Inc.	87,920.56
Kingston Trust Fund	699,727.21
KLM Royal Dutch Airlines	235,574.29
L-3 Communications Retiree Medical Plan	979,572.22
Labor- Management Healthcare Fund	1,825,270.97
Laborers Intl Union of N A Welfare Fund Local 754	133.81
Lancaster Central School District	35,601.64
LeRoy Central School	3,222.80
Letchworth Central School	692.38
Livonia Central School	28,224.13
Local 342 Health Care Fund	49,857.95

Rocky Mountain UFCW Unions & Employers Health Benefit Fund	1,450,662.30
West Metro Firefighters Health Benefits Trust	149,720.41
Westmoreland Coal Company	179,187.68
Woodward Governor Company	181,015.69
Connecticut	
Aetna Inc.	3,904,133.07
Alstom Power Inc.	268,233.76
Arch Chemicals, Inc.	254,464.44
ASSA ABLOY, Inc.	157,054.86
Barnes Group Inc.	210,515.56
Bethel Board of Education	161,988.47
Board of Trustees Local 493 Health Service & Insurance Plan	407.54
Board of Trustees Local 677 Health Service & Insurance Plan	614.70
Citigroup Inc.	8,025,097.27
City of Bridgeport, CT	2,260,053.33
City of Bristol	305,808.51

UFCW National Health and Welfare Fund	499,412.54
Unilever United States, Inc.	4,056,371.29
United Association Local No. 322 Health and Welfare Fund	139,709.55
United Water Resources Inc.	125,288.00
Verizon Communications Inc.	162,963,934.39
West Windsor Township	8,724.54
Woodbridge Township	392,376.72
New Mexico	
Los Alamos National Security, LLC	1,323,668.02
New Mexico Retiree Health Care Authority	5,915,300.20
Sandia Corporation	2,213,916.02
University of New Mexico	451,441.07
New York	
1199SEIU Natl Benefit Fund for Health and Human Service Employees	4,359,989.34
Advance Publications, Inc.	372,836.28
Albany International Corp.	498,638.82

American Express Company	2,079,836.34
American Federation of Teachers	74,367.14
American International Group, Inc.	214,163.98
Amherst Central School District	99,258.55
Associated Press	191,888.00
Attica Central School	37,187.67
Auburn Enlarged City School District	220,212.80
Avon Central School District	1,971.62
Avon Products, Inc	2,073,932.15
Bath Central School	101,878.17
Bedford School District	580,121.00
Board of Education	40,823.07
Board of Education City School City of Rochester	1,415,032.80
Board of Trustees Local 21 Welfare Fund	401,647.24
Board of Trustees of Local 295/851 Employer Group Welfare Fund	431,490.36
Bradford Central School District	8,543.42

Herkimer County	101,473.60
Herkimer-Fulton-Hamilton-Otsego BOCES	812,761.60
Hess Corporation	101,577.94
Honeoye Central School District	33,976.29
Horace Mann School	12,993.86
Horseheads Central School District	16,432.00
I.B.E.W. Local 43 & Electrical Contractors Welfare Fund	192,938.43
IBEW 325 Joint Trust Fund	65,888.74
IBEW Local 1249 Insurance Fund	74,969.76
IBEW Local 86 Insurance Fund	142,536.80
International Business Machines Corporation ("IBM")	30,963,516.39
International Flavors & Fragrances Inc.	516,107.00
ITT Corporation	1,171,577.65
Jamestown Board of Public Utilities	19,730.51
Jefferson Lewis Et Al. School Employees' Healthcare Plan	1,506,823.06
John D. Brush & Co., Inc.	23,862.94

Mr. WAXMAN. They show that health reform is helping hundreds of thousands of people in each of our districts. In my district, health reform has provided 8,600 young adults with health coverage and given 9,600 seniors an average discount of $700 per person on their prescription drugs under Medicare Part D. And Mr. Chairman, in your district, because of health reform, 113,000 seniors have received Medicare preventive services without paying copays, coinsurance or deductibles, up to 42,000 children with preexisting health conditions can no longer be denied coverage by health insurance, and 250,000 of your constituents no longer have to worry about lifetime coverage limits on their health plan. And in the months and years to come, even more critical benefits and protections will go into effect.

Later this year, every health insurance policy sold in this country will begin providing consumers with a clear, consistent summary of the costs and benefits of their coverage like food and nutrition labels for health care plans.

In 2014, when the law is fully implemented, plans in the private market will be sold in transparent and competitive exchanges where consumers can be sure that the plans they purchase will be there for them when they need them without annual or lifetime limits, regardless of a preexisting condition, without insurers making unjustifiable premium increases or wasting huge percentages of premium dollars on administrative costs and profits.

These are the facts. They show the Affordable Care Act is working and will continue to benefit the American people. What won't work is the Republican alternative. They want to repeal the law. They say they we will repeal and replace. Now we know what their replacement is. From the Budget Committee chairman yesterday, the proposal would repeal health care reform, decimate Medicaid, cutting over $800 billion from this critical safety net program, and it would slash hundreds of billions of dollars from Medicare. After all the money that people complained about that was taken from the Medicare overpayment and some of the insurance companies, the Republicans would leave that in place and they would cut additional hundreds of billions of dollars as well, ending the program's basic health guarantee for seniors.

Mr. Chairman, these Republican solutions are wrong. They would devastate Medicare and Medicaid, leave tens of millions of Americans without health insurance at all. Their way of holding down costs is to shift those costs on to the Medicare individuals, and for the States, they would tell the States here is less money for Medicaid, you can cut back on health care for disabled people and very, very poor people under Medicaid while we are going to make sure that we are going to give wealthier Americans further tax breaks. I think that is obscene and I think the American people will see through this Republican effort.

Mr. STEARNS. The gentleman's time is expired. We will now go to our witnesses. Our first panel, of course, is Senator Ron Johnson from Wisconsin and Congresswoman Donna Edwards from Maryland. We welcome both of you today. And Senator Johnson, we will recognize you for 5 minutes.

STATEMENTS OF HON. RON JOHNSON, A UNITED STATES SENATOR FROM THE STATE OF WISCONSIN; AND HON. DONNA F. EDWARDS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

STATEMENT OF HON. RON JOHNSON

Mr. JOHNSON. Thank you, and good morning, Chairman Stearns, Ranking Member DeGette and members of the committee. Thank you for the opportunity to participate in today's hearing on the Patient Protection and Affordable Care Act.

Unfortunately, this Orwellian-named law will neither protect patients nor make health care more affordable. It is my current mission to paint a picture of what America's health care system, our freedoms and our Federal budget will look like in the unfortunate event that Obamacare is fully implemented. It will not be a pretty picture.

Nancy Pelosi famously stated that we have to pass this bill so you can find what is in it. I am determined to make sure we don't have to fully implement it to see what it will cost.

Twenty-eight years ago, our infant daughter, like millions of other Americans, was saved by a health care system and medical professionals that dedicate their lives to saving the lives of others. Today, our daughter is a nurse herself helping to save infants in a neonatal intensive care unit. These are the people that President Obama chose to demonize in his quest to take over one-sixth of our economy. The result of his efforts was an ill-conceived, totally partisan, 2,700-page bill whose benefits were wildly overstated and whose costs will prove to be dangerously understated.

Let me start there, understated costs. To sell the fiction that Obamacare would provide health care to 25 million uninsured Americans without adding one dime to our deficit, the original budget window included 10 years of revenue and fictional cost savings totaling $1.1 trillion to pay for only 6 years of benefits totaling $938 billion. Increased taxes, fees and penalties account for roughly half of the $1.1 trillion "pay for." The other half supposedly results primarily from reduced payments to Medicare providers and cuts in Medicare Advantage. But Congress has not allowed the enactment of the $208 billion provider payment cuts required under the Sustainable Growth Rate formula because it understands those cuts would dramatically reduce seniors' access to care. For the same reason, how likely is it that Obamacare's Medicare reductions will actually occur.

In addition, how likely is it that on net, only 1 million out of the 154 million Americans that have employer-sponsored health insurance will lose that coverage and be forced to obtain coverage through the exchanges. Not very. Yet that was the CBO estimate that helped produce Obamacare's unrealistic deficit reduction score.

Instead of trying to interpret and comply with over 15,000 pages of rules and regulations, and instead of paying $20,000 in 2016 for family coverage, why wouldn't business owners simply pay the $2,000 penalty? And by dropping coverage under Obamacare, they wouldn't be exposing their employees to financial risk. They would be making them eligible for huge subsidies in the exchanges, $10,000 if their household income is $64,000. A recent study by

McKenzie and Company found that 30 to 50 percent — that would be 48 to 80 million Americans — 30 to 50 percent of employers plan to do just that, drop coverage.

CBO's March 2012 baseline estimates 9-year Obamacare outlays will exceed $1.9 trillion. Adding that many individuals to the exchanges could add trillions to these projections. Can America afford to take that risk? Those trillions of dollars for Obamacare will be taken from hardworking American taxpayers and the private sector filtered through the Federal Government in order for Washington to dictate the terms of health care consumption and delivery to every American. If that happens, we will be ceding a significant portion of our personal freedoms for the false promise of economic and health care security.

There are too many uncertainties, and the stakes are far too high to proceed with implementing Obamacare. It is time to put the brakes on until we fully understand all its costs and consequences.

In closing, let me ask some questions the administration should answer before Obamacare is fully implemented and it really is too late. If the Medicare cuts actually are enacted, how many doctors will stop taking Medicare patients? What services will be cut? How will quality suffer? Isn't this how rationing begins?

Because Medicaid reimbursement rates are often lower than provider costs, approximately 40 percent of providers do not accept Medicaid patients. How will the remaining 60 percent handle the 25 million new Medicaid beneficiaries?

Faith in the Federal Government is appropriately at an all-time low. How many Americans actually believe Washington can effectively and efficiently take over one-sixth of our economy? Does anyone think government would have invented the iPhone or iPad? What will happen to medical innovation under government control?

Will Americans like Federal bureaucrats telling them they cannot get mammograms until they reach the age of 50, or the Independent Payment Advisory Board becoming Medicare's de facto rationing panel?

Defensive medicine and junk lawsuits cost Americans hundreds of billions of dollars each year. Why was malpractice reform rejected? Did it have anything to do with President Obama's support from trial lawyers? Why would anyone think that increasing taxes on health insurance plans, medical devices and drugs would help bend the cost curve down? The actual result: instead of lowering the cost of a family insurance plan by $2,500 per year as President Obama promised, family plans are now $2,200 higher. Does anyone really think that on net, only 1 million American will lose their employer-sponsored care and be forced into the exchanges? And finally, why have 1,722 waivers covering 4 million Americans been granted if implementing Obamacare doesn't threaten current health insurance plans?

President Obama promised: "If you like your health care plan, you will be able to keep your health care plan. Period. No one will take it away, no matter what." I am not sure what you would call that statement, but whatever you call it, it was a doozy.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Johnson follows:]

Statement of Senator Ron Johnson
Ranking Member of the Senate Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia

before the Committee on Energy and Commerce,
Subcommittee on Oversight and Investigations
U.S. House of Representatives

March 21, 2012

Introduction

Good Morning Chairman Stearns, Ranking Member DeGette, Members of the Committee. Thank you for the opportunity to participate in today's hearing on the Patient Protection and Affordable Care Act (PPACA).

Unfortunately, this Orwellian named law will neither protect patients nor make healthcare more affordable.

It is my current mission to paint a picture of what America's health care system, our freedoms, and our federal budget will look like in the unfortunate event that PPACA is fully implemented. It will not be a pretty picture.

Nancy Pelosi famously stated that: "We have to pass this bill so you can find out what's in it." I am determined to make sure we don't have to fully implement it to see what it will cost.

Twenty-eight years ago, our infant daughter, like millions of other Americans, was saved by a health care system, and medical professionals that dedicate their lives to saving the lives of others. Today, our daughter is a nurse herself, helping to save infants in a neo-natal intensive care unit. These are the people that President Obama chose to demonize in his quest to take over one-sixth of the American economy.

The result of his efforts was an ill-conceived, 2,700 page bill, whose benefits were wildly overstated, and whose costs will prove to be dangerously understated.

Effect on Federal Budget and Costs

Let me start there...understated costs. To sell the fiction that PPACA would provide healthcare to 25 million uninsured Americans without adding one dime to the deficit, the original budget window included 10 years of revenue and fictional cost savings, totaling $1.1 trillion, which pays for only six years of benefits, totaling $938 billion.

Increased taxes, fees, and penalties account for roughly half of the $1.1 trillion "pay for." The other half supposedly results primarily from reduced payments to Medicare providers and cuts in Medicare Advantage.

But Congress has not allowed enactment of the $208 billion provider payment cuts required under the Sustainable Growth Rate formula because it understands those cuts would dramatically reduce seniors' access to care. For the same reason, how likely is it that PPACA's Medicare reductions will actually occur?

Effect on Private Insurance

In addition, how likely is it that on net, only one million out of the 154 million Americans that have employer-sponsored health insurance will lose that coverage and be forced to obtain coverage through the exchanges? Not very, yet that was the Congressional Budget Office (CBO) estimate that helped produce PPACA's unrealistic deficit reduction score.

Instead of trying to interpret and comply with over 15,000 pages of rules and regulations, and instead of paying $20,000 in 2016 for family coverage, why wouldn't business owners simply pay the $2,000 penalty?

And by dropping coverage under PPACA, they wouldn't be exposing their employees to financial risk. They would be making them eligible for huge subsidies in the exchanges - $10,000 if their household income is $64,000.

A recent study by McKinsey & Company found that 30 percent to 50 percent of employers plan to do just that. CBO's March 2012 baseline estimates nine-year PPACA outlays will exceed $1.7 trillion. Adding this many individuals to the exchanges could add trillions of dollars to those projections. Can America afford to take that risk?

Those trillions of dollars for PPACA will be taken from hardworking American taxpayers and the private sector then filtered through the federal government in order for Washington to dictate the terms of health care consumption and delivery to every American.

If that happens, we will be ceding a significant portion of our personal freedoms for the false promise of economic and healthcare security.

There are too many uncertainties, and the stakes are far too high to proceed with implementing PPACA. It is time to put the brakes on until we fully understand all its costs and consequences.

Conclusion

In closing, let me ask some questions the Administration should answer before PPACA is fully implemented and it really is too late.

If Medicare cuts actually are enacted, how many doctors will stop taking Medicare patients? What services will be cut? How will quality suffer? Isn't this how rationing begins?

Because Medicaid reimbursement rates are often lower than provider costs, approximately 40 percent of providers do not accept Medicaid patients. How will the remaining 60 percent handle the 25 million new Medicaid beneficiaries?

Faith in the federal government is appropriately at an all-time low. How many Americans actually believe Washington can effectively and efficiently take over one-sixth of our economy?

Does anyone think government would have invented the I-phone or I-pad? What will happen to medical innovation under government control?

Will Americans like federal bureaucrats telling them they cannot get mammograms until they are 50, or the Independent Payment Advisory Board becoming Medicare's de facto rationing panel?

Defensive medicine and junk lawsuits cost Americans hundreds of billions of dollars each year. Why was malpractice reform rejected as part of health care reform?

Why would anyone think that increasing taxes on health insurance plans, medical devices, and drugs would help bend the cost curve down?

The actual result: instead of lowering the cost of a family insurance plan by $2,500 per year as President Obama promised, family plans are now $2,200 higher.

Does anyone really think that on net, only one million American will lose their employer sponsored care and be forced into the exchanges?

And finally, why have 1,722 waivers covering four million Americans been granted if implementing PPACA doesn't threaten current health insurance plans?

President Obama promised: "If you like your health care plan, you'll be able to keep your health care plan. Period. No one will take it away, no matter what." I'm not sure what you would call that statement, but whatever you call it, it was a doozy.

Thank you for the opportunity to testify before you today on what I believe is the most important issue facing our nation. I look forward to your questions.

Mr. STEARNS. I thank you, Senator, and we recognize the gentlelady from Maryland for 5 minutes.

STATEMENT OF HON. DONNA F. EDWARDS

Ms. EDWARDS. Thank you, Mr. Chairman and Ranking Member DeGette, and thanks for holding this important and timely hearing on the Nation's health care system, and for the opportunity to be here to testify today.

I represent Montgomery and Prince George's counties right outside of Washington, D.C. Even in my Congressional district close to the Nation's capital, there are thousands of people who go without health care every day. I was honored to preside over the passage of the Affordable Care Act in the House and filled with pride actually to witness President Obama sign the landmark bill into law.

Although the health care reform law has faced opposition from some, I am proud and steadfast in my support of the Affordable Care Act and the preventive care, the primary care, the community-based care and the quality care that will now be received by millions of Americans.

Before the enactment of the Affordable Care Act, our health care system had been failing a large part of our population who most needed insurance coverage. In a national survey, 12.6 million nonelderly adults, 36 percent of whom tried to purchase health insurance directly from an insurance company in the individual market, had been discriminated against because of a pre-existing condition just in the last 3 years. With a Federal high-risk pool, these Americans will have access to a critical program that provides lifesaving health care coverage, and the Affordable Care Act also encourages and enables people to seek out care sooner, saving the system money and increasing the chance of positive health outcomes in the long run. That we should look to as very encouraging.

I worked with my colleagues, and I was interested to hear you, Mr. Chairman, particularly Jan Schakowsky, in championing a provision that holds insurance companies accountable for excessive premium increases. That ensures affordability for working families who have health care coverage, but for whom costs are skyrocketing.

In my congressional district, this provision has already helped protect 190,000 residents from price gouging by requiring health insurers to post and justify rate increases of 10 percent or more. This is true all across the country in every single Congressional district.

At this important 2-year anniversary, for constituents in my district and throughout the country, health care reform has already delivered important and tangible benefits due to a number of provisions in effect today. I am proud that our system would allow me the option to keep on my health insurance policy my 23-year-old up until age 26 in the event that he doesn't receive coverage through an employer.

I visit senior centers regularly where seniors now understand that the Affordable Care Act strengthens their Medicare benefit by closing the prescription drug donut hole and expanding coverage, all while lowering costs to them. Under the expanded benefits of

Medicare, seniors can receive annual physical and preventive screenings. And the small businesses in my district and all across this country have received the benefit of a 35 percent, enhanced to 50 percent in 2014, tax credit to help them as employers cover the cost of premiums paid to insure their workers. And with the filing deadlines approaching, employers should look for that credit filing on their return.

And for women, and I am proud that for women all across this country Affordable Care Act has had a remarkable impact on their ability to finally obtain affordable and comprehensive coverage. According to The Commonwealth Fund, when the law is fully implemented, nearly all the 27 million women in this country ages 19 to 64 who were uninsured in 2010 will gain health coverage that meets their needs at a fair price.

By 2014, health care reform will keep insurance companies from denying women coverage due to preexisting conditions like experiencing domestic violence or pregnancy or even acne. What a shame that we needed a law to ensure that insurance companies would not penalize women for those or other conditions, but you know what? I am happy we have that law to do exactly that.

And further, as members of this panel, male and female, know, the act of choosing a doctor for your health needs is an important and personal decision. The Affordable Care Act ensures that women are able to choose any doctor they trust without a referral. As if the insurance companies didn't have enough influence over the health care decisions of women, before the passage of the Affordable Care Act insurers could also choose to charge a woman more for her insurance policy just because of her gender. The National Women's Law Center reports the practice of charging women more than men for the same coverage cost women $1 billion a year with little evidence to explain the difference.

And now with the Affordable Care Act in place and the scientific findings of the Institute of Medicine, women will receive a full range of preventive services at no cost including mammograms, colonoscopies, Pap tests, as well as well-woman visits, HPV testing, contraception methods, and support for interpersonal and domestic violence. To date, 20 million women have accessed these free preventive services.

And for minority women like me who too often go uninsured, the Affordable Care Act will provide equal access to health care and close health disparity gaps that plague women in underserved communities.

And so I appreciate the opportunity to be here today to celebrate the good news of health care delivery for the American people through the Affordable Care Act, and I thank you, and I am happy to answer any questions.

[The prepared statement of Ms. Edwards follows:]

Testimony of
The Honorable Donna F. Edwards
Before the House 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"
March 21, 2012

Thank you, Chairman Stearns and Ranking Member DeGette, for holding this important and timely hearing on the nation's health care system and for allowing me the opportunity to testify before the Subcommittee. I am Congresswoman Donna F. Edwards, and I represent Montgomery and Prince George's Counties in the Fourth Congressional of Maryland, located just outside of Washington, DC.

I was honored to preside over the passage of the Affordable Care Act in the House and filled with pride to witness President Obama sign the landmark bill into law. Although the health reform law has faced opposition from some, I stand proudly and steadfastly in support of the Affordable Care Act and the preventive care, primary care, community-based care—quality care—that will now be received by millions of Americans.

Prior to the enactment of the Affordable Care Act, our health care system had been failing a large proportion of our population who most needed insurance coverage. In a national survey, 12.6 million non-elderly adults, 36 percent of whom tried to purchase health insurance directly from an insurance company in the individual insurance market, had been discriminated against because of a pre-existing condition in the last three years.[1] With a federal high risk pool, these Americans will have access to a critical program that provides life-saving health care coverage. The Affordable Care Act also encourages and enables people to seek out care sooner, saving the system money and increasing the chance of a positive outcome in the long run – things that we should be encouraging.

I worked with my colleagues, particularly Rep. Jan Schakowsky (D-IL), to champion a provision that holds insurance companies accountable for premium increases, ensuring affordability for millions of working families who have health care coverage, but for whom costs are

[1] Coverage Denied: How the Current Health Insurance System Leaves MILLIONS Behind. http://www.healthreform.gov/reports/denied_coverage/coveragedenied.pdf

skyrocketing disproportionate to inflation. In my congressional district, this provision has already helped protect 190,000 residents from price gouging by requiring health insurers to post and justify rate increases of 10% or more.[2] Across the country this provision has been used by state commissioners to save consumers millions of dollars.[3]

At this important 2-year anniversary, for constituents in my district and throughout the country, health care reform has already delivered important and tangible benefits due to a number of provisions in effect today. The parents of children living with preexisting conditions no longer have to worry about being denied coverage for their young ones. As a mother of a healthy 23 year old son, I am proud that our reformed health care system would allow me the option to keep him on my insurance policy until the age of 26 in the event he did not receive coverage through his employer. I visit senior centers regularly where seniors now understand that the Affordable Care Act strengthens their Medicare benefit by closing the prescription drug "donut hole," and expanding coverage – all while lowering costs to them. Under the expanded benefits of Medicare, seniors can receive annual physical and preventive screenings. And the small businesses in my district and around the country know that health care reform included a new 35 percent—enhanced to 50 percent in 2014—tax credit to help them as employers cover the cost of premiums paid to insure their workers. With tax filing deadlines approaching, employers should look for that credit filing on their return.

For women, the Affordable Care Act has had a remarkable impact on their ability to finally obtain affordable and comprehensive coverage. According to The Commonwealth Fund, when the law is fully implemented, nearly all the 27 million women ages 19 to 64 who were uninsured in 2010 will gain health coverage that meets their needs at a fair price.[4] By 2014, health care reform will keep insurance companies from denying women coverage due to "preexisting conditions," like experiencing domestic violence or pregnancy or acne. What a shame that we needed a law to ensure that insurance companies would not penalize women for those or other conditions—but I am happy to have a law that does just that.

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[2]Democratic Staff Report. House Committee on Energy and Commerce. Benefits of the Health Care Reform Law in the 4th Congressional District of Maryland. March 2012.
[3] U.S. Department of Human Services
[4] Robertson, Ruth and Sara R. Collins. (2011). Realizing Health Reform's Potential: Women at Risk: Why Increasing Numbers of Women Are Failing to Get the Health Care They Need and How the Affordable Care Act Will Help. The Commonwealth Fund. http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/May/1502_Robertson_women_at_risk_reform_brief_v3.pdf

Further, as the members of this panel – male and female – know, the act of choosing a doctor to care for your health needs is an important and personal decision. The Affordable Care Act ensures that women are able to choose any doctor they trust without a referral.

As if the insurance companies did not have enough influence over the health care decisions of women, prior to the passage of the Affordable Care Act insurers could also choose to charge a woman more for her individual insurance policy just because of her gender. The National Women's Law Center reports the practice of charging women more than men for the same coverage cost women $1 billion a year with little evidence to explain the difference.[5] Thankfully, today under the Affordable Care Act, the 7.5 million women who buy their own insurance are protected from these costly and discriminatory practices.

And now with the Affordable Care Act in place and the scientific findings of the Institute of Medicine, women will receive a full range of preventive services at no-cost share, including mammograms, colonoscopies, Pap tests, well-woman visits, HPV testing, contraception methods, and support for interpersonal and domestic violence. To date, 20 million women have accessed these free preventive services.[6] For minority women, who too often go uninsured, the Affordable Care Act will provide equal access to health care and close the health disparity gaps that plague women in these underserved communities.

The Patient Protection and Affordable Care Act is an historic improvement that will put health care back into the hands of consumers while ushering quality, affordable, and more accessible coverage for millions of Americans. In Maryland, by making sure people are healthy and care is accessible, we will save taxpayers and the health system $829 million over the next ten years while cutting the number of uninsured in our state in half.

I appreciate the opportunity to appear before the committee today to offer my perspective on this vital law and am happy to answer any questions that my colleagues may have.

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[5] Garrett, Danielle. (2012). "Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act." National Women's Law Center. http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf.

[6] U.S. Department of Health and Human Services

Mr. STEARNS. I thank both of you.

Senator Johnson, do you have time to answer any questions?

Mr. JOHNSON. I believe so. I will run out of here at the last minute.

Mr. STEARNS. OK, because I saw that you might have a vote here in the Senate.

I guess the question for you would be, what experiences in the private sector have you had that give you insight into our impending problem with Obamacare?

Mr. JOHNSON. Well, really, two pretty significant ones. First of all, as a small- to medium-size business owner, I purchase health care for the people who worked with me for over 31 years, so I certainly understand the thought process, the decision-making process that will be going into those health care purchasing decisions moving forward and certainly the passage of Obamacare changes the equation entirely. I mean, put yourself in the position of a business owner trying to comply with currently 15,000 pages, and that is just simply going to grow, and then take a look at the cost equation. So we have totally changed the equation in terms of how are we going to buy health care.

But the other experience, life experience, that was pretty significant was the birth of our first child, our daughter, Carrie, who was born with a very serious congenital heart defect, her aorta and pulmonary artery reversed. So the first day of life, she was rushed down where, you know, one of those doctors came in 1:30 in the morning and saved her life. And then 8 months later when her heart was the size of a small plum, some other incredibly dedicated medical professionals reconstructed the upper chamber of her heart. So her heart operates backwards right now. But she is a nurse herself and she is a 28-year-old woman practicing medicine because my wife and I had the freedom. Again, this was ordinary insurance coverage. This was no Cadillac plan. We had the freedom to seek out the most advanced surgical technique at the time which allowed Carrie to have such a wonderful result. So I have got very direct experience both in terms of buying health care as well as being on the consumption side of that in a wonderful story that has a very happy ending.

Mr. STEARNS. Senator, I also had a small business myself, and understanding the complexities. Do you think if health care is put in place, do you think employers will sort of dump employees all into the exchanges? What is your estimation of what will happen there?

Mr. JOHNSON. Well, that is a concern, and the CBO initially estimated only a million people would, but there have been surveys, and the McKenzie is the one that I quoted that said 30 to 50 percent of employers—and by the way, that percentage goes up the more they know about the health care law—plan to do just that.

Now, will they actually do it? Nobody knows. But what we are trying to get the CBO to do is let us give us the information just in case. I mean, what if half of the people that get their insurance through employer-sponsored plans actually lose it and access the exchanges under very high levels of subsidy? That would be 75 to 80 million people, and then of course, that would result in cost shifting, putting more pressure on premium rates, which would

cause even more employees to lose their health care overage. And quite frankly, Chairman, I think that is exactly the way that this health care was designed. It was designed to lead to government takeover of the health care system basically a single-payer system.

Mr. STEARNS. Congresswoman Edwards, you heard the opening statement of Ms. DeGette in which she talked about the Medicare, and I think either she or Mr. Waxman talked about Medicare and how the Paul Ryan budget would impact Medicare. Are you concerned, I think like a lot of us are, that when we passed Obamacare, there was a cut of $500 billion from Medicare? Does that concern you at all that these cuts are, one, feasible or are they accounting gimmicks or will it ever happen, I guess?

Ms. EDWARDS. Thank you, Mr. Chairman, for the question, but let us look at the facts. In fact, what has happened is that we are actually saving seniors and providing additional benefits with the savings that have been achieved in Medicare, because after all, that went back into the Medicare system, and so when I look at our seniors, for example, who receive—who are working up to that donut hole and that they now can actually receive a benefit that wouldn't by closing the donut hole, those are benefits. When I look at seniors who now can go for an annual physical so that they can look down the line to avoid illnesses or conditions that might otherwise impact them negatively, those seniors are actually receiving benefits through the savings that we actually achieve in Medicare. And so I think the American people should actually have the facts straight in terms of what we did with Medicare and what we did was enhance benefits for Medicare recipients so that we can ensure the coverage of preventive care, close the donut hole, and make sure that we have a system where we are able to enforce fraud as well.

Mr. STEARNS. I would say in defense of what you said is, what you are talking about, paying for subsidies, but the $500 billion is actually impacting Medicare and this is something that the second panel can bring out because most of us feel that $500 billion will have a huge impact on Medicare and that is going to what I think Senator Johnson talked about, a lot of these doctors and others are just going to not want to take Medicare.

With that, I recognize the ranking member.

Ms. DEGETTE. Thank you very much, Mr. Chairman.

Senator, thank you for coming over, slumming it with us here in the House. When you talked about your young daughter who had the heart surgery, it struck a chord with me because I have a daughter who was diagnosed with type 1 diabetes at age 4 when I was in my first term in Congress, and I lived like you did, you know, with the uncertainty of a chronically ill child who would be ill for her whole life, and I was terrified for many, many years about the idea that when she turned 18 or when she graduated from college, she might be uninsurable. In fact, my husband and I actually went to see our attorney about trying to set up some kind of a fund from our earnings. You know, forget about college, we were worried, could she afford to pay for her diabetes care. And there is 17 million children in this country who have preexisting conditions like your daughter and my daughter who now will be guaranteed that they will have insurance. I would imagine—I know

that you are against the Affordable Care Act and I know that you would like to repeal it, but I would imagine you would think it would be a good thing if insurance companies couldn't simply drop kids because they had preexisting conditions.

Mr. JOHNSON. Well, first of all, there is a far simpler solution. We didn't need a 2,700-page bill. We didn't need——

Ms. DEGETTE. What is that solution?

Mr. JOHNSON. So the solution is what many States have, most States have, high-risk pools, and they work very well. And the way they work is, every insurance carrier that is licensed in the State has to participate in those pools, and it is a known risk, it is actually pooling the risk. That is what insurance is all about. So that when people are uninsurable, they become eligible for those high-risk pools and those insurance rates are subsidized. Again, we are a very compassionate society here and we want to provide a strong social safety net so we are very certainly supportive of that but we didn't need to pass a 2,700-page bill and a virtual national takeover, Federal takeover of our health care system to accomplish that goal.

Ms. DEGETTE. So in Wisconsin, for example, under the Affordable Care Act, there is 95,000 kids that would be in that situation. Does Wisconsin have a high-risk pool?

Mr. JOHNSON. Yes, it does.

Ms. DEGETTE. And were all of those kids covered in the high-risk pool?

Mr. JOHNSON. That I couldn't say. Am I saying the high-risk pools are perfect? No, but we could have made adjustments to those on a State-by-State basis as opposed to a total Federal Government solution.

Ms. DEGETTE. OK, and do you have any idea how much it would cost, say, in Wisconsin or Colorado to insure 95,000 kids that weren't already insured in those high-risk pools?

Mr. JOHNSON. I don't have exact figures but I have in my previous life as a business owner, I have looked at the insurance rates for the high-risk pool in Wisconsin. They were very comparable to the same rates we were paying on an annual basis with our business plan, very comparable.

Ms. DEGETTE. Right. And does every State have a high-risk pool like that?

Mr. JOHNSON. I am not sure. Not every State but the vast majority do.

Ms. DEGETTE. See, the question I am asking is, all of these 17 million kids who now can't be discriminated against, these are kids who previously were not insured in the high-risk pools. So I am just wondering if you or your staff had done the math to figure out how much extra it would cost in the States to give those subsidies, because I don't know about your State but in my State, we are having difficulty keeping our police officers and our firefighters and our teachers on the payroll.

Mr. JOHNSON. Let me just answer by saying I would like to dispel a notion, because I hear it over and over again that now seniors are obtaining preventive services for free and we are offering coverage to, you know, children up to the age of 26 for free. Nothing is free. We are just spreading the risks. And I would say when we

spread it and we filter it through the Federal Government, which by the way there aren't too many Americans who think that the Federal Government is capable of taking over one-sixth of our economy, to do it effectively and efficiently. I think going through a Federal government is the least efficient way of pooling those risks and taking care of those individuals.

Ms. DEGETTE. OK. I hear what you are saying. I disagree but I hear what you are saying.

Now, Congresswoman Edwards, I just wanted to ask you a question. The chairman asked you about Medicare cuts under the Affordable Care Act. Have you glanced at the new Ryan budget that was introduced yesterday?

Ms. EDWARDS. Well, it is very disturbing actually because I think that what the new majority budget does it, it actually undercuts Medicare. I mean, we would in effect be saying to our seniors, not only are we going to get rid of the program that you have known and that you trust and that delivers efficient care; we would be saying to you, we are going to ask you to reach into your pocket for thousands of dollars that we know that you don't have in order to—I don't know. It looks to me it would be turning Medicare into a private kind of system where individual seniors would be kind of out on the marketplace in order to obtain their health care. I don't think that that is the system that the American people want, and I think for the seniors that I visit in my Congressional district and I would imagine that this is true across the country, that those seniors right now must be wondering what it is that we are thinking here on Capitol Hill that we would take a system that is working, that is providing a benefit that they too have paid into and ripping that out from under them.

Ms. DEGETTE. Thank you very much.

Mr. STEARNS. The gentlelady's time has expired.

Senator Johnson has to leave in about 5 minutes or less. Anybody on my side would like to ask questions? Dr. Burgess?

Mr. BURGESS. I thank the chairman for yielding.

Senator Johnson, this is something with which I worked with the previous ranking member on the Health Subcommittee, Nathan Deal, who is now Governor of Georgia, on the preexisting condition issue, and I think you are exactly right. In fact, when Senator McCain was running for President, one of the difficulties he had when he articulated a very detailed plan on health care as opposed to an amorphous plan but the detailed plan that Senator McCain talked about in fact built on the very structure that you talked about, the already existing State risk pools, State reinsurance programs and I think there were a couple of other novel ways that States dealt with this. In Texas, I am a physician. I practiced for a long time. I can't tell you that I ever saw anyone who was covered under one of the risk pools but I understand since entering into this discussion in the last several years that there are many people in Texas who are covered and do not want to see that coverage changed in any way whatsoever. I can promise you, I never got a reimbursement check from the State high-risk pool as a physician, but at the same time, I think there is ample evidence that they do work.

The problem is, that the State is limited in the amount of subsidy that they can provide, so if we were going to build something, it would have made a lot more sense to build on those 35 State programs that already existed. Now, Nathan Deal was very sensitive not wanting to create a new State mandate but he suggested that a Federal subsidy could be available to a State that was willing to provide such coverage and make it an incentive rather than a punishment. Those bills were introduced in the 111th Congress, H.R. 4019, 4020, for anyone who is keeping score at home. Those things are ready to go as part of any replacement strategy if something happens to the Affordable Care Act like the Supreme Court voids its existence at the end of June when they provide us with their ruling.

So I just wanted to emphasize, I think you are right on the mark. We will hear from Mr. Larsen about the high-risk pools and the success they have had but we were led to believe when this debate was going on, and I don't believe you were in the Senate when the debate was going on, but we were led to believe through the popular media and through discussions with the President that this number was 5 million people, 8 million people, 15 million people who were not covered because of preexisting conditions, 50,000 people in the first 2 years of this new Federal subsidy that was set up and how much more could have been done had a program been designed that would have helped the States do what they were doing already, in other words, augmented the help that they were providing, and for the life of me I have never understood why we took it upon ourselves to set up a brand-new Federal program, a brand-new Federal agency, all new computers, all new staplers, and didn't utilize the structure that was already there in your State and my State and 35 other States across the country. Do you have any thoughts on that?

Mr. JOHNSON. Before I go, I will make two points. First of all, as I recall, and I wasn't here at the point in time, but it was very difficult to get people signed up for the Federal program initially. With the initially set premiums, only a couple thousand people signed up, so they had to drastically the premium rate to even get the 50,000 which is way under the estimate. I also want to just dispel the notion that Republicans don't have solutions. We have plenty of solutions. You know, why don't we reform our malpractice and save hundreds of billions in defensive medicine, and finally dispel the notion that Medicare and Federal Government doesn't deny benefits. They actually deny benefits to almost twice the rate of large employers at about a 4 percent rate versus about a 2 percent for most large insurance companies. So again, there is an awful lot of misinformation, and with that, Mr. Chairman, again, I appreciate it and I am going to have to go take a vote.

Mr. STEARNS. Senator Johnson, thank you very much for taking your time to come over from the Senate.

Mr. BURGESS. Let me reserve the balance of my time. We will let the Senator leave, but I just to make one other point on the preexisting conditions for kids. There was a drafting error in the Affordable Care Act as it was passed by the House and Senate and signed. Indeed, the Affordable Care Act said that insurance companies could not limit coverage for kids but there was nothing that

prevented them from denying coverage to children. So the actual loophole that would have allowed insurance companies to get out from under covering preexisting conditions for children still existed at the signing of the Affordable Care Act, and because most of the insurance companies said "Hey, look, we understand it was a drafting error, we will do the right thing and not deny coverage to those children." In fact, that is what allowed the Affordable Care Act to work. But it was just one more example of the numerous drafting errors that were contained in this thing, and the reason there were drafting errors was because it was rushed through, it was force fed through the Congress and force fed on the American people, which is why it has never enjoyed immense popularity, and we are going to get into more of that as this goes on. I will yield back.

Mr. STEARNS. All right. We would thank the gentlelady from Maryland for attending with Senator Johnson. You also can leave and we will go onto our second panel. Thank you.

I would say just a comment to my colleague from Texas, that it would be nice to see on the Democrat side their plan to save Medicare. Congressman Paul Ryan has come up with a plan to save Medicare and it would be awfully nice to hear either the President or the Democrats provide us a plan.

With that, the second panel is welcomed. We have just one witness, my colleague, Mr. Steve Larsen, the Director of the Center for Consumer Information and Insurance Oversight.

Mr. Larsen, I think you are aware that the committee is holding an investigative hearing, and when doing so has had the practice of taking testimony under oath. Do you have any objection to testifying under oath?

Mr. LARSEN. No.

Mr. STEARNS. OK. The Chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony this morning?

Mr. LARSEN. No.

Mr. STEARNS. In that case, if you would please rise and raise your right hand?

[Witness sworn.]

Mr. STEARNS. You are now under oath and subject to the penalties set forth in Title XVIII, Section 1001 of the United States Code. We welcome your 5-minute summary of your written statement.

STATEMENT OF STEVE LARSEN, DIRECTOR, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. LARSEN. Chairman Stearns, Ranking Member DeGette, members of the subcommittee, thank you for opportunity today to highlight the efforts of CMS and my office, CCIIO, in implementing the provisions of the Affordable Care Act.

Over the last 2 years, we have been focusing on implementing the ACA as smoothly as possible in a way that continues to strengthen the productive partnership between the private sector and our office and the government.

I would like to highlight some of the very important provisions of the ACA and the benefits that they provided to millions of Americans already. For example, in the past, young adults making the transition from school to work have been more likely than any other group to go without health insurance. The ACA makes it easier for younger Americans to get health insurance coverage because the law allows young adults to be covered under their parents' policies up through the age of 26, and about 2–1/2 million young adults have already gained health insurance coverage because of this part of the law.

In addition to helping young people find health care coverage, CMS established the Preexisting Condition Insurance Program or PCIP, which we talked about. It was created under the ACA and it provides an affordable coverage option for uninsured people with preexisting conditions until the broader reforms of the ACA take effect in 2014. Already, PCIP is helping 50,000 Americans with preexisting medical conditions to access critical health care services. Many of these individuals have been diagnosed with cancer and other life-threatening diseases, and without PCIP would have no other coverage options.

Besides ensuring that people have access to private health insurance coverage, CMS is working to implement new rights and benefits for consumers. For example, insurance companies can no longer drop or rescind someone's policy simply because they made an unintentional mistake on their application. Insurance companies can't place lifetime limits on the dollar value of the benefits in the policy. Before, cancer patients and individuals with serious and chronic and expensive diseases often had limited treatment or went without treatment because they had reached their insurer's lifetime dollar limits on their health insurance coverage. Now with this provision in place, about 105 million Americans including nearly 28 million children enjoy better coverage without the worry of bumping up against lifetime dollar limits.

Also, about 54 million Americans in new insurance plans are receiving expanded coverage for recommended preventive services without additional out-of-pocket payments including colonoscopy screenings for cancer, Pap smears and mammograms for women, well-child visits, flu shots and other preventive services.

The ACA also increases transparency for consumers. Starting this September, health insurers in group health plans will have to provide clear information about health plan benefits and coverage in a consistent, easily understandable format that allows apples-to-apples comparisons.

The ACA also helps make sure people get value for insurance premiums. For example, the rate review program does this by making sure that proposed rate increases that exceed 10 percent in the small group and individual market are reviewed by experts in order to make sure that they are reasonable. Rate review is primarily a State-based reform with the majority of the States, not HHS, conducting these reviews.

The medical loss ratio provision makes sure that people get value for their premiums by requiring that insurance companies spend 80 or 85 percent of the premium revenue for medical care and to improve the health care quality for their customers. We know many

insurers are moderating their rates in order to meet the MLR standard already.

We have worked steadily towards establishing the Affordable Insurance Exchanges. We have issued extensive guidance to States and other stakeholders over the last 2 years in many areas related to exchanges, and earlier this month we released the final rules on exchanges that provide flexibility to States to build exchanges that work for them in their State. And we know that States are making good progress toward establishing their own exchanges.

CMS is proud of all that we have accomplished in the last 2 years, and I look forward to partnering with Congress, the States, consumers, businesses and other stakeholders across the country to strengthen insurance options.

Thank you for the opportunity to discuss the work that CMS and CCIIO has been doing to implement the ACA.

[The prepared statement of Mr. Larsen follows:]

STATEMENT OF

STEVEN B. LARSEN

DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT,
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

MARCH 21, 2012

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"
March 21, 2012

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 States[2] 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.

Mr. STEARNS. Mr. Larsen, thank you very much. I will start with my questions.

You know, the main point of contention is the mandate, and of course, the Supreme Court will be looking at that shortly. So if you can, just answer the question yes or no. Is your office going to be responsible for enforcing the mandate? Yes or no.

Mr. LARSEN. Well, in conjunction with our colleagues at the Department of Treasury and the IRS.

Mr. STEARNS. So will you have the main responsibility in your office for enforcing the mandate?

Mr. LARSEN. Well, the individual responsibility provisions ultimately are enforced through the Tax Code, so it is largely IRS and Treasury.

Mr. STEARNS. But have you worked out any provisions in terms of a narrative on how you are going to enforce the mandate in your office?

Mr. LARSEN. Not yet, no.

Mr. STEARNS. And since you run the exchange, how will you determine if an individual has purchased health care or not?

Mr. LARSEN. Well, that is one of the issues that we are working through now is the data that we collect through the exchanges and through employers to know who has coverage and who doesn't, and again, that is——

Mr. STEARNS. Will this data be precise? Will you be able to tell if a person has health care or not?

Mr. LARSEN. Yes.

Mr. STEARNS. And how will you determine that?

Mr. LARSEN. Well, it will involve getting information from both employees and individuals and——

Mr. STEARNS. Is this going to be voluntary?

Mr. LARSEN [continuing]. From employers to provide the information.

Mr. STEARNS. Will this be voluntary to the employees and to the employer?

Mr. LARSEN. Well, the employees and individuals will want to provide the information so that they can know that we know that they have health insurance coverage, and employers will want to give the information so that they know that they——

Mr. STEARNS. So you are saying it is all voluntary?

Mr. LARSEN. Well, I am not sure quite how to answer that because obviously there are——

Mr. STEARNS. I think it is not voluntary.

Mr. LARSEN. Well, there are financial provisions that apply.

Mr. STEARNS. It is called a mandate.

Mr. LARSEN. People can choose——

Mr. STEARNS. Let me ask you, what kind of manpower is going to be required in your office to enforce this mandate?

Mr. LARSEN. That I don't know yet.

Mr. STEARNS. So you have no idea whether you are going to increase the number of people?

Mr. LARSEN. Well, we have plans to increase our staff in connection with the areas that we are enforcing. I don't know what the plans are with respect to IRS.

Mr. STEARNS. OK. When does enrollment in the exchanges begin?

Mr. LARSEN. Well, the exchanges have to be up and running in January of 2014, and so there will be an open enrollment preceding that in October of 2013.

Mr. STEARNS. What rulemaking have you issued with regard to these exchanges?

Mr. LARSEN. We have issued a number of rules both final rules, proposed rules and then guidance to the States on a range of topics. As I mentioned, we did just release the final exchange rule. There is a rule that we call the 3 R's rule that is——

Mr. STEARNS. Three R's?

Mr. LARSEN [continuing]. Insurance, risk adjustment and risk quarters, which are financial mechanisms to stabilize the market in 2014, so that final rule was issued. There were final rules on the Medicaid provisions that relate to exchanges as well, and there have been a number of papers and bulletins that we have released on topics such as——

Mr. STEARNS. It sounds a little complicated.

Mr. LARSEN. Well, it is not complicated but there is a lot of work to do to get ready for 2014.

Mr. STEARNS. When can we expect the rules on essential health benefits and actuarial value to be released?

Mr. LARSEN. Hopefully soon. We are working on that. We released initial guidance to the States back in December and we have issued additional guidance after that in the form of questions and answers, and we know States and issuers are anxious to get that information, so hopefully in the near future.

Mr. STEARNS. Have you conducted any analysis of the effect on family or individual premiums?

Mr. LARSEN. We have not conducted an analysis of that at this point.

Mr. STEARNS. Who is going to do that, or when it is going to be done?

Mr. LARSEN. Well, we will be doing that. I know CBO has looked at that. A number of private entities have looked at potential rate impacts. States have looked at that. It does vary——

Mr. STEARNS. Wouldn't this affect some of the decisions you make? You are saying CBO is going to do this but shouldn't you folks do analysis of your own to see the effect of the premiums on individuals and families?

Mr. LARSEN. We will.

Mr. STEARNS. You will? So you are not going to kick it to CBO, you expect to do your own?

Mr. LARSEN. Yes.

Mr. STEARNS. In the analysis that you have done so far, does it appear that the premiums are going to go up or go down?

Mr. LARSEN. It really varies by State and by the individual involved because——

Mr. STEARNS. Well, let us take Virginia, for example.

Mr. LARSEN. Well, I don't know the specifics of any particular State. I guess what I was going to say is——

Mr. STEARNS. Do you know the particulars of any State?

Mr. LARSEN. No, I don't know the particulars of any State.

Mr. STEARNS. OK. Your testimony states that beginning in 2014, the exchanges will provide improved access to insurance coverage

choices for an estimated 20 million Americans by 2016. How was this analysis done? Who did it? In-house?

Mr. LARSEN. The 20 million comes from the CBO report, in other words, when CBO estimated both the financial impact and the uptake through the exchanges, that was in their—and that was in their most recent report.

Mr. STEARNS. Are these people that already have health insurance or are these people that don't?

Mr. LARSEN. Well, it is a combination of people but it is a number of people that will be eligible for the subsidies that are available for people with incomes below 400 percent, and then there will be people that aren't eligible for subsidies but will still access the exchanges.

Mr. STEARNS. Would it be fair to say a lot of those people in the 20 million already have health insurance of their own and that their employer provides?

Mr. LARSEN. Most of them won't because again, according to the CBO estimates, you have got a reduction in the number of uninsured in the United States by about 30 million people as a result of the Affordable Care Act so there are many, many people that don't have access to affordable coverage today that will be able to have that.

Mr. STEARNS. All right. I will just conclude. Mr. Larsen, if you could provide this analysis for us, that would be appreciated.

Mr. LARSEN. OK.

Mr. STEARNS. With that, the ranking member is recognized.

Ms. DEGETTE. Thank you very much, Mr. Chairman.

Mr. Larsen, Senator Johnson seemed to—one of his main concerns, and this is a valid concern, I think, is what will happen to employer-based coverage under the Affordable Care Act because what we tried to do was to build, as you know—we tried to build off of the employer-based system that is already in place while adding some new consumer protections and trying to increase the pool so that that will decrease actuarial costs. CBO's most recent analysis of the employer-based health insurance coverage under the Affordable Care Act, as you know, presented a range of scenarios for potential changes in employer coverage, and Senator Johnson seemed to assume that the vast majority of employers are simply going to drop their employees. But while CBO said it was possible there could be a net reduction, they said roughly maybe 3 to 5 million might lose their employer-based coverage. They also said that "a sharp decline in employment-based health insurance as a result of the ACA is unlikely" and the CBO maintained its position that the bill will extend health coverage to more than 30 million people. Do you agree with CBO's assessment that the new law is not likely to result in a sharp decline in employer-based coverage?

Mr. LARSEN. We don't think it will, and I think if you look at the number of models that other groups have done whether it is Rand Health or the Urban Institute, both of those groups have indicated that in fact employer-based coverage will increase, and then you are right, CBO estimated a very small reduction in employer-based coverage, but of course, that is across a base of about 160 million Americans.

Ms. DEGETTE. So why would employers choose to keep their people on insurance under the Affordable Care Act? Why would they choose to keep their people on employer-based insurance under the Affordable Care Act?

Mr. LARSEN. There are many reasons. One is that both the employer and the employee get tax advantages from employer-based coverage.

Ms. DEGETTE. Right. So like if there is a small employer that wants to offer insurance right now, and most employers do, I would think, they would get a tax advantage by offering that they don't have until this is implemented, right?

Mr. LARSEN. Exactly. Yes.

Ms. DEGETTE. OK. Now, let us say there are some employees who lose their employer-based insurance. They are like the Senator. They don't want a Federal mandate so they say I am not going to offer the insurance. Those employees could go into the exchanges then, right?

Mr. LARSEN. Yes.

Ms. DEGETTE. Now, what would happen to people like that? You know, in the economic downturn, a lot of employers just couldn't offer insurance to their employees. What happened to those employees who lose their employer-based insurance?

Mr. LARSEN. Well, they ended up in—at least now without exchanges and the protections in the market, they ended up probably without coverage.

Ms. DEGETTE. I mean, they have the option in the individual market right now.

Mr. LARSEN. They do.

Ms. DEGETTE. But that is wildly expensive in most places.

Mr. LARSEN. It is expensive, and there is underwriting so that if you have a preexisting condition, in most States you may not get coverage or you may not have coverage for your preexisting condition.

Ms. DEGETTE. So under the Affordable Care Act, if, heaven forbid, an employer drops somebody, they can still go through the exchanges?

Mr. LARSEN. That is right.

Ms. DEGETTE. And is it anticipated that those exchanges are going to be as costly for those individuals to buy insurance policies as the private market is right now?

Mr. LARSEN. Well, the exchanges bring major advantages compared to the individual market today. One is administrative efficiency, and two is a much broader risk pool that is segmented today and CBO estimated that there were reductions that would occur in premiums as a result of the better risk pool and the administrative efficiency.

Ms. DEGETTE. Thank you. Now, I want to ask you a couple of questions about the women's health care benefits under the Affordable Care Act. I just want to ask you a basic question. Prior to enactment of the ACA, did all Americans and in particular women have access to basic preventative health services?

Mr. LARSEN. No.

Ms. DEGETTE. Can you give me an example of the types of services that are not currently always covered by health insurance and that will be covered by the Affordable Care Act?

Mr. LARSEN. Well, many of the ones that IOM recommended including, you know, cancer screening, counseling, domestic violence screening and education, contraception, the recommendations that IOM came up with.

Ms. DEGETTE. And the IOM did that on a scientific basis, deciding what actually was necessary for women's health, correct?

Mr. LARSEN. That is right.

Ms. DEGETTE. And HHS implemented the recommendations of the Institute of Medicine?

Mr. LARSEN. We did.

Ms. DEGETTE. OK. Now, my understanding is that an estimated 20 million women nationwide are already benefiting from these new preventative care requirements. Is that correct?

Mr. LARSEN. Well, the broader range of preventive services that went into effect already, and of course, the specific dialog about the contraceptive services around a different schedule.

Ms. DEGETTE. OK, but everything except for the contraceptive services——

Mr. LARSEN. Yes.

Ms. DEGETTE [continuing]. 20 million people are already benefiting from that?

Mr. LARSEN. Yes.

Ms. DEGETTE. One last question. Would you expect that preventive care benefits might result in cost savings, not only for patients but for the health care system overall?

Mr. LARSEN. Yes.

Ms. DEGETTE. Thank you.

Mr. STEARNS. The gentlelady's time is expired.

Dr. Burgess is recognized for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman.

Mr. Larsen, again, thank you for being here. Thank you for the information you have provided our office. In the passed law, there was a broad $1 billion implementation fund to administer the implementation of the health care law. Is that correct?

Mr. LARSEN. That is right.

Mr. BURGESS. Section 1005, as I recall. You provided us some documents November 1st, that $150 million of this fund had been spent by the Senator. Is that correct?

Mr. LARSEN. It sounds a little high to me but I would have to go back and look.

Mr. BURGESS. Well, the October numbers you provided showed $116 million in outlays, so that was about a $35 million increase, but also in October you provided information that there were $242 million in obligations. Now, the obligation figure wasn't provided for December but I have to assume that the obligation number had to go up as well as the number for outlays. Is that correct?

Mr. LARSEN. I would have to check because we executed a number of procurement contracts to help with the building of the exchanges, which would be reflected as an obligation, and those were done last year as opposed to the outlays, which were——

Mr. BURGESS. Well, here is the question. Can you tell us today how much money remains unobligated in the implementation fund?

Mr. LARSEN. The entire implementation fund? I can't. I mean, as I think you saw in the materials we provided in January, the $1 billion implementation fund is for all agencies at this point, so IRS, Treasury, Department of Labor, HHS. So there are kind of other folks that I would have to consult with to get you that number.

Mr. BURGESS. But still, I mean, you know of our interest in this and we are having the hearing, so we need the information.

Mr. LARSEN. OK.

Mr. BURGESS. And I referenced this in my opening statement. I mean, the Supreme Court is going to hear this case next week, and whether you think that is a good thing or a bad thing, I mean, it is a fact of life. It is going to happen. They will rule and they will provide us a ruling presumably before their term ends in June. Now, you may think that the likelihood is low that they would agree with Judge Vincent and the Federal District Court in Florida that the entire law is unconstitutional, not severable, therefore gone, and you may disagree with that, but there is a possibility that the court will find in accordance with Judge Vincent's ruling from Florida.

Now, I already referenced in my opening statement that you were never authorized in statute. You don't have to worry. If they void the entire law, you weren't authorized in it anyway so you will still be there but your money won't, will it, if the entire Affordable Care Act were to be struck down, or does your money exist outside the structure of the Affordable Care Act?

Mr. LARSEN. You know, that is a—I hate to say it. I mean, I think that is a legal issue that we would have to consult with our lawyers. If the court were to strike down the law, which we don't believe it will, and that means the entire law as opposed to, you know, certain portions of it, I don't know the exact mechanism that occurs with respect to funding for the law. For example, the billion dollars largely is for the implementation of exchange-related activity.

Mr. BURGESS. You know, an observation. If I were in your position, and I thank God every day that I am not, but if I had your job and this was out there, I think I would at least have in the back of my mind some contingency plan for what happens next because you have got all these States that are planning their exchanges. They are all looking to you for guidance. They are waiting on the rules to be finalized. I mean, there is a lot of people whose lives will be turned upside down and you would be the logical place to minimize that tumultuousness, if that is a world.

Mr. LARSEN. Right, but there is a whole range of activities and provisions within the ACA, not just the individual responsibility, guaranteed issue, guaranteed renewability, the market reforms and of course the exchange provisions, many of which are not I think being challenged, although some people would like to see the whole law overturned.

Mr. BURGESS. Well, again, Judge Vincent——

Mr. LARSEN. Many people are focused primarily on the individual responsibility part.

Mr. BURGESS. Right, but Judge Vincent in his opinion said the whole thing went away.

Donna Edwards in her testimony, she talked about how women are going to be able to choose any doctor they want without a referral. Section 1311(h) in the law, and I questioned the Secretary about this and she seemed absolutely unprepared to answer, maybe you can help us with that. Under 1311(h) in the law as written, really, you are not going to have the availability of any doctor you want. You are going to have the availability of any doctor that the Secretary says you can have, as I read Section 1311(h), the health provider only if such provider implements such mechanisms to improve health quality as the Secretary may be regulation require. Now, that could be something like board certification but it could also be quality as determined by will you accept Medicare or Medicaid as well as patients in the exchange. Have you all looked into how that actual aspect of the law is going to be administered?

Mr. LARSEN. I will have to go back and look at that because I have not focused on that particular provision.

Mr. BURGESS. It seems like no one is focusing on that within the agency but it is really going to be quite, again, tumultuous to the provider community out there if their lives are suddenly turned upside down by a ruling by the Secretary of Health and Human Services. So do everyone some—provide some value in doing that.

Thank you, Mr. Chairman. I will yield back.

Mr. STEARNS. The ranking member from California is recognized for 5 minutes.

Mr. WAXMAN. Mr. Chairman, the benefits from health reform are already being delivered. Millions of seniors are saving billions of dollars on Medicare prescription drugs. Hundreds of millions of Americans have new insurance protections and millions of children with preexisting conditions have access to coverage for the first time, and the law will reduce the deficit by hundreds of billions of dollars. Yesterday, the House Republicans released a new budget plan that turns its back on all this progress.

Mr. Larsen, what impact would the Ryan budget have on the reforms your office has put into place?

Mr. LARSEN. Congressman Waxman, I will have to defer on that question because I actually haven't had——

Mr. WAXMAN. Well, the Republican budget would repeal the important Affordable Care Act provisions that expand health care——

Mr. DINGELL. If the gentleman would yield, could you summarize for the record?

Mr. WAXMAN. The Republican budget would repeal the important Affordable Care Act provisions that expand health care coverage and prevent the worst abuses performed by the insurance industry.

If the Ryan budget became law, would insurance companies again be able to impose lifetime coverage limits on the 105 million more Americans who now benefit from this protection?

Mr. LARSEN. If it were repealed, absolutely.

Mr. WAXMAN. If the Ryan budget became law, would the 2.5 million young adults who now have health insurance coverage continue to be covered under their parents' plan?

Mr. LARSEN. No.

Mr. WAXMAN. If the Ryan budget became law, would insurers again be able to deny coverage to the up to 27,000 children in my district and the 17 million nationwide with preexisting conditions?

Mr. LARSEN. Yes.

Mr. WAXMAN. If the Ryan budget became law, would insurers again be able to spend, 30, 40, even 50 percent of enrollees' premiums on profits and administrative costs?

Mr. LARSEN. Yes.

Mr. WAXMAN. And if the Ryan budget became law, what impact would it have on the number of Americans without insurance coverage?

Mr. LARSEN. Well, they would have the situation that they have today which is a very challenging, broken market where it is difficult for individuals——

Mr. WAXMAN. Thirty million Americans would be covered under the Affordable Care Act who are not now covered, and I assume that they will go without coverage if the act is repealed?

Mr. LARSEN. As many are today.

Mr. WAXMAN. There is no Republican alternative to the Affordable Care Act benefits. They offer only repeal. But the Republican budget goes beyond repeal. It decimates all the critical consumer protections in the Affordable Care Act without offering any solutions to the broken insurance market. It puts Americans back at the mercy of the health insurance companies, and it leads to 33 million more uninsured Americans. But that is not all it does. The Ryan budget eliminates Medicare as we know it and destroys the Medicare safety net, all in the name of tax breaks for millionaires and billionaires. The cuts are staggering and deeply disturbing.

The Ryan budget cuts $810 billion from Medicaid by turning it into a block grant and then another $931 billion from the program by repealing the Affordable Care Act. That is a $1.7 trillion cut over 10 years from the program that protects poor children born with disabilities and pays for the care of our sickest and most vulnerable seniors.

The Republican budget could not be more wrong for America. It would roll back the clock on the dramatic benefits we are already seeing from the Affordable Care Act. It would decimate Medicaid, cutting three-quarters of our support, three-quarters of our support for the sickest and most vulnerable people in the Nation. It would cut hundreds of billions of dollars from the Medicare program on top of the cuts they complain about on the other side of the aisle in Medicare expenditures in the Affordable Care Act. They keep that in place. And they would end the Medicare program's guaranteed benefit for seniors.

Mr. Chairman, this is not the right path for this Nation. I yield back my time.

Mr. STEARNS. I thank the gentleman. I assume that was a question you had.

We recognize on this side, Mrs. Blackburn is not here, Mr. Scalise is recognized for 5 minutes.

Mr. SCALISE. Thank you, Mr. Chairman, and Mr. Larsen, I appreciate you coming back to our committee as we approach the 2-year anniversary. I know a lot of the questions that many of us have deal with the effects that we are already hearing from our

constituents about, and, you know, unfortunately, the constituents that I talk to and especially our small business owners who I constantly meet with back home, the biggest complaint that they have is that under the rules they have already seen, let alone the rules that haven't been written, they don't see how they are going to be able to comply with the law and in fact many of them are facing the not desirable option but the almost necessity that they will no longer be able to provide health care for their employees. We have seen reports that millions of Americans will lose the health care that they have today that they like. You know, with that, one of the big promises that President Obama made was if you like what you have, you can keep it. Do you feel—you are under oath. Do you feel that that promise has been kept?

Mr. LARSEN. Yes, I do, absolutely, and I think that——

Mr. SCALISE. Well, are you denying then that there are already, millions of people that are facing losing their health care because of this law that they like?

Mr. LARSEN. Well, it is not because of this law, and I think if you look back——

Mr. SCALISE. That might be your opinion.

Mr. LARSEN [continuing]. In the last 10 or 20 years, and I have been doing this for a long time starting with when I was insurance commissioner, even back in the '90s, the rising insurance rates for small businesses was a huge issue, and that continues today, and it really illustrates why we need the Affordable Care Act.

Mr. SCALISE. Well, but if you go back to the beginning of the debate on the health care law, you know, 3 or so years ago, you know, the biggest problems back then were cost and other problems like discrimination against people based on preexisting conditions. Now, we put forth legislation that would have actually lowered the cost of health care. That was rejected by the President. We put forward legislation that would prevent discrimination based on preexisting conditions. The President's health care law has actually been scored to have increased the cost of health care. It actually made it worse. The cost is worse now. And our small businesses—and maybe you talk to different people than I do, and I guess that gets to this question of the waivers. You know, so many small businesses I talk to would love to have a waiver from the law, and even components of the law, and I know, you know, we have talked about this waiver issue before, you know, but it seems like there was a lot of crony capitalism that was played in issuing of waivers to people that in many cases helped support the law, came to Washington and said pass this law, it is important to pass, and then they went to the White House and got a special waiver from the law. How many waivers have been given, you know, whether from——

Mr. LARSEN. Well, first, I do have to say that is not how the process worked. We ran a very open, transparent fair process that didn't favor anybody based on what their political background is.

Mr. SCALISE. Well, why is it that small businesses I talk to——

Mr. LARSEN. The GAO——

Mr. SCALISE [continuing]. Not one of them heard about the waiver program, not one of them, and I tell them about it. They said, "Hey, I would love to get it." I mean, we have a list here. What

is the current number? I have got over 1,400 companies that got a waiver from Obamacare——

Mr. LARSEN. Well, the waiver——

Mr. SCALISE [continuing]. Yet small businesses I talk to never even heard about it, and once they heard about it, you all ended the program.

Mr. LARSEN. Well, the waiver was for a very targeted group of employers that offered these mini-med policies that many people don't like. They don't provide great coverage. Employees that are in the mini-med policies——

Mr. LARSEN. According to you, but somebody who has no coverage versus that coverage, and they like that coverage, you are going to sit here and testify——

Mr. LARSEN. Well, that is exactly why we had a waiver program.

Mr. SCALISE [continuing]. That is not good coverage. What if they think it is good coverage?

Mr. LARSEN. We came to the same conclusion.

Mr. SCALISE. Shouldn't that be their choice?

Mr. LARSEN. We came to the same conclusion, which was in the law, the ACA specifically permitted and authorized and contemplated this where you would have these groups of policies. They are a small percentage but nonetheless they are something for people that have them, so the law permitted the Secretary to set up a waiver program. We did that for exactly the reason that you suggest so that people that have that coverage, even though it isn't great coverage, it is something and they can continue——

Mr. SCALISE. But did you end the program? I mean, this waiver program, you know, a new company that now knows about it, because a lot of companies have heard about it because we have been telling them. You know, you go look, a lot of these labor unions that came here and said pass this law, we need this law, they went to the White House and got a waiver, and we got the list.

Mr. LARSEN. Well, the White House didn't make the waiver decisions, and only 2 percent of——

Mr. SCALISE. Well, again, I call it crony capitalism because it was a lot of the people who supported the law found out about it. Now, you say it was advertised.

Mr. LARSEN. It was.

Mr. SCALISE. Most small businesses never heard about it, so you didn't do a good enough job of advertising or maybe you only advertised to people who supported the law, but it is curious that most people that I talk to that don't like this law that are trying to figure out how to comply with it but can't, they didn't even know about this waiver program that you saw was so well advertised yet so many of the groups that came here and said pass the law conveniently found out about the waiver program and got it. They got a waiver from a program that they said we needed. They got the waiver. And the companies who didn't want it can't get the waiver and now you have ended the waiver program. Can a company that didn't know about the waiver program that now knows about it, can they apply for a waiver?

Mr. LARSEN. No, but I can say that small businesses were a very large percentage of the people that——

Mr. SCALISE. So the companies, and I have seen a long list of Fortune 500 companies that got the waivers too, but, you know, AARP, groups that supported this law, got the waiver but these small businesses I talk to, they never knew it existed. They would love to get the waiver now and you are telling me under oath that they can't get it today.

Mr. LARSEN. That is right.

Mr. SCALISE. So the other companies that got the waiver, are you going to take the waiver away from them or are you going to let them keep it?

Mr. LARSEN. No, they got notice, they applied, they met the criteria.

Mr. SCALISE. So they get to keep it. The guys that knew about it, friends that helped pass the law——

Ms. DEGETTE. Mr. Chairman.

Mr. SCALISE [continuing]. Get to keep the waiver from it. They don't have to comply with it, and the folks that——

Mr. LARSEN. Well, as I said, the GAO looked at the way we ran the process and found——

Ms. DEGETTE. Excuse me, Mr. Chairman.

Mr. SCALISE [continuing]. Crony capitalism. I yield back the balance of my time.

Mr. STEARNS. The gentleman yields back the balance of his time.

Ms. DEGETTE. I would just make an observation, which is, if members would actually like the witness to answer questions, I would suggest they would stop badgering——

Mr. SCALISE. It is not badgering.

Ms. DEGETTE [continuing]. And give them the time to answer the question.

Mr. SCALISE. We recognize the gentleman from Michigan. Mr. Dingell, you are recognized for 5 minutes. Take the floor. You are on.

Mr. DINGELL. Coming to the waiver question, I would like a yes or no. At the time of this hearing, waivers have been granted to over 90 percent of the applicants. The average wait time for a decision is 13 days, and union health plans are less likely to receive waivers than non-union plans were. Isn't that true?

Mr. LARSEN. That is true.

Mr. DINGELL. Now, some other yes or no questions. As you know, the Affordable Care Act provides $40 billion in tax credits for small businesses so that they may offer health insurance to their workers. I believe that it is true that in 2011, 360,000 small employers took advantage of the small business tax credit, providing insurance for better than 2 million employees. Yes or no?

Mr. LARSEN. I think that is right, yes.

Mr. DINGELL. It is true that since the implementation of the Affordable Care Act, that Medicare Part B deductible has gone down for the first time in Medicare history? Yes or no.

Mr. LARSEN. Yes.

Mr. DINGELL. Is it true that over 2 million additional young adults are now insured because ACA allows them to stay on their parents' plans until they are 26? Yes or no.

Mr. LARSEN. Yes.

Mr. DINGELL. Prior to ACA, many people faced lifetime limits on health insurance. These limits had potential to financially cripple people if they faced a chronic disease or severe illness such as cancer. These limits would also force them to make decisions to compromise the quality of health care. Isn't it true that since the implementation of ACA in 2010, 105 million Americans no longer face lifetime limits on their insurance?

Mr. LARSEN. Yes.

Mr. DINGELL. Is it true that once the Affordable Care Act is fully implemented in 2014, 20 million more Americans who still lack coverage will become insured? Yes or no.

Mr. LARSEN. Yes.

Mr. DINGELL. Is it true that CCIIO's implementation of the Transitional Preexisting Condition Insurance Plan led to health coverage for tens of thousands of previously uninsured Americans?

Mr. LARSEN. Yes.

Mr. DINGELL. Is it true that CCIIO is moving now towards full implementation of the Affordable Care Act in 2014 by working with States to make sure that the health insurance exchanges required by ACA are designed properly to meet the needs of each of the individual States?

Mr. LARSEN. Yes, sir.

Mr. DINGELL. Finally, as we move toward the future, I am very much concerned about the Americans who will lose coverage if my colleagues on the other side are successful in repealing this bill. Am I correct in saying that 33 million Americans will lose insurance if my colleagues on the other side of the aisle repeal ACA?

Mr. LARSEN. Yes.

Mr. DINGELL. Now, wouldn't such an increase in the number of our uninsured in this country increase costs to the health care system?

Mr. LARSEN. Yes.

Mr. DINGELL. Now, isn't it a fact that the ACA has in fact reduced the deficit?

Mr. LARSEN. It is projected to reduce the deficit.

Mr. DINGELL. All right. Now, isn't it a fact that in 2008, people without insurance did not pay for 63 percent of their health care cost?

Mr. LARSEN. I think that is right.

Mr. DINGELL. All right. Now, when President Obama was elected, he quickly recognized the inescapable truth: an individual mandate was essential to make the plan work. Without that, the larger pool of premium payers, there is no feasible way to require insurance companies to cover all applicants and charge the same amount regardless of the health status of the beneficiaries?

Mr. LARSEN. Individual responsibility is an important part of the matrix.

Mr. DINGELL. Now, I believe this is an overwhelming truth: Those with insurance now are supporting those who do not have insurance, and they are winding up paying much of the bill for those who do not have insurance and that those people are running up health costs of about $116 billion annually.

Mr. LARSEN. That is right.

Mr. DINGELL. And so this means that the families and persons with insurance are now paying more than $1,000 a year for those who do not have health insurance?

Mr. LARSEN. That is right.

Mr. DINGELL. Now, the function of insurance is to spread the risk. Previous to the time ACA was passed, we found the insurance companies had to avoid the risk and so now we have a broad pool which covers everybody. Isn't that right?

Mr. LARSEN. That is right.

Mr. DINGELL. And that makes it possible for insurance companies to do the things that are mandated in the ACA. Isn't that right?

Mr. LARSEN. Right.

Mr. DINGELL. And without that, we are going to go back to the dismal days when we were not able to take care of our people, see to it that young people stayed on their parents' policies and we won't be able to see to it that preexisting conditions are dealt with without cost and charge to people?

Mr. LARSEN. That is right.

Mr. DINGELL. Thank you, Mr. Chairman.

Mr. STEARNS. I thank the gentleman.

Mr. Griffith is recognized for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman.

Our staff is going to hand you some excerpts from the February 17, 2012, Early Retirement Reinsurance Program update. This is a list of those who received money from the program. Now, I will give you a second to take a look at that as well. But before I get to that, as I understand your testimony, the Early Retirement Reinsurance Program has spent $4.73 billion of the $5 billion allocated. Is that correct?

Mr. LARSEN. That is correct.

Mr. GRIFFITH. Now, that number appeared in that February 17th report and in your testimony today but surely there has been some of the small amount left spent in that last month. Is that not true?

Mr. LARSEN. Well, there will be, because as we go through and make sure that all the claims have been submitted appropriately, it may turn out that we have the money——

Mr. GRIFFITH. But at this point it is certain that $4.73 billion of the $5 billion has already been spent?

Mr. LARSEN. We are effectively at the end of the program. There will be some continued claims.

Mr. GRIFFITH. But wasn't the program supposed to go through 2014?

Mr. LARSEN. I think it was originally intended to go through 2014 but many sponsors took advantage of the program, which I think reflects the outstanding need for the program.

Mr. GRIFFITH. Can you take a quick look at that material that was handed to you?

Mr. LARSEN. Is there anything in particular you want to me to—the highlighted ones?

Mr. GRIFFITH. Well, I am getting ready to ask you about all those companies that are highlighted.

Mr. LARSEN. OK.

Mr. GRIFFITH. Could you provide me a yes or no answer to the following, and I am going to ask you, of the companies I am going to name off, if they received money from the Early Retiree Reinsurance Program, and I think the ones that you have got that I am going to ask you about are highlighted so you can see them easily. ConocoPhillips?

Mr. LARSEN. It looks like they did, yes.

Mr. GRIFFITH. General Electric?

Mr. LARSEN. They are listed here as well.

Mr. GRIFFITH. General Motors?

Mr. LARSEN. They are listed on the sheet that you have given me.

Mr. GRIFFITH. Bank of America?

Mr. LARSEN. They are here.

Mr. GRIFFITH. Ford Motor Company?

Mr. LARSEN. I see Ford Motor Company.

Mr. GRIFFITH. Hewlett Packard Company?

Mr. LARSEN. That is here.

Mr. GRIFFITH. AT&T?

Mr. LARSEN. Yes.

Mr. GRIFFITH. J.P. Morgan?

Mr. LARSEN. Yes.

Mr. GRIFFITH. Citigroup?

Mr. LARSEN. Yes.

Mr. GRIFFITH. Verizon?

Mr. LARSEN. Yes.

Mr. GRIFFITH. AIG?

Mr. LARSEN. Yes.

Mr. GRIFFITH. IBM?

Mr. LARSEN. Yes.

Mr. GRIFFITH. Now, what we just went over is a list of companies that are not just in the Fortune 500 but that receive this taxpayer money but are companies that are in the top 20. Twelve of the top 20 of the Fortune 500 received money from this program. And I think you told us in a previous hearing that that is because the underlying law didn't make a distinction for those that needed the money, it was just out there if you met the criteria.

Mr. LARSEN. The law was based on the fact that historically, the number of companies that are able to provide retiree coverage has dropped off, I think by half in the last 10 years. So it was not needs-based. And I think as you probably saw, many of the biggest recipients of the funds were in fact State retiree programs, State teachers, State employees.

Mr. GRIFFITH. One of my concerns, though, is that if the intent of the bill was to give this early retirement assistance to companies so that they could fund their programs, I think we have the same problem Mr. Scalise pointed out. A lot of the big companies got in, the rich folks got it because they had people to monitor all this stuff and keep track of it. I am not sure that the small companies that probably needed the assistance got it. Wouldn't you say that is a fair assessment?

Mr. LARSEN. I don't think so. We have had, I think, over 2,800 sponsors of a wide range of size and background come to get money from this program. Remember, it has to be companies that are al-

ready providing benefits to their retirees, so that is, you know, typically going to be some larger companies, although, as I said, it is frequently States and their State employee retirement systems that got the money as well as some of the companies you mentioned here.

Mr. GRIFFITH. Now, you said in testimony—and I am switching gears on you. You said in testimony earlier that this would not necessarily be enforced, the act would not be enforced by your agency but by the IRS because it was——

Mr. LARSEN. Getting back to the individual responsibility provision?

Mr. GRIFFITH. Yes. And that would be enforced by the IRS. Is that the 16,000 new IRS agents we have heard so much about?

Mr. LARSEN. I don't believe so. I don't think that it is how it enforced. It will be enforced electronically through the filing and through the verification of whether someone has purchased insurance. And that doesn't occur until 2015 because that is when the responsibility provisions actually kick in to confirm that someone had coverage in 2014.

Mr. GRIFFITH. All right. My time is just about up but I want to ask you about CBO said it going to cost more than the trillion that we were originally told it was going to cost when this passed before I got here, and it looks like, is it fair to say that based on that information over the 10 years that this may actually cost $2 trillion or more?

Mr. LARSEN. Actually, the CBO report found that there would be about 50 billion fewer costs associated with implementing this because of the number of changes that they highlighted, so the numbers in the CBO report that just came out said that over the 10-year period from 2012 to 2021 would be $49 billion or $50 billion less than what they had projected a year ago in March of 2011.

Mr. GRIFFITH. But it is going to be more for the first 10 years. Isn't that correct? Isn't that what CBO said?

Mr. LARSEN. No.

Mr. GRIFFITH. All right. I yield back, Mr. Chairman.

Mr. STEARNS. The gentlelady, Ms. Christensen, is recognized for 5 minutes.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. And Mr. Chairman, before I ask my question, I just wanted to make some comments about the Early Retiree Reinsurance Program because the attacks on it are really unfair and unjustified.

Prior to the passage of the Affordable Care Act, employers were dropping coverage for their retirees at an alarming rate or finding themselves saddled with huge and rapidly increasing health care costs. The program was an effort to help employers bridge the transition to 2014 when more affordable coverage options will be available, and in the face of overwhelming need, the ERRP program had great results. The program has helped more than 2,800 employee health plans sponsors across the country cover the cost of medical care for early retirees. These plans cover more than 19 million beneficiaries. ERRP funds support employers that continue to provide private health coverage and help early retirees keep the private coverage they already have. This important transitional program worked to support employers making the right choice for

their retirees, and I think it is an important way to support that choice.

Mr. Larsen, let me ask you some questions about the Preexisting Condition Insurance Plan. You testified before the subcommittee on April 1st to discuss the Preexisting Condition Insurance Plans, the PCIP, or high-risk pools established under the Affordable Care Act. In that hearing, we heard about thousands of Americans with preexisting conditions who finally had access to coverage, and we established that maybe somewhere around 50,000 Americans have enrolled in the PCIP. And I understand that many of these individuals have serious health conditions including 1,900 individuals with cancer, nearly 4,700 with heart disease. What type of coverage options did these individual with preexisting conditions have before we passed the Affordable Care Act?

Mr. LARSEN. Well, the fact is that they really wouldn't have any other coverage options. I think many of these people would be diagnosed with cancer and end up in the emergency room or not get care at all for their condition.

Mrs. CHRISTENSEN. And how will those options improve in 2014?

Mr. LARSEN. Well, when the insurance reforms kick in, at that point we will have guaranteed issue, guaranteed renewability and so we will have a much larger insurance pool and people that would get locked out of the system today by the insurance companies won't be locked out in the future, but we will also have many, many more people in the insurance pool to offset those costs.

Mrs. CHRISTENSEN. Thank you. The only complaint I have about that program is that it didn't extend to the territories, Mr. Larsen. Still working on that.

But, you know, Republicans should love the PCIP program. It has been the centerpiece of their past reform proposals, but instead they attack it because they say it is not popular enough unless of course they are attacking it for the opposite reason, that it is too popular and may spend too much money. So Mr. Larsen, what happens if the program becomes so popular that the expenditures might exceed $5 billion?

Mr. LARSEN. Well, we have to manage within the amount that Congress has appropriated for this so we continue to monitor the progress that States are making in their enrollment and their costs, and if we have to make adjustments in the future, we will do so.

Mrs. CHRISTENSEN. Are there procedures in place to make sure that they don't exceed the program costs?

Mr. LARSEN. We have to make sure that we don't exceed program costs.

Mrs. CHRISTENSEN. And what happens if you do not spend the entire $5 billion?

Mr. LARSEN. That is a good—I don't know the exact answer to that but I will say that if we exceed our costs, then there are a number of different options that we can pursue to make sure that we stay within the $5 billion.

Mrs. CHRISTENSEN. OK. So we have a win-win scenario here. In one case, the program becomes extremely popular, many people receive coverage and you still have processes in place to protect taxpayers and to make sure expenditures do not exceed authorized

amounts. The other scenario involves low enrollment. In that case, I think what happens is you will return the extra money to the Treasury, which would help reduce the national debt. So I appreciate your walking us how the money is being spent.

I know that there are many unfair attacks against the health reform law, the Patient Protection and Affordable Care Act, but I think the record is clear that you are administering the PCIP program and the law as a whole in a very effective and efficient fashion, and it is a humongous task, so we really commend CCIIO and the entire department for the way that you are doing it. And I do have some specific territory-related questions that I will submit for the record.

Mr. LARSEN. OK. We will look forward to answering those.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. TERRY [presiding]. Thank you. Now the Chair recognizes the gentlelady from Tennessee for her 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman, and Mr. Larsen, we are pleased that you are back with us today.

I want to talk about the nonprofits. You said that you had awarded more than $638 million in loans already from the consumer operated and oriented plan, but OMB has estimated that under the co-op program, that taxpayers could lose $370 million from unpaid loans to the nonprofit insurers. Do you think that is accurate? Are we missing something here? Are they missing something?

Mr. LARSEN. Well, I guess for purposes of the loan program, OMB has to make some type of projection as they would for any loan program about the rate at which recipients would not repay their loans. I can tell you that in our review process for the applicants that we got, we hired an outside consultant with extensive financial expertise to look at the applications that we got. So OMB has to make some assumptions, I guess, for purposes of releasing the money. But we are running a very vigorous process and we——

Mrs. BLACKBURN. So basically you are saying this is a bad investment for the taxpayer?

Mr. LARSEN. Not at all, no.

Mrs. BLACKBURN. You are not saying that?

Mr. LARSEN. I am not saying that.

Mrs. BLACKBURN. You are saying the taxpayer should expect to lose money because $370 million——

Mr. LARSEN. No, I am not. I am saying the opposite.

Mrs. BLACKBURN [continuing]. Is a health care Solyndra. Well, you just told me that you thought OMB has to expect a certain amount of this, and, you know, if they are saying as much as 50 percent of the loans issued under the program may not be repaid, I mean, do you think that is accurate?

Mr. LARSEN. Well, we don't think there is going to be a default rate on these loans. I think they have to make projections for certain purposes, but again, I can tell you from our perspective, we are doing everything we can to make sure that we only provide the loans to——

Mrs. BLACKBURN. Then let me approach it this way with you because reading this is of concern to me, and after what this committee has been through looking at the DOE loan program and the

bankruptcies that are there, let us kind of agree to get out ahead of this, and what I would love for you to do is to submit the analysis and the documents related to the program and then your approval of or rejection of the loans. I think as we oversee this, that that would be very helpful to do that. Would you submit that to us for the record?

Mr. LARSEN. Yes, assuming that we can provide that application material, but I would be happy to kind of explain for you exactly what process we ran to make sure that we got the best applicants.

Mrs. BLACKBURN. That would be great. I have got just a little bit of time left, and I do have another question for you. Last time you were with us and we discussed the waivers, I asked if you had a plan B for when the waivers ran out, and you did not have a plan B, and now we are looking at is, what is it, 1,800 waivers that have been given, as you look at your cost in the coming years and you look at 2014 when these waivers—have you come up with a plan B for how you are going to integrate these programs and what the expectations are going to be for the impact on the system?

Mr. LARSEN. Well, essentially the plan B or the transition is that in 2014, when the requirements of the annual limits provisions would apply, these mini-med policies would no longer be offered because employees would have access to full, comprehensive coverage. Many of them would be able to access the tax credits that are available because it is often lower income workers that are in these mini-med plans and those are exactly the kinds of people——

Mrs. BLACKBURN. OK. Let me ask you this——

Mr. LARSEN [continuing]. Who would have access to the tax credit in 2014.

Mrs. BLACKBURN. OK. All right. As you have gone through the waiver program, how many people were denied waivers? How many companies were denied waivers?

Mr. LARSEN. It was a very—we approved over 90 percent. I think it was only, 90 or 100 that were denied.

Mrs. BLACKBURN. OK. And the waiver program is closed. You can no longer get a waiver?

Mr. LARSEN. That is right.

Mrs. BLACKBURN. All right. The ones that were denied, what was the reason for the denial to them?

Mr. LARSEN. Well, to be approved for the waiver program, you had to show that applying the high annual limits, at the time, $750,000 annual limits, to your policy would result in a substantial increase in premiums or a decrease in access to coverage. So for policies that had coverage of $25,000 or $5,000, which are these mini-med policies, typically applying that standard, it would raise premiums. Some people might not be able to afford them. So that is how you were approved for a waiver. If you weren't approved for a waiver, it meant that you didn't meet the regulatory criteria. In other words, it wasn't going to cause a large increase in premiums to comply with the annual limits provisions that were in place at the time.

Mrs. BLACKBURN. All right. Yield back.

Mr. TERRY. I thank the gentlelady from Tennessee.

Now we recognize the gentleman from Texas, Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, and again, welcome, Mr. Larsen.

I know there are some concerns, and our committee actually spent a lot of time on the Affordable Care Act when we were marking it up both in our subcommittee and the full committee 2 years ago, and I have a district that has such a huge impact the Affordable Care Act will do. Before the passage, the 29th district that I represent had the largest percentage of uninsured in any district in our country, a very urban area in Houston, again, not a wealthy area. We still have a lot of work to do but things are getting better. As many as 53,000 children in our district can't lose the security offered by health insurance due to preexisting conditions. Thirty-four hundred seniors have saved an average of $540 on prescription drugs and 9,000 young adults have health insurance they couldn't have before the Affordable Care Act. Additionally, about 60,000 of my constituents, most of them minority and historically underserved communities, are receiving an array of preventive health services without copays, coinsurance or premiums, and this is a result of the Affordable Care Act and its tremendous help toward reducing health care disparities in our district particularly but in our country.

I am proud to represent part of Houston. We have a great Texas Medical Center there, I think one of the largest in the country. It is just hard for my folks to get there except through our public hospital system. Individuals in underserved communities, minorities, rural areas and communities with high poverty rates need the Affordable Care Act, and I would like to ask you some questions about how this act is serving the underserved areas.

First, what are some of the biggest barriers to access to care for these underserved communities, again, very urban like mine or even rural areas?

Mr. LARSEN. One of the main ones is cost for lower-income individuals, the cost of coverage and access and coverage, and the Affordable Care Act of course addresses that through the tax subsidies that are available for people.

Mr. GREEN. The health care law provides billions of dollars in public health grants for community health center expansion. I know we had received some of those grants in our district and we need more because Houston in Harris county is the fourth largest city in the country and yet we are behind the curve on community-based health centers, and I know a few years ago when we authorized it, we had a provision in there that if you are a very urban area and all being equal, if you had a huge underserved population, that your grant application was given a higher priority. I know that is helpful, but will the Affordable Care Act address some of those barriers, expanding and health care providers and community health centers?

Mr. LARSEN. It will, and there are provisions in the exchange rule that requires network adequacy to make sure that health plans have a full network of providers including essential community providers, which are an important part of the support for the individuals you are referring to.

Mr. GREEN. Can you just verbalize some of the preventative health care benefits that we are seeing now on the second year anniversary?

Mr. LARSEN. Well, there is a whole range, particularly for wellness visits for women, for children, cancer screenings, colonoscopy screenings, you know, the things that have been approved by IOM that have been shown to be effective in terms of prevention.

Mr. GREEN. OK. I realize this is not your area but the health care reform law also contained funding and new programs to help expand the health care workforce, especially primary care workforce. Can you give us an update on how that will help, not only minorities and underserved but individuals in those underserved areas?

Mr. LARSEN. I know that there is substantial funding available in HHS for a number of workforce initiatives, which is extremely important and it is significant, the details of which I don't have in front of me but I know that it is a key part of this law.

Mr. GREEN. Finally, the Affordable Care Act coverage provisions, expansion of Medicaid, new health care credits for small businesses and the State insurance exchanges that will make health insurance less expensive and easier for individuals. I know, for example, in Texas, and a lot of States, I think 26 States, are waiting until the Supreme Court decides whether they are going to participate, even though my home State received planning money for it, they have decided to wait. But even if they are waiting, HHS will provide an exchange system for those States that do not participate.

Mr. LARSEN. We will. One way or another, there will be an exchange for the health care consumers in each State including Texas, although many States, even States that are challenging the law, actually have applied for and received extensive grants and are moving forward to be ready in 2014.

Mr. GREEN. And I know in Texas, again, the political decision has been made, but hopefully the Supreme Court will come back with an argument and realize that health care is just like Social Security, like a lot of other things, Farm Bill, things like that, that Congress has the right to make that mandatory.

So Mr. Chairman, thank you for your time.

Mr. TERRY. Thank you, Mr. Green.

The Chair recognizes the gentleman from Pennsylvania, Mr. Murphy, for 5 minutes.

Mr. MURPHY. Thank you, Mr. Chairman.

Mr. Larsen, do we have any numbers yet of what we estimate an individual will pay for their premium and copay under new insurance plans under the Affordable Care Act?

Mr. LARSEN. I don't have an estimate, and the estimate really varies depending on the State and how old they are and whether they are buying in the individual and small group market.

Mr. MURPHY. Will it be $1,000 a year, do you think?

Mr. LARSEN. I don't know.

Mr. MURPHY. Well, current policies now average what nationwide?

Mr. LARSEN. You know, I think the typical estimate is for, you know, $12,000 for an individual. I think that is in the individual market.

Mr. MURPHY. I understand. Now, with regard to this plan, will it be open enrollment year round, a person can sign up for an insurance plan?

Mr. LARSEN. Now, there will be open enrollment periods, you know. In the reg that we put out, there is an initial open enrollment period that is a little longer and then each year there will be open enrollment windows.

Mr. MURPHY. And do we have estimates of how much we think that coverage under the Affordable Care Act will increase or decrease? I know as part of the mandate, everybody is supposed to get a policy. There is a belief that somehow that will have an impact. But do we know exactly how much it may reduce individual costs, keep it the same, increase, slow growth?

Mr. LARSEN. You know, there are a number of different estimates. I know CBO did one that said for the small group market, it could be flat to advantageous because of the economies of scale you get coming in. It somewhat depends in a particular State whether they have a full range of benefits today or a modest range, and then you get of course the efficiencies in the individual market of having everyone in one single insurance pool in a State.

Mr. MURPHY. But as far as the States go, there still is a required amount of coverage that each plan has to have but some States——

Mr. LARSEN. That is the essential health benefits.

Mr. MURPHY. So some States have very few mandates, some States have a lot. This will have a set amount that every plan has to have?

Mr. LARSEN. Well, one of the things we did in the bulletin that we issued was to allow States to select their own benchmark for essential health benefits so you are exactly right. In some States they have more mandates than other States, and that State could select that as their benchmark, and the State that has a small, a thinner mandate, benefit package, assuming that it kind of met the basic criteria, could choose that as their benchmark.

Mr. MURPHY. So we are still not clear on this. Now, we do know that if an employer drops coverage, they would pay a $2,000 fine?

Mr. LARSEN. There is a penalty, yes, for not offering coverage.

Mr. MURPHY. And I have seen estimates all over the place as have you. I have seen some as high as 85 million people may not be covered. Some say it may be 10 million. It is all over the board. Some say 20 million won't be covered by employers. Does that sound right, estimates all over the place?

Mr. LARSEN. Well, I would say this. There are many different estimates but I think most of the estimates like CBO suggest, there could be a small number of people that have it today that might not have it then, but then there are many other people that don't get it offered today that will have it offered in the future. So when you net those things out——

Mr. MURPHY. Big question mark there. I know that is estimated about $40 billion a year is lost for uncompensated care that hospitals say they need that money, or is it more than that? Do you know?

Mr. LARSEN. Right. I mean, that that was one of the premises of the act that we all pay for that uncompensated care.

Mr. MURPHY. And what they are looking at, so an employer may drop coverage and pay a $2,000 fine. As I understand it, an individual, if they choose not to have coverage, they will pay, I think, a fine of $695 or 2–1/2 percent of their income, whatever is higher. Am I correct?

Mr. LARSEN. Right.

Mr. MURPHY. Now, given what people are facing here now, there are multiple open enrollment periods during the year, you have people also facing increased energy costs with the policies where many coal-fired power plants are going to drop, we are going to lose about 20 percent of our power generation so people's electric bills are estimated to go up 30 to 40 percent, with gasoline costs going up now where an individual this year is paying about $2,500 or $5,000 more a year, families are going to continue to make individual choices. So although there is a mandate to require people to purchase health care, you still can't make them purchase health care. If they decide to not purchase it, they can still hold off and not purchase it?

Mr. LARSEN. Well, they pay the financial penalty.

Mr. MURPHY. But if they say look, I will pay $695 versus several thousand dollars, they may make that decision?

Mr. LARSEN. Some could, although for many lower-income individuals, up to 400 percent of poverty, there are the tax credits available that significantly offset the cost.

Mr. MURPHY. A tax credit for somebody who is on poverty and doesn't pay taxes?

Mr. LARSEN. Well, many of them do. I mean, obviously people that are on Medicaid may not but the credits are available for people up to 400 percent of poverty.

Mr. MURPHY. I mean, the issue that still baffles me is the preventative care issues. I mean, there is still—we know that there is decreased cost for people who don't see a doctor. There is decreased cost for people who eat healthy foods, decreased cost for people who have optimal weight. I think obesity costs our health care system $147 billion a year. Decreased costs for people who exercise regularly, follow their prescriptions carefully. I think misusing prescriptions is a $250 billion drain a year. People who are chronically ill, if you monitor them, work with them on health, there can be a 40 percent cost savings. If this is the where all the costs are, will we be mandating those things in order to really save? Because those things add up to be several hundred billion dollars a year. Will we be mandating these behavior changes too?

Mr. LARSEN. Well, not behavior changes certainly but there are a lot of incentives in the Affordable Care Act for health and wellness programs for insurance companies who will get a credit on their medical loss ratio calculation if they provide health and wellness programs.

Mr. MURPHY. So you are believing that the financial incentives to help people drive to behavior changes on this versus mandating them?

Mr. LARSEN. I think in this case, yes, for the health and wellness.

Mr. MURPHY. Thank you.

Mr. STEARNS. The gentleman's time has expired. I think we are ready, I would say to my ranking member, we will go a second round to Mr. Larsen, and I will start with this, and I tell members who would like to stay a second round, stick around.

Let me just start by sort of asking you, Mr. Larsen, a sort of general question. We have heard from Mr. Waxman and others how the cost of health care is going to come down. Do you actually believe that the cost of health care in America will come down? Is that what you are saying to us today, that Obamacare will cause the cost of health care to come down?

Mr. LARSEN. Well, many aspects of the ACA will lower health care costs, first by getting more people——

Mr. STEARNS. I understand, but has it lowered premiums so far? I mean, this bill has been enacted 2 years. Have you seen the premiums come down, in your opinion?

Mr. LARSEN. The provisions that help address the——

Mr. STEARNS. I mean yes or no.

Mr. LARSEN [continuing]. Insurance premiums don't take effect until 2014.

Mr. STEARNS. So you say it is too early to see the impact of Obamacare?

Mr. LARSEN. Well, with respect to premiums. I mean, we have expanded coverage, we have provided people with better coverage. The provisions that help address some of the cost efficiencies with the exchanges don't——

Mr. STEARNS. But the fact is, health insurance premiums have shot up 9 percent, three times the rate of inflation. This is according to the Kaiser Family Foundation. And I think you would agree that the Kaiser Family Foundation said the costs have gone up 9 percent, 3 percent above inflation. Wouldn't that indicate that a lot of the things that you have talked about that have been implemented have really not brought costs down?

Mr. LARSEN. Well, first of all, that rate of increase has been consistent over the last 10 years, which is why we need——

Mr. STEARNS. So the fact is, it has not changed with Obamacare.

Mr. LARSEN. Well, in fact, I think the CBO in their recent report found that the rate of health care spending and premiums had actually moderated in the last year when they looked at the estimates for the costs——

Mr. STEARNS. Don't you think that is probably the economy more than anything?

Mr. LARSEN. Well, it could be a number of factors. I guess what I am saying is, that we don't think the provisions of the ACA are what is at work when you look at the historical rate of increase of premiums year over year. The ACA will help fix those provisions.

Mr. STEARNS. So Mr. Larsen, you are saying today, we can expect health care costs for families to go down?

Mr. LARSEN. We hope and expect that costs will moderate with the provisions of the ACA.

Mr. STEARNS. Now, the President promised lower premiums by an average of $2,500 per family. Do you think this is going to happen?

Mr. LARSEN. I think costs will be much lower compared to what they would have been if the ACA hadn't been enacted.

Mr. STEARNS. Your testimony talked about the rate review on insurance increases in New Mexico, Connecticut, Oregon, New York and Rhode Island, correct?

Mr. LARSEN. That is right.

Mr. STEARNS. In any of these situations, did the premiums go down?

Mr. LARSEN. I think in the examples we cited, that the insurance commissioner in that State worked to lower the initial rate filings that came in.

Mr. STEARNS. Well, I think your testimony indicated that the rate review situation resulted in premiums going up. The government really said they couldn't go up so much but I think that is true.

Mr. LARSEN. Oh, I see. You mean their increases were approved but they were lower than what originally was filed by the insurance company?

Mr. STEARNS. Yes.

Mr. LARSEN. Right.

Mr. STEARNS. Where in your testimony do you discuss lowering premiums?

Mr. LARSEN. Well, lowering—it is all relative, right? I mean, lowering premiums means lower than what they would have been if we hadn't had these types of provisions.

Mr. STEARNS. That is like we do in Congress. We say we reduce spending by lowering the spending more than we projected.

The example you cite, you say that "The Government Accountability Office found that in a survey of seven insurers, most of the insurers were adjusting premiums." Is that it?

Mr. LARSEN. Well, that was a result of the medical loss ratio provisions. GAO did a very limited survey of a number of companies to see whether they were taking action to comply with the MLR and what it is, and in some cases, companies were moderating their premium increases. We did have an example, and there may be others, of a company that actually lowered premiums. There is a case——

Mr. STEARNS. Can you give me a specific example?

Mr. LARSEN. Aetna Insurance Company in Connecticut actually lowered premiums.

Mr. STEARNS. OK. So is that the only one, Aetna of Connecticut?

Mr. LARSEN. Well, that is the one that I am aware of.

Mr. STEARNS. Can you name anyone else that has lowered premiums specifically because of Obamacare?

Mr. LARSEN. Well, when you say lowered, you mean moderated the premium increases that would occur?

Mr. STEARNS. To use your term——

Mr. LARSEN. I can find that and get it to you in writing because, yes, many companies have been on the record both with us and in Wall Street indicating that they were moderating their rate increases based on the MLR provisions in the Affordable Care Act.

Mr. STEARNS. Do you provide waivers if companies find out that their premiums are going up significantly? Is that one of the factors which you provide a waiver for?

Mr. LARSEN. Well, in the waiver program that we don't operate anymore, but at the time, that was one of the criteria, that is right.

Mr. STEARNS. Mr. Scalise talked about, I don't know, 1,200, 1,400, I think there is 1,700 entities that got waivers. Isn't that true?

Mr. LARSEN. Overall, though that included about 400 or 500 companies that offered HRAs, or health reimbursement accounts, that we really concluded didn't need a waiver under the law.

Mr. STEARNS. All right. My time is expired. Mr. Dingell is recognized for 5 minutes.

Mr. DINGELL. Thank you, Mr. Chairman. You have, first of all, Mr. Larsen, given us a very good statement today, and Mr. Chairman, I think that the information that we got in this hearing has been most helpful in understanding how we are doing and moving forward, and also in having some significant appreciation of the chores which yet remain. I think if we all are willing to work together, we are going to see this program be a good one of which we will all be proud.

Mr. Larsen, you made some points here. In your statement, you said States are already using this authority to save money for families and small business. Starting out in New Mexico, the State insurance division denied a request from Presbyterian Health Care for a 9 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 9 percent, instead limiting to a 3.9 percent increase. In Oregon, the State denied a proposed 22 percent rate hike by Regency, limiting it to 12.8 percent. In New York, the State denied increases for Emblem, Oxford and Aetna that averaged 12.7 percent, holding it instead to an 8.2 percent increase. In Rhode Island, the State denied rate hikes to United Health Care of New England ranging from 18 to 21 percent, instead seeing them cut to 9.6 to 10.6 percent. I know what you are telling us, that these provisions are working in terms of assuring the protection of consumers. Is that a fair statement?

Mr. LARSEN. Yes, sir.

Mr. DINGELL. Now, we have talked a little bit about the health insurance exchanges. You will note that as you have indicated, CCIIO is charged with helping States set up these exchanges. Isn't that right?

Mr. LARSEN. Yes.

Mr. DINGELL. How will these exchanges change consumers' experience in purchasing health insurance on the individual market?

Mr. LARSEN. Well, individuals will now have access to a competitive market, an affordable market.

Mr. DINGELL. Will he know what he is getting?

Mr. LARSEN. They will know what they are getting, and they will get comprehensive coverage and they will have the ability to get tax credits if they meet the criteria.

Mr. DINGELL. They will be written in a simple, understandable way?

Mr. LARSEN. Yes.

Mr. DINGELL. So that the purchaser of the insurance policy will be able to understand what he is buying and what the advantages of the different plans might happen to be. Is that right?

Mr. LARSEN. Exactly.

Mr. DINGELL. And you don't need to be a Philadelphia lawyer to understand this. Is that right?

Mr. LARSEN. That is right.

Mr. DINGELL. So in addition to improving the market for individual coverage, then we must assume that the exchanges will also provide for small businesses to have for the first time ever the ability to pool their risk and buying power together to drive down costs. Is that right?

Mr. LARSEN. That is right.

Mr. DINGELL. Now, there seems to be some misunderstanding here. Insurance companies over the years have been forced to go to the idea that they will avoid the risk because they didn't have a decent insurance pool, so what they did is, they curtailed the size of the pool by getting rid of the most risky people, and that is why they used preexisting conditions and other things to prevent certain classes of people from buying insurance. Is that right?

Mr. LARSEN. That is right.

Mr. DINGELL. So now the insurance companies are going to be able to engage in the practice that is so important in terms of having real insurance. They will cover everybody.

Mr. LARSEN. That is correct.

Mr. DINGELL. And this is going to enable insurance companies to then practice insurance in the classical sense by making it available to all persons and then we will all share the risk that flows from the possibility of sickness or illness or debilitation. Is that right?

Mr. LARSEN. That is correct.

Mr. DINGELL. And this is one of the main ways in which we are going to see significant savings of monies to the Federal Government, to the employers and to of course the purchasers of the insurance. Is that right?

Mr. LARSEN. That is right.

Mr. DINGELL. Mr. Chairman, I am going to surprise you. It is 38 seconds I yield back.

Mr. STEARNS. All right. Thank you, Mr. Dingell.

Dr. Burgess is recognized for 5 minutes in our second round.

Mr. BURGESS. Thank you, Mr. Chairman. I am tempted to actually go to the left of John Dingell but I am going to resist the temptation.

He was talking about—and we do this all the time—the ERISA market is not the same as the small group market and the individual market. Mr. Dingell's questions really were about the small group market and the individual market, not the employer-sponsored insurance market, because preexisting conditions are covered then in the open enrollment, are they not?

Mr. LARSEN. You mean for the self-insured market?

Mr. BURGESS. No, no, I am talking about for someone who works for, say, a big telecom company that is known only by its——

Mr. LARSEN. Yes, that is one of the big advantages of working for a large company.

Mr. BURGESS. Right. Those individuals in the large group market were not subject to the same constraints that Mr. Dingell was just discussing. Is that correct?

Mr. LARSEN. Typically that is right, yes.

Mr. BURGESS. And it really seems like had we wanted to reform the system, we would have tried to help the individual market and the small group market behave more like the large group market, and I think we could have gotten a lot more bang for the buck, but that is another story. We didn't get to do it. Am I going to be able to keep my HSA?

Mr. LARSEN. There is nothing in the Affordable Care Act——

Mr. BURGESS. There is not? What about the medical loss ratio? Are you going to count the amount of money that I contribute to my health savings account as a medical expense or is that administrative expense?

Mr. LARSEN. Well, at this point I don't think it counts in the MLR provisions but we are looking at HSAs and HRAs in connection with——

Mr. BURGESS. Can you guarantee me that I will be able to keep my HSA when this thing is fully implemented?

Mr. LARSEN. I don't see any reason why you couldn't keep your HSA.

Mr. BURGESS. Well, I will tell you, my read of it is that there is a risk, and if we really want to control costs without rationing, and I do, because I don't like rationing, but if we really want to control costs, we will leave the health care consumer, the patient, in charge of a lot of the decisions and the money of their expenditures because I know from my own experience, I am a much more cost-conscious shopper in health care because it is my money that I am spending, that money being designated from my health savings account. President Obama himself, and he is from the White House, told us this last year when he had all us down there to talk to us about the debt limit, he referenced how expensive health care was, and he said he got a rash on his back, he put some cream on it and there was a $5 copay but he was out on the campaign trail, he didn't have his card, and he went to the pharmacist to explain his predicament. The pharmacist got the prescription transferred—thank you, electronic health records—but when the prescription was handed up to him, he was told that it would be $400, and the President said you know, this rash is not that bad. And exactly right, Mr. President. You became an informed health care consumer. So the power of putting—putting this power in the hands of the consumer really can be a powerful incentive to hold costs down, and the only other thing you have got, the only other lever you can pull is you say we are going to have waiting lists or rationing, or we are going to cut reimbursements to physicians. We saw what happened in Medicare with the SGR. You cut my reimbursement. My fixed costs remain the same, so what do I do? I do my stuff so I cost you more money because I have still got to pay the same bills that I had to pay before. So I really think getting away from an HSA-type model, especially for people who are in the immediate pre-Medicare years, that is going to be a big mistake and it is going to drive costs up, not the other way around.

Now, having been in practice and having seen what happened when an insurance company went bankrupt and seeing the effect on patients and the people who are supposed to be paid by all those claims that didn't get paid and yes, there was a small State fund

that we could go to but nowhere near covered the expenses, are you concerned at all that when a company comes to you and says we need to raise our rate and it is based on actuarial evidence, are you concerned at all when you hold these rates down that you may be driving companies toward insolvency, maybe not tomorrow, maybe not next year, but over time?

Mr. LARSEN. Well, first of all, HHS, when we review rates in the small number of States that we do it, we don't have the ability or the authority under the ACA to actually force the company to do anything different. We make a conclusion and the company can proceed if they want to with the rate, and certainly in the States that do have the authority to modify rates, it is something that they—and I did this as well—you need to take into account when you are looking at their——

Mr. BURGESS. Wait a minute. I thought under the Affordable Care Act rates are going to go down because you are going to prevent large increases from the insurance companies? Did I not hear that said several times this morning?

Mr. LARSEN. And I think the evidence shows that that is happening. I think all I am saying is that when regulators look at the rates, they have to make sure they are reasonable and not excessive, and you are absolutely right. They have to make sure they are not inadequate as well and that companies——

Mr. BURGESS. So a recent news story——

Mr. LARSEN [continuing]. And that companies have enough revenue.

Mr. BURGESS [continuing]. Said rates went up 26 percent in Alaska, 23 percent in Florida, 20 percent in Washington State, all since the implementation of the Affordable Care Act. Is that going to be modified in the future? Are those rates are going to be going up less because of the Affordable Care Act?

Mr. LARSEN. I am not sure what you are citing there.

Mr. BURGESS. Well, there was an article in the general news.

Mr. Chairman, I will yield back at this point, but I am going to submit that question with more detail, and I would appreciate a thoughtful answer to that.

Mr. LARSEN. OK.

Mr. STEARNS. All right. The gentleman's time is expired.

The gentleman from Virginia is recognized for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman.

Let us talk about medical loss ratio rebates. Your testimony states "Consumers will receive a notice explaining their carrier's medical loss ratio, MLR, if their carrier owes them a rebate on their premium payments." Now, as I understand it, this is to be issued in August of 2012. Is that correct?

Mr. LARSEN. That is right. If rebates are repaid, they would come out—they are supposed to be done by August.

Mr. GRIFFITH. By August of 2012?

Mr. LARSEN. Um-hum.

Mr. GRIFFITH. And the law requires the companies to send these notices out, or the rebates out?

Mr. LARSEN. Yes. I mean, we proposed in our regulations that when an individual gets a rebate, that they would get a notice from their insurance company describing what it is they are getting and

whether their company complied with the law and what the MLR was.

Mr. GRIFFITH. Let me ask you this question. Does the carrier have to send all of their customers a letter whether or not they get a rebate or only if they get a rebate?

Mr. LARSEN. Well, two things. One, in the rule that's on the books now, we from the beginning had made it clear that when there is a rebate to be provided, yes, the consumer would get a notice. We did propose for consideration and posted the idea that for consumers whose company complied with the MLR requirements but didn't get a rebate, that they would get a notice so the company would—the consumer would understand that their company complied with the law and they got value for their insurance premium. So that is a proposal that we have made and we haven't finalized that idea yet.

Mr. GRIFFITH. So if that proposal were to be finalized, everybody would receive a letter in August 2012 talking about either rebates or we complied with the law in regard to this section——

Mr. LARSEN. Yes.

Mr. GRIFFITH [continuing]. Right before the election, but all the costs under the bill to the hardworking American taxpayers occur after the election. Isn't that correct?

Mr. LARSEN. Well, the timing——

Mr. GRIFFITH. You didn't fix the timing. I understand that.

Mr. LARSEN. And it doesn't have anything to do with the election.

Mr. GRIFFITH. But it is an accurate statement, is it not, sir?

Mr. LARSEN. It is accurate——

Mr. GRIFFITH. Thank you very much. I yield to Dr. Burgess.

Mr. BURGESS. Just one last series of questions on the budget, and going back to Section 1311(a) on the authority that you have, CCIIO has, to draw funds from the Treasury and administer grants to the States and territories to establish exchanges, the end of November 2011, I think you told us, $733 million was obligated to the States and $27 million had actually been spent. Does that sound about right?

Mr. LARSEN. Yes.

Mr. BURGESS. So that was November. You may not have in right in front of you but can you provide to the committee what has gone out to the States since November?

Mr. LARSEN. Yes, we had another round of establishment grants so I think the total grants including everything—innovation grants, planning grants, establishment grants—I think is up to $800 million or $900 million. The rate at which States are drawing down on that money continues to lag behind the grants that we make as they go out and they do a procurement to hire outside experts and IT consultants and then procurement has to come on board and then the procurement agency has to bill, so there is a lag between the obligations and the outlays for the State grants.

Mr. BURGESS. Well, the previous projections estimated total of $2 billion would be spent in the exchange grants over the life of the program. When do you expect this money will be fully exhausted?

Mr. LARSEN. Well, unlike the $1 billion, the money that is available to provide grants to States is not limited. It is from a separate funding source.

Mr. BURGESS. So do you have a new projection for us on what the——

Mr. LARSEN. On how much States ultimately will spend? We don't. I mean, we are getting better insight into that as States come in with their grant applications and tell us what they think it is going to cost to build an exchange in their State, so——

Mr. BURGESS. Let me just ask you something. There are a lot of things that the last Congress and this Congress has done to sort of kick cans down various roads, and it looks to me like all the roads end in December of this year.

Mr. LARSEN. December of this year?

Mr. BURGESS. Yes, the doc fix, the unemployment insurance expiration, the unemployment insurance payroll tax holiday, Bush-Obama tax cuts, a lot of things expire at the end of this year. Of course, the alternative minimum tax always expires at the end of every year, so there is a lot of stuff that is going to happen at the end of this year. It is quite possible we will be at or near exceeding the statutory debt limit of the United States of America by that time as well. It is difficult as the increase in the debt limit was in August of last year. This time it will be without all the good feelings that we had last August. Do you worry at all that the subsidies and the exchange, which Mr. Griffith has already talked about, are you concerned that that may have to be postponed simply because we are out of money and cannot afford it?

Mr. LARSEN. Well, I certainly hope not and hope that everyone will come together to make sure that that doesn't happen because they are an important part of expanding the coverage provisions in the ACA.

Mr. BURGESS. Even if we are borrowing in excess of 40 percent of those dollars that we are going to be handing out to people to subsidize their insurance?

Mr. LARSEN. We hope it doesn't happen because, you know, it is such an important part of the Affordable Care Act.

Mr. BURGESS. There is no place else to go for another sequester other than the Affordable Care Act. It has been remarkably protected. It has led a charmed life with all the other budget-cutting things that are going on. I have to believe at some point that charmed life expires.

Thank you, Mr. Chairman. You have been generous. I will yield back.

Mr. STEARNS. I thank the gentleman, and we are all finished with our hearing. Does the chairman emeritus have any closing comments before I close the committee?

Mr. DINGELL. Just to thank you, Mr. Chairman, and thank our witness. Mr. Larsen, you have done a superb job.

Mr. LARSEN. Thank you.

Mr. DINGELL. I think it has been a very useful and very helpful hearing, Mr. Chairman, and I commend you for it.

Mr. STEARNS. All right. Thank you.

Mr. DINGELL. And I think that we have laid to rest a lot of the concerns that I have heard expressed, and we have been able to observe that some of the concerns I have heard have been essentially red herrings drawn diligently across the pathway of success in the future. I want to thank you for your fine participation in this, Mr.

Chairman, and you, Mr. Larsen, thank you for your kindness. To my colleagues here, I want to say we appreciate your getting these questions out because they are valuable and they will lead us to a better understanding of the events before us in this legislation. Thank you, Mr. Chairman.

Mr. STEARNS. And with that, I would agree that this hearing will give us a better understanding of Obamacare.

I want to thank the witness for coming today and for the testimony and members for their devotion to this hearing today. The committee rules provide that members have 10 days to submit additional questions for the record to the witness.

With that, the subcommittee is adjourned.

[Whereupon, at 12:22 p.m., the subcommittee was adjourned.]