THE CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT AND THE IMPLEMENTATION 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

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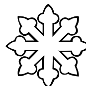

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THE CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT AND THE IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

WEDNESDAY, APRIL 24, 2013

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

The Subcommittee met, pursuant to call, at 10:00 a.m., in room 2123 of the Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Members present: Representatives Murphy, Burgess, Blackburn, Scalise, Harper, Olson, Gardner, Griffith, Johnson, Long, Ellmers, Upton (ex officio), DeGette, Braley, Lujan, Schakowsky, Butterfield, Castor, Tonko, Green, and Waxman (ex officio).

Staff present: Mike Bloomquist, General Counsel; Sean Bonyun, Communications Director; Matt Bravo, Professional Staff Member; Karen Christian, Chief Counsel, Oversight; Andy Duberstein, Deputy Press Secretary; Brad Grantz, Policy Coordinator, O&I; Sydne Harwick, Legislative Clerk; Brittany Havens, Legislative Clerk; Sean Hayes, Counsel, O&I; Robert Horne, Professional Staff Member, Health; Alexa Marrero, Deputy Staff Director; Andrew Powaleny, Deputy Press Secretary; Brian Cohen, Democratic Staff Director, Oversight & Investigations, and Senior Policy Advisor; Karen Nelson, Democratic Deputy Committee Staff Director for Health; Stephen Salsbury, Democratic Special Assistant; and Matt Siegler, Democratic Counsel.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Good morning. I convene this hearing of the Subcommittee on Oversight and Investigations to examine the Department of Health and Human Services' management of the Affordable Care Act as we approach the January 1, 2014, deadline for full implementation.

Mr. Gary Cohen, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight, or CCIIO—by the way, it is known as CCIIO—is here to testify on behalf of HHS. Good morning.

CCIIO was responsible for implementing the Patient Protection and Affordable Care Act's many changes to the private health in-

surance market. Mr. Cohen and those at CCIIO certainly have their work cut out for them. At the beginning of the next year, full implementation of the PPACA will finally take place. And on that day, Americans have been promised the ability to purchase health insurance plans through new exchanges. The American people have been promised good coverage that is also affordable.

We all remember the many promises that were made in the rush to pass the bill by any means necessary, that if you liked your coverage, you could keep it. Yet, we see many stories about impending doctor shortages and companies faced with tough decisions on whether to continue providing coverage. The decision of whether to provide that coverage is related to another promise that will surely be broken—that the law will lower costs. One large health insurance company's CEO has already noted that Americans should get ready for premium rate shock. A school district in my district has said that they are going to see their premiums go up by something like $1 million in cost.

Yet, there is yet another promise that we are hearing more recently from the law's defenders: that the health insurance exchange will be ready for enrollment on October 1 and full implementation on January 1. Since only 18 States elected to establish their own exchanges, CCIIO is currently preparing the federally facilitated exchanges that will cover 26 additional States, along with the partnership exchanges CCIIO will operate with 7 other States. I hope we will be able to hear today about the progress being made in building those exchanges.

Recent news reports have indicated—and even President Obama's budget has confirmed—that the Administration is seeking additional funding to operate the exchanges. This is troubling considering that a substantial amount of funding has already been expended building those exchanges and they have yet to even begin.

Today, I expect the witnesses to provide a full accounting of where CCIIO stands with regard to building the federally operated exchanges and those that will be run in partnership with States, including where CCIIO is obtaining funding for these programs and will they ask for more.

Since passage of PPACA this committee has had many questions about the funding being used to implement the law. Most recently, we have heard many stories about the healthcare law's Prevention and Public Health Fund. Most notably, that money from this fund is being utilized to hire thousands of healthcare navigators who will assist the public in signing up for Obamacare.

Considering that we have also heard that funding from the Prevention Fund is being used on many different projects, we are concerned that it is being rated as an ever-ready piggy bank, or slush fund, to throw money at and hide the many problems inherent with implementing Obamacare. I hope that Mr. Cohen will be able to address the potential overutilization that has become so common that the Washington Post has dubbed it "the incredible shrinking Prevention Fund."

We have many concerns about those navigators, including how they will be trained and supervised. CCIIO is actively soliciting navigators from the community and consumer groups, yet those that receive any compensation from insurance companies are pro-

hibited from becoming navigators. We recognize the need to have impartial navigators, but the realities of the insurance market also indicate that those who have been selling insurance for many years may have some expertise of value.

Furthermore, we have questions about what standards will be put into place to ensure that we are not simply paying groups chosen to be navigators to pad their membership rolls or funding drives. In other words, someone with experience and training is not qualified and is excluded, whereas someone without any experience stands in front of the line for hiring.

But this only scratches the surface of many activities and responsibilities of CCIIO. Today, I hope we will also be able to discuss CCIIO's ability to determine whether health insurance premiums' increases are legitimate. As I mentioned before, one large health insurance company has already warned of rate shock, and this is an obvious concern for many Americans.

Obamacare has consistently promised lower costs and now we all hear from supporters of the law that there are tax credits and subsidies available, but a recent study showed that only 8 percent of the public will qualify for those subsidies. I hope we can hear from the witnesses today what the other 92 percent of us can expect.

Thank you again, Mr. Cohen, for joining us today. And now I would like to recognize the ranking member, Ms. DeGette, for an opening statement.

[The prepared statement of Mr. Murphy follows:]

PREPARED STATEMENT OF HON. TIM MURPHY

I convene this hearing of the Subcommittee on Oversight and Investigations to examine the Department of Health and Human Services' management of the Affordable Care Act as we approach the January 1, 2014, deadline for full implementation. Mr. Gary Cohen, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight, or CCIIO, is here to testify on behalf of HHS. CCIIO is responsible for implementing the Patient Protection and Affordable Care Act's many changes to the private health insurance market.

Mr. Cohen and those at CCIIO certainly have their work cut out for them: At the beginning of next year full implementation of the PPACA will finally take place. On that day Americans have been promised the ability to purchase health insurance plans through new exchanges. The American people have been promised good coverage that is also affordable.

We all remember the many promises that were made in the rush to pass the PPACA by any means necessary. That if you liked your coverage you could keep it. Yet, we see many stories about impending doctor shortages, and companies faced with the tough decision of whether to continue providing coverage. The decision on whether to provide that coverage is related to another promise that will surely be broken: that the law will lower costs. One large health insurance company's CEO has already noted that Americans should get ready for premium "rate shock."

There is yet another promise that we are hearing more recently from the law's defenders: that the health insurance exchanges will be ready for enrollment on October 1 and full implementation on January 1. Since only 18 states elected to establish their own exchanges, CCIIO is currently preparing the federally facilitated exchanges that will cover the other 26 states, along with the partnership exchanges CCIIO will operate with seven other states. I hope we will be able to hear today about the progress being made in building those exchanges.

Recently news reports have indicated-and even President Obama's budget has confirmed-that the administration is seeking additional funding to operate the exchanges. This is troubling considering that a substantial amount of funding has already been expended building those exchanges and they have yet to even to begin. Today I expect the witness to provide a full accounting of where CCIIO stands with regards to building the federally operated exchanges and those that will be run in

partnership with states, including where CCIIO is obtaining funding for these programs.

Since passage of the PPACA this committee has had many questions about the funding being used to implement the law. Most recently we have heard many stories about the health care law's Prevention and Public Health Fund—most notably that money from this fund is being utilized to hire thousands of health care "navigators" who will assist the public in signing up for Obamacare. Considering that we have also heard that funding from the Prevention fund is being used on many different projects, we are concerned that it is being raided as an ever-ready piggy bank to throw money at and hide the many problems inherent with implementing Obamacare. I hope that Mr. Cohen will be able to address the potential overutilization that has become so common the Washington Post has dubbed it "The incredible shrinking prevention fund."

We have many concerns about those Navigators, including how they will be trained and supervised. CCIIO is actively soliciting Navigators from community and consumer groups, yet those that receive any compensation from insurance companies are prohibited from becoming Navigators. We recognize the need to have impartial Navigators, but the realities of the insurance market also indicate that those who have been selling insurance for years may have some expertise. Furthermore, we have questions about what standards will be put in place to ensure that we are not simply paying groups chosen to be Navigators to pad their membership roles or funding drives.

Yet, this only scratches the surface of the many activities and responsibilities of CCIIO. Today I hope we will also be able to discuss CCIIO's ability to determine whether health insurance premium increases are legitimate. As I mentioned before, one large health insurer has already warned of "rate shock", and this is obviously a concern considering how supporters of Obamacare have consistently promised lower costs. Now, we all hear from supporters of the law that there are tax credits and subsidies available, but a recent study showed that only eight percent of the public will qualify for those subsidies. I hope we can hear from the witness today what the other 92 percent of us can expect.

# # #

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

Ms. DEGETTE. Thank you very much, Mr. Chairman, and welcome to you, Mr. Cohen.

Thanks to the Affordable Care Act, tens of millions of Americans who would otherwise be uninsured will receive health insurance for the first time. Americans will enjoy protections from the worst abuses of the insurance industry: rescissions, coverage denials, and annual and lifetime limits that cruelly cut off coverage for folks when it is needed most. These are all big changes and the time to implement them is coming up very, very fast.

In just over 5 months, citizens will be able to sign up for health insurance through the federal or state marketplaces. Now, while signing up for coverage should be easy come October, implementation is going to be a complicated process over these next few months, not because of any flaws in the law, but because this is a new approach to providing coverage nationwide, and these things are always difficult to implement.

And by the way, this CBO has predicted that overall consumer costs will go down once these marketplaces are implemented. There is no reason to think it won't work. It worked great in Massachusetts under Mitt Romney. But we have to educate millions of people about the marketplaces in advance. CCIIO and the States have set up complex data systems to manage the process.

So, Mr. Chairman, I am super glad that you are doing this oversight, and I think we need to hear from Mr. Cohen, probably not just today, but as we go through the summer, about how CCIIO was doing, where there are challenges, and how the agency expects to address those challenges. I do think, though, that we should conduct this oversight with an appropriate perspective.

I wish, for example, that when the naysayers raise the specter of a potential increase in premiums for some young healthy people, particularly young men, that they can also put this into perspective by understanding that the tax credits and caps on out-of-pocket costs will sharply lower overall costs for these individuals and millions of other Americans.

And I wish that folks raising the specter of high premiums for young men in particular could add to that perspective the millions of women of all ages who will pay lower premiums and who won't be discriminated against by insurers simply because they are female or the millions of Americans who will receive dramatically better and more dependable insurance coverage.

When people complain about the fact that the Obama Administration is, heaven forbid, spending money to make sure that citizens understand the new law, I wish they would take the perspective to remember that the Bush Administration did the same thing, even hiring blimps to spread the word about Medicare and spending $300 million on a public relations campaign for Medicare Part D.

And Mr. Chairman, I will say, I voted against the Medicare Part D Bill because it didn't allow negotiation by the Secretary of HHS to lower prescription drug costs. But even though I voted against it, I had town hall meetings all throughout my district and I had internet training to help my constituents figure out how to sign up for it. And I think we need to have that kind of bipartisan cooperation as we implement these exchanges at the national and state level. And so I hope that we take that appropriate perspective and I hope that we can develop that perspective as the Affordable Care Act is implemented over the coming months.

In January 2006, when we implemented the Medicare Part D program, Time magazine described a "initial nightmares of implementation," noting snafus that have resulted in many low-income seniors being turned away by the compounding new prescription drug program. In Vermont, the implementation of the law was described as a "public health emergency." Now, those problems are almost forgotten until today. Ultimately, the Part D program got off the ground and even those who initially voted against the bill, like me, took a stake in it and worked to fix the problems. The biggest problem, the donut hole, was eliminated by the Affordable Care Act.

So I think, Mr. Chairman, as usual, there is a lesson to be learned in this history. I hope that the implementation of the Affordable Care Act goes smoothly. I certainly hope it goes more smoothly than the implementation of the Medicare Part D. But I am not naïve enough, and no one should be, to think it will be completely wrinkle-free. What I do hope is, as problems arise, we can work together to identify and fix them instead of using them to simply score political points, because we all have a stake in pro-

viding quality, affordable health insurance coverage for all Americans.

I hope this hearing and our future work on this subject represents an effort by everybody to truly work together to implement this law. I thank you for having the hearing and I yield back.

Mr. MURPHY. The gentlelady yields back. I now recognize the chairman of the full committee for 5 minutes, Mr. Upton of Michigan.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Thank you, Mr. Chairman.

Today's hearing continues this committee's rigorous oversight of the Obama Administration's implementation of the healthcare law. Since the law's passage, we have had CCIIO before this subcommittee three times, and during previous hearings, we uncovered that the promises made about the Affordable Care Act didn't quite match up with reality.

In 2011, we learned that CCIIO was granting waivers from the law to individuals and companies that would face large premium increases or the loss of coverage because of Obamacare. We also found that, through its implementation of the Early Retiree Reinsurance Plan, CCIIO had handed out millions of dollars to certain corporations, unions, and state governments. Even more troubling was the fact that the Early Retiree Plan burned through the $5 billion allocated to it so quickly that it actually stopped accepting applications in May of 2011, more than 2 years before the program was supposed to and. Yet, this is the same amount of money that was given to the Preexisting Condition Insurance Plan.

This bill has been the law of the land now for over some 3 years and we are just 8 months away from the full implementation, and by all accounts, the Administration still doesn't have its act together. It doesn't bode well when just last week a top supporter of the President and leading Senate architect of the law publicly warned the HHS Secretary that he sees a train wreck coming. Will the exchanges be ready? How will families be able to prepare for it? Will they be able to rely on the promises that if you like your coverage you can keep it? Will young adults be able to afford higher costs?

The alarm bells over how Obamacare will unfold are getting louder by the day. Costs are going up, insurers are warning about premium increases, and small businesses are indeed struggling with the choices about whether they can provide employees with coverage. Patients need certainty. Employers need certainty. And I hope that HHS and CCIIO will always show us what they are doing to implement the law by the deadline.

Finally, last week, this committee marked up a bill that targets the Prevention and Public Health Fund to give that money to those who need it most: Americans with preexisting conditions who were promised coverage by supporters of Obamacare, only to find that the program was closed to new applicants a few weeks ago. The Preexisting Condition Insurance Plan has been an unfortunate example of the problems of Obamacare. The promises don't match reality, and I think that it is unacceptable that this is going to hap-

pen, and I look forward to the vote this afternoon to fix it. And I yield the balance of my time to Dr. Burgess.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

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This bill has been the law of the land for over three years. We are just eight months from the full implementation and by all accounts the Obama administration does not have its act together. It does not bode well when, just last week, a top supporter of the president and leading Senate architect of the law publicly warned the HHS Secretary that he sees a "train wreck" coming. Will the exchanges be ready? How will families be able to prepare for this? Will they be able to rely on the promise that if you like your coverage you can keep it? Will young adults be able to afford higher costs? The alarm bells over how Obamacare will unfold are getting louder by the day: costs are going up, insurers are warning about premium increases, and small businesses are struggling with the choice about whether they can provide employees with coverage.

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# # #

Mr. BURGESS. I thank the gentleman for yielding.

Mr. Cohen, thank you for coming back to our humble little subcommittee.

Of course, my interest in CCIIO actually predated CCIIO when you were OCIIO, right after the Affordable Care Act passed and Mr. Angoff was good enough—I didn't get a hearing on that. We were in the minority but Mr. Angoff was good enough to come to my office and talk to me at least. Mr. Larson has been in a couple of times, and you have been in before us at least one time before. But I have got to tell you, it has been very, very difficult to get information out of the Center for Consumer Information and Insurance Oversight, the basic budgetary information.

Now, the ranking member says that we all ought to be in a posture of working together. It is difficult to do that when the most basic questions remain unanswered. So we got October 1, it is coming fast, 5 months away, and it seems like there are more and more questions about the readiness of your office, and indeed, the

Administration to get the answers that people want. I mean, you yourself went to AHIP, the American Health Insurance Plans conference this month and, "it is only prudent to not assume everything is going to work perfectly on day one." I agree with that, but I think we at this committee need to hear from you, where are the concerns? Where do you see the lights blinking on the dashboard? What are you doing to prepare yourself and your agency and your center for that day in October that dawns and everyone goes online on the federal hub that may or may not exist to be able to sign up for these programs? Senator Rockefeller actually said it pretty well the other day. People are going to get a bad impression and it is going to stay with them.

I think the references to Part D are reasonable to make. But remember, that they happened after 2 years of preparation. You have had 3 years of preparation. The 6 weeks of turmoil with Part D could likely turn into many more weeks and/or months, or even years of turmoil when this program is unfolded next year.

So the application process is lengthy and complex. People are asked to estimate whether or not they think their employer will provide insurance next year, what their earnings are going to be next year. I mean, these are tough questions that need answers and we hope we get some today, and certainly, we will be adding additional questions in writing in the period that they are allowed.

So I thank you for being here today and look forward to your answering questions.

Mr. MURPHY. The gentleman's time has expired. I now recognize 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. Thank you very much, Mr. Chairman.

The Republicans on this committee and our Health Subcommittee have held 5 hearings since December on the Affordable Care Act, and each of these 5 hearings repeats the themes that they expressed when they opposed the bill. And they certainly never expected this to become law. Republican members can't accept the health reform is working and it is now the law of the land. They opposed it from the beginning, and until the day the President signed the bill into law, they insisted it had no chance of passing. Until the Supreme Court ruled it constitutional, the Republican said, oh, it is not constitutional. Until the day President Obama was reelected, they insisted the American people would vote him out of office so they could overturn this law. None of that happened.

And now, they call this an oversight hearing because they predict all these terrible things to happen. They are not predicting; they are wishing bad things to happen. This is not a hearing to be constructive; it is a hearing to attack the law and hope that it doesn't work. Well, the Affordable Care Act will go fully into effect and Americans will never again have to worry about their ability to get affordable, high-quality health insurance. So the Republicans are

saying, well, the implementation is not going to go smoothly. Well, implementation of any new big program has its kinks.

But the Affordable Care Act is proceeding on schedule and it has done a remarkable amount of good for people. Over 3 million young adults now have health insurance. Over 100 million Americans have received free preventive health benefits. More than 6 million seniors have saved $6.1 billion in the Medicare Part D drug program. And beginning next year, tens of millions of Americans, who would otherwise be without health coverage, will have dependable, quality health insurance.

My Republican colleagues said people want certainty. Well, the certainty they would have if there was no Affordable Care Act is that millions of people would be discriminated against because they had preexisting health conditions, because they offer a risk to the insurance companies. They have to pay more money for their care. They would have the certainty of knowing that insurance companies would do everything they could to keep them from getting coverage if it is going to cost the insurance companies money. And that is what we wanted to change.

Republicans still oppose the Affordable Care Act. They are not taking a constructive approach. They are not saying, what can we do to make this law and its implementation work more smoothly? They are saying, what can we blame people who supported this law about the problems that may come up?

While I am pleased that we have at this hearing today again Gary Cohen, who was here in December answering many of the same questions I am sure he will be addressed today. The Center for Consumer Information and Insurance Oversight has made huge progress in implementing the Affordable Care Act. Success doesn't change the opinions of my colleagues on the Republican side of the aisle. It makes them even more determined to look for something they can criticize. And today on the House Floor, we are going to vote on a bill that they produced, because under the Affordable Care Act, we had a high-risk pool for people with preexisting conditions who are waiting until January to be able to buy health insurance without being discriminated against, without being charged more money because of those preexisting conditions.

We have spent $5 billion on a program to precede that to help people with preexisting conditions to be in a high-risk pool and we ran out of money. Republicans don't mind that we run out of money for everything that the government does because they supported the idea of sequestration happening. And we are running out of money in all sorts of places where the government has an obligation. But we have run out of money for that preexisting medical problems pool until the last few months of this year.

So the Republicans are suddenly concerned about people with preexisting conditions decided to make sure that fund has enough money to go on for the rest of this year. But they funded by taking away the Public Health Prevention Funds until 2016. It makes no sense whatsoever. We are happy to support the continuation of that preexisting pool to the end of this year, but certainly, we could have found a better funding source and the Republicans have denied the opportunity for any other source to be offered on the House Floor today.

You have to question how sincere they are about wanting to help people with preexisting conditions, how sincere they are for wanting to see a smooth implementation of the bill now that it is law. They want this bill to fail. They want to go back to the time when millions of people had no chance for insurance. That is the certainty they want to offer and it is a certainty that led us to have the Affordable Care Act passed into law.

I congratulate Mr. Cohen and his agency for doing all that they are doing. It is an important service to make sure the law succeeds. And that is what we should all want to see happen now that it is the law and they lost the last election and their last chance to repeal it.

Mr. MURPHY. The gentleman yields back. All right.

For our witness, Mr. Cohen, you are aware that this committee is holding an investigative hearing, and when doing so, has the practice of taking testimony under oath. Do you have any objections to testifying under oath?

Mr. COHEN. No, sir.

Mr. MURPHY. 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 desired to be advised by counsel during your testimony today?

Mr. COHEN. No, sir.

Mr. MURPHY. In that case, if you would please rise and raise your right hand; I will swear you in.

[Witness sworn.]

Mr. MURPHY. Thank you. You are now under oath and subject to the penalties set forth in Title XVIII, Section 1001, of the United States Code. You may now give a 5-minute summary of your written statement, Mr. Cohen.

TESTIMONY OF GARY COHEN, DIRECTOR, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT

Mr. COHEN. Thank you and good morning, Chairman Murphy, Ranking Member DeGette, and members of the committee. I appreciate the opportunity to tell you about CCIIO's accomplishments over the past year. A lot has happened since your last hearing on implementation of the Affordable Care Act, and I would like to describe to you some of the progress we have made and explain how I know that we are on track for open enrollment this October.

We achieved a major milestone earlier this month when we opened the window for issuers to begin submitting plans to be sold through the federally facilitated marketplace. We said that would happen on April 1 and it did, right on schedule. We have had a very encouraging response and we expect to see robust competition for the business of millions of Americans who will be shopping for health insurance in this new marketplace. States that are operating their own marketplaces had begun accepting submissions from issuers as well.

It is also important to understand the ways in which we have continued to improve our process since the window opened on April 1. We have gotten feedback from States and issuers as they have accessed the system, and we have addressed whatever issues have come up. We have a helpdesk that responds by email to anyone

with questions about how to submit information to us. We hold regular phone calls and we regularly publish answers to frequently asked questions. At last count, there were over 200 answers to frequently asked questions in connection with this process that have been provided to issuers and States. I am extremely proud of the work that the team is doing to make sure that we will have products on the shelves by October 1.

Another key element of this process is the federal data hub. As you know, consumers will be providing certain information in order to determine whether they are eligible for tax credits to help pay their premiums for the commercial health insurance that will be offered in the marketplaces. This data will be transmitted to the data hub in real time to be checked against information that is available regarding income, citizenship, incarceration, and so forth. The hub will not store any individual's data. It is a conduit from the agencies where this data is kept such as the IRS, Social Security, and Department of Homeland Security. This will enable real-time electronic verification of information needed to determine eligibility and will reduce, to the greatest extent possible, the need for people to submit paper documentation.

States that are operating their own marketplaces will also have access to the data hub. We have recently begun testing the connection between state systems and the hub and have succeeded in transferring data back and forth. This is another major milestone that has been achieved on schedule. Testing will continue and the hub will be fully operational in time for open enrollment this fall.

Another key element is the single streamlined application the consumers will use in order to find out whether they are eligible for Medicaid or CHIP on the one hand or tax credits to purchase commercial insurance plans through the marketplace on the other. We have gone through an extensive consumer testing process since the draft of the application was published and we have continued to work to make it as simple as possible. The results have been encouraging. Highlighted messaging will help answer questions, alleviate concerns, and direct consumers to where they can get additional help. We found that most applicants will need to complete less than ⅓ of the total number of items included in the entire physical form.

Now, no matter how simple and straightforward we are able to make the application process, we know that buying health insurance is not like buying a book on Amazon or shoes from Zappos. Many of the people coming to the marketplace will never have had commercial health insurance before and will need help in choosing the plan that is right for them and their family.

During the past year, we have been putting in place a variety of ways for people to get that help. On healthcare.gov, people can learn about the Affordable Care Act, review health insurance basics in order to understand what their coverage costs, and interact with a checklist on how to prepare for shopping for coverage in the new marketplace. There are several short videos explaining how shopping for Qualified Health Plans in the federally facilitated marketplace will work.

In addition, healthcare.gov will have a chat capability so that people can get their questions answered quickly as they use the

site. The call center will begin operating in June, and during open enrollment, it will be answering questions 24 hours a day, 7 days a week.

On April 9, we announced a funding opportunity for recipients to operate as navigators for the federally facilitated and partnership marketplaces. Navigators will provide fair, accurate, and impartial information to help consumers use the marketplace and select a Qualified Health Plan. Meanwhile, licensed agents and brokers, compensated by the issuer and regulated under state law, may enroll consumers in coverage through the marketplace in every State.

As you can see, CMS has been hard at work over the past year improving the health insurance market for all Americans. This work and these achievements make me confident and excited for the future health insurance market. Soon, consumers will have better access to health coverage that best fits their needs.

So I thank you for holding this hearing and I would be happy to answer your questions.

[The prepared statement of Mr. Cohen follows:]

STATEMENT OF

GARY COHEN, J.D.

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

ON

THE CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT
AND THE IMPLEMENTATION OF
THE PATIENT PROTECTION AND AFFORDABLE CARE ACT
BEFORE THE

U. S. HOUSE COMMITTEE ON ENERGY & COMMERCE,
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

APRIL 24, 2013

U. S. House Committee on Energy & Commerce,
Subcommittee on Oversight & Investigations
The Center for Consumer Information and Insurance Oversight and the Implementation of the Patient Protection and Affordable Care Act
April 24, 2013

Good morning, Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee. Thank you for the opportunity to speak about our work implementing the Affordable Care Act to put in place strong consumer protections, provide new coverage options, and give Americans the additional tools to make informed choices about their health insurance. In the past three years, the Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare & Medicaid Services (CMS) has completed an extraordinary amount of work under tight deadlines, and I am proud of what we have achieved.

This subcommittee has been interested in and involved in our work since the beginning, and I would like to give you an update on the progress CCIIO has made since we last testified before you a year ago, and in particular during the eight months since I became Director of CCIIO. A year ago, you and our stakeholders had many questions: What would the reformed insurance market look like? What essential health benefits would health plans be required to cover? Which states would be operating their Marketplaces, and which would choose to get help from CMS? How would issuers submit plans to be sold in the Marketplaces? How would consumers learn whether they are eligible for subsidies and shop for and enroll in coverage?

Thanks to all the work that has been done over this past year, I am pleased to be able to say that we now have answers to just about all of those questions, and many more. While work remains to be done, we are on schedule and I am confident that Americans in all states will enjoy the benefits of the Affordable Care Act that start on January 1, 2014.

After the Affordable Care Act passed, we implemented early market reforms that provided new rights and benefits to put consumers in charge of their health care. Specifically, most insurance companies can no longer deny coverage or specific benefits to children with pre-existing

conditions, can no longer drop or rescind people's coverage because they made an unintentional mistake on their application, and can no longer place lifetime limits on the dollar value of essential health benefits. We also helped make insurance coverage more affordable and available through the implementation of the Medical Loss Ratio (MLR) rule, the rate review program, the Pre-Existing Conditions Insurance Plan program, and the Early Retiree Reinsurance Program. During this past year, we have built on these reforms. Today, I would like to update you on that recent progress.

Health Insurance Market Reforms

The Affordable Care Act has the broad goal of making health coverage more available and affordable for everyone, while also helping to improve the broken health insurance market, especially for consumers in the individual and small group markets. In the past year, we have built upon the early market reforms and have focused on implementing provisions of the Affordable Care Act that will be effective in 2014. Soon, a variety of consumer protections will end the many insurance practices that make health care coverage too expensive or unavailable for many consumers.

Guaranteeing Availability of Coverage and Fair Premiums

We recently finalized a rule that, beginning in 2014, will generally prohibit health insurance companies from discriminating against individuals because of a pre-existing or chronic condition.[1] Under this rule, health insurance issuers of non-grandfathered coverage in the individual and small group markets would only be allowed to vary individual enrollees' premiums based on age, tobacco use, family size, and geography within limits. Health insurance issuers would thus be prohibited from charging higher premiums to certain enrollees because of their current or past health problems, gender, occupation, and small employer size or industry. Our final rule also should ensure that young adults and people for whom coverage would otherwise be unaffordable have access to catastrophic plans in the individual market. These provisions also extend the guarantee of availability and renewability of coverage.

[1]Health Insurance Market Rules; Rate Review Final Rule, 78 Fed. Reg. 13406 (Feb. 27, 2013) (available at http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf).

Stabilizing Premiums

The Affordable Care Act creates three programs – risk adjustment, reinsurance, and risk corridors – that reduce incentives for health insurance plans to avoid insuring unhealthy people or people with pre-existing conditions. These programs help stabilize the market when the market reforms begin in 2014. They will also help ensure that health insurance plans compete based on quality, benefits, and service and not by attracting the healthiest individuals. Better competition leads to improved coverage so that consumers—no matter how healthy they are—can pick the best plan for their needs.

We implemented these three programs through the Notice of Benefit and Payment Parameters for 2014[2] and the Reinsurance, Risk Corridors, and Risk Adjustment final rule.[3] The temporary risk corridors and transitional reinsurance programs will operate only through the 2014 to 2016 plan years, unlike the permanent risk adjustment program. The temporary risk corridor program will provide issuers additional protection against inaccurate rate setting. During the first three years of Marketplace operation, the transitional reinsurance program will help stabilize premiums for coverage in the individual market through payments to individual market issuers that cover individuals with high medical costs. The permanent risk adjustment program will transfer payments from health insurance issuers that cover lower-risk populations to those with higher-risk populations. These programs are designed to reduce issuer incentives to avoid sicker Americans, keep premiums in the individual and small group markets reasonably priced, protect against uncertain rate setting, and make insurance more affordable.

Providing Essential Health Benefits

In the last year, we have proposed and finalized the Essential Health Benefits rule,[4] which outlines policies and standards for coverage of essential health benefits, while giving states flexibility to implement this provision of the health care law. While the law states that all non-grandfathered health plans in the individual and small group markets must cover essential health benefits, which include ten statutory benefit categories, such as ambulatory patient services

[2] 78 FR 15541 Available at: http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04904.pdf
[3] 77 FR 17219 Available at: http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf
[4] Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834 (Feb. 25, 2013) (available at http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf).

(including doctors' visits), hospitalization, prescription drugs, and maternity and newborn care, we gave states the flexibility to select a benchmark plan that reflects the scope of services offered by a "typical employer plan." This approach gives states the flexibility to select a plan that would best meet the needs of their residents. If states did not select a benchmark, the default benchmark will generally be the small group plan with the largest enrollment in the state.

Beginning in 2014, non-grandfathered health plans in the individual and small group markets must meet certain actuarial values. The required actuarial value levels are 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. Actuarial value means the percentage paid by a health plan of the total allowed costs of benefits. For example, if a plan has an actuarial value of 70 percent, the average consumer generally would be responsible for about 30 percent of the costs of the essential health benefits the plan covers (though individual experiences may vary based on plan design and individual health needs). These tiers will allow consumers to compare plans with similar levels of coverage, which, along with comparing premiums and other factors, will help consumers make more informed health insurance coverage decisions. To streamline and standardize the calculation of actuarial values for health insurance issuers, the rule incorporates a publicly available actuarial value calculator, which issuers can use to determine health plan actuarial values, based on a national, standard population. This approach allows consumers to more transparently compare the plans available in 2014.

Under the Essential Health Benefits rule, beginning in 2015, CMS will accept state-specific claims data sets for the standard population if states choose to submit alternate data for the calculator. The rule includes standards and considerations for plans with benefit designs that the actuarial value calculator cannot easily accommodate. Recognizing that simply calculating the actuarial value of a high-deductible health plan based on the insurance plan alone could understate the value of the coverage, the rule counts employer contributions to health savings accounts offered in conjunction with the plan and amounts newly made available under integrated health reimbursement accounts that may be used only for cost-sharing within the plan design. The actuarial value calculator is posted on the CCIIO website.[5] These rules are shaping

[5] Actuarial Value Calculator: http://cciio.cms.gov/resources/regulations/index.html#pm

how Americans will obtain insurance in the individual and small group markets, both through and outside the Marketplaces.

Establishing the Health Insurance Marketplaces

Over the last year, CMS has been working with health insurance companies, states, consumers, and other stakeholders to improve the availability, affordability, and accountability of private insurance. To continue our goal of supporting and improving the private health insurance market, CMS steadily worked towards creating the Health Insurance Marketplaces. Qualified individuals will be able to access qualified health plans through the Marketplaces when they do not have affordable insurance through their employers, are self-employed, or are currently unemployed. The robust employer-sponsored insurance market will continue, with the additional protections and benefits described earlier that make private insurance more fair and affordable for consumers.

Marketplaces 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 best fit their needs. New premium tax credits and cost-sharing reductions will help ensure that eligible individuals and families can afford to pay for the cost of a private qualified health plan purchased through the Marketplaces.

The planning, development, and testing necessary to build the Marketplaces has been well underway over the past year. CMS has been diligently working with states through Marketplace Planning and Establishment Grants to support their infrastructure. To date, 49 states, the District of Columbia, and four territories have received grants to help them plan and establish the Marketplaces.

Last year, we released a final rule that offered a framework to assist states in setting up their Marketplaces.[6] The rule allows states to decide whether their Marketplaces should be operated by a non-profit organization or a public agency, how to select and certify plans to participate, and whether to work with CMS on some key functions. The rule offers significant additional

[6] 77 FR 31513 Available at: http://www.gpo.gov/fdsys/pkg/FR-2012-05-29/pdf/2012-12914.pdf

flexibility regarding eligibility determinations for Marketplaces and insurance affordability programs.

In the last year, we have issued further guidance to help guide states and to inform the public about the establishment of the Marketplaces. CMS released the Blueprint guidance,[7] which sets forth the approval process for State-based Marketplaces (Marketplaces that will be run by a state). Additionally, on December 10, 2012, CMS issued Frequently Asked Questions[8] to respond to questions that we have received from states to ensure that states have all of the information they need to make their decisions about running their Marketplaces. We will continue to provide additional guidance about the Marketplaces as needed, and we will do everything possible to answer specific state questions on a one-on-one basis and provide technical assistance to states and stakeholders.

This policy has helped states continue their progress in setting up their Marketplaces. In the last few months, we have conditionally-approved 18 State-based Marketplaces.[9] Each of these State-based Marketplaces has the authority, through either state laws or an Executive Order, to establish a Marketplace, and have established a board and governance structure. Meanwhile, most of the State-based Marketplaces have conducted statewide marketing research, including focus groups and surveys, and have reports that include the best messaging for outreach materials for their specific communities. For example:

- Colorado has been meeting with community organizations one-on-one since November 2012;
- Oregon is working with their Medicaid agency's network of partners to promote consumer assistance opportunities;
- Connecticut has had 14 town hall meetings across the state, and commissioned a needs assessment to identify potential community assistance organizations;

[7] Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges: http://cciio.cms.gov/resources/files/hie-blueprint-11092012.pdf
[8] http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf
[9] The conditionally-approved State-based Marketplaces are: California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, and Washington.

- California has done extensive outreach through social network sites, webinars, listservs, targeted county-by-county recruitment, and organizations that work with specific populations; and
- Seven states[10] have published Requests for Proposals for their Navigator programs, which is a community consumer assistance program established in the Affordable Care Act, and four of those states[11] have received and are now reviewing those Navigator applications.

States have also been hard at work creating the technology that will operate in the new insurance market. Already, the majority of the State-based Marketplaces have finalized their detailed systems' design requirements. States are also working together by using the same vendors to build their IT platforms to maximize efficiencies. For example:

- Maryland and Minnesota are leveraging one another's software code for various modules through their shared IT vendor and subcontractors, as are Colorado and Vermont.
- The Department of Health and Human Services (HHS) is facilitating multiple Community of Interest Networks centered around four vendors who are serving multiple states building Marketplaces.

To ensure that residents of every state have access to the affordable health insurance offered through the Marketplaces in 2014, CMS will operate a Federally-facilitated Marketplace in each of those states that have not established a State-based Marketplace. In order to build robust and competitive Federally-facilitated Marketplaces, CMS has worked closely with issuers to ensure consumers will have access to many different types of qualified health plans when they come to each Marketplace to shop for health insurance. For example, since May 2012, CMS has consulted with issuers on technical matters related to the eligibility and enrollment process standards for the Marketplaces and has responded to issuer questions and listened to their ideas and feedback. CMS has also provided targeted, comprehensive issuer trainings. On April 1, 2013, CMS began accepting and certifying issuers' qualified health plans' applications to participate in the Federally-facilitated Marketplaces. We will post the qualified health plans' rate and benefit packages on HealthCare.gov when open enrollment begins on October 1, 2013.

[10] Colorado, Washington, New York, Nevada, Vermont, Massachusetts, and Connecticut
[11] Colorado, Washington, New York, and Nevada

We also have taken a number of steps to ensure that consumers can easily compare and enroll in private health insurance plans through the Marketplaces. Beginning on October 1, 2013, when consumers visit the website of their Marketplace, they will be able to submit an application, find the qualified health plans and financial support available to them, and compare and choose a qualified health plan based on quality, benefits, and cost. We have already designed and released a model application for comment, which consumers will use to determine their eligibility for premium tax credits, cost-sharing reductions, Medicaid or the Children's Health Insurance Program (CHIP). This single, streamlined application will be used in the Federally-facilitated Marketplaces and will be available for use by states that are running their own Marketplaces, as well as by state Medicaid and CHIP agencies. To develop the application, CMS consulted with stakeholders, consumer groups, and the National Association of Insurance Commissioners (NAIC), and tested the applications with consumers. We expect to release an improved, shortened, final version of the application soon.

After a consumer fills out the single, streamlined application, the Marketplace will verify applicant information with existing electronic data sources from federal and state agencies and commercial entities. This information will be subjected to strong privacy and security protections and its disclosure among the federal agencies will be subject to compliance with the Privacy Act and all other relevant confidentiality statues and regulations. Regardless of what entity operates each Marketplace, CMS is working to ensure streamlined and secure access to a variety of information sources that are essential for operation.

To facilitate this access, CMS has built a single Data Services Hub that will be available to all Marketplaces in every state. The hub verifies consumer information through one connection to each agency involved, including the Social Security Administration, Department of Homeland Security, Internal Revenue Service (IRS), and other sources. In the hub, data will be routed, and not stored in the system, ensuring that the data flows where it is needed. The hub will access only the information needed to determine individual eligibility. CMS has completed the hub's technical design, a framework for security across agencies, protocols for connectivity, and is now

testing the hub with our federal and state partners. The hub will begin officially supporting the verification of applicant information on October 1, 2013, when open enrollment begins.

Through these streamlined processes that we have established and have begun testing, consumers will be able to fill out an application quickly, receive information about whether they are eligible for premium tax credits, or cost-sharing reductions, Medicaid, or CHIP, and begin shopping for qualified health plans, all in one sitting. Consumers can submit an appeal if they disagree with the eligibility determination they receive.

CMS and the states are also taking a number of steps to ensure that consumers can easily compare and enroll in private health insurance plans through the Marketplace. Marketplace Navigators will provide information to consumers in a fair, accurate, and impartial manner. Additionally, where permitted by the state,[12] licensed agents and brokers, including online brokers, may help consumers and employers enroll in a qualified health plan through the Marketplace. CMS and the states are working hard to ensure that people are aware of the new tools, benefits, and protections that will soon be available to them. On www.HealthCare.gov, people can learn about the Affordable Care Act, review health insurance coverage basics, such as understanding what their coverage costs, and access an interactive checklist to help prepare them to shop for coverage in the new Marketplaces.

CMS is also working with federal agencies and the private sector to reach, engage, and assist potential enrollees. We have an inter-departmental working group that includes a wide range of federal agencies to developing ideas and plans to encourage enrollment and distribute information. Other programs can provide Marketplace referral information in regular notices to clients, post Marketplace information on agency websites, and use local and regional offices to inform and reach out to specific populations. CMS is also working with private partners, including non-profits, provider and trade associations, advocacy groups, corporations and businesses, and faith- and school-based groups to distribute information, encourage enrollment, and support community engagement.

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[12] Per section 1312(e) of the Affordable Care Act and 45 C.F.R. § 155.220.

Conclusion

As you can see, CMS has been hard at work over the past year improving the health insurance market for all Americans. This work, and these achievements, makes me confident and excited for the future health insurance market. Soon, consumers will have better access to care. Beginning October 1, 2013, eligible consumers who need health coverage will be able to logon to HealthCare.gov to shop for affordable coverage or will be able to access in-person consumer assistance or over the phone to choose the health coverage that best fits their needs. As soon as January 1, 2014, their coverage will begin, and they can be assured that if they become sick or injured, they will have comprehensive coverage that will help them get the care they need. Of course, our work does not end once the market reforms have taken effect and the Marketplaces are up and running. We will continue testing and refining our systems, reaching out to people who need health coverage, and providing and improving affordable health coverage. I look forward to working with you and keeping you informed as we continue this important and intensive work.

Mr. MURPHY. I thank you very much, Mr. Cohen. Let me recognize myself for 5 minutes here.

Regarding the navigators, I believe the law says that if they have received compensation from an insurance company, they are not eligible to be employed as a navigator. Is that correct?

Mr. COHEN. That is what we have said in our regulations. If they have received compensation from an insurance company in connection with enrolling people in health coverage, they are not eligible to be navigators.

Mr. MURPHY. So let's say Mary Smith is an insurance agent in Pennsylvania, 20 years in the field. Now, she has received a license to sell insurance in the State of Pennsylvania. In order to do that, she had to have 24 credit hours of training. Then, she takes a test. She passed the test, must continue to take 24 credit hours of training every 2 years to maintain her license. Let's say she has sold a wide range of insurance for multiple companies for profit and nonprofits to perhaps thousands of individuals. She would like to apply for a job as a navigator. There is also John Doe who is applying for a job as a navigator with a high school degree and zero experience selling insurance. Who is eligible to be hired?

Mr. COHEN. So I think it is important to understand that there really is a difference between what a navigator does and what an insurance agent does.

Mr. MURPHY. I understand.

Mr. COHEN. Mary Smith——

Mr. MURPHY. But I just want——

Mr. COHEN. Mary Smith——

Mr. MURPHY [continuing]. To make sure I understand. Mary Smith is not qualified? Or she is——

Mr. COHEN. Mary Smith is qualified to offer insurance in the marketplace as——

Mr. MURPHY. But not as a navigator. She is prohibited——

Mr. COHEN. She is not eligible for a navigator——

Mr. MURPHY. But she is discriminated from being a navigator because she has experience in the field that is paid. Am I correct?

Mr. COHEN. But she is welcome to help clients obtain coverage in the marketplace as an agent.

Mr. MURPHY. I understand. But someone who has actually done this for a living is prohibited from being hired to advise people to buy insurance under the exchanges or to be advised on how to buy insurance in the States. Am I correct?

Mr. COHEN. Well, she could choose no longer to be selling insurance——

Mr. MURPHY. But if——

Mr. COHEN [continuing]. Like half of issuers, and be a navigator. That is her choice.

Mr. MURPHY. So as long as she is no longer taking any money from insurance companies——

Mr. COHEN. She is eligible. Correct.

Mr. MURPHY. Now, let me ask you this because some of this still I am still puzzled about. In terms of the time frame here—because a lot of employers are saying to me I have got to make decisions now. They are not going to start budgeting, or having budget decisions on December 31st but want to make decisions now. How soon

will the information be available to them in terms of what is going to be in these exchanges? Do you have some date of that?

Mr. COHEN. Yes. The plans are being submitted now. They will be reviewed both by us and by the state insurance regulators that have to approve the plans. And then issuers will have an opportunity to make any changes——

Mr. MURPHY. Just give a date in terms of when those will be available.

Mr. COHEN. September.

Mr. MURPHY. In September. Now, the navigators are going to have complete final training in August, so that seems a bit odd according to your calendar. They can't really get final training before they see the exchanges, so I hope you would adjust that date.

Mr. COHEN. Well, the primary function of the navigators in the early period will be outreach and enrollment. And then once open enrollment starts in October, then that is when they will be helping people——

Mr. MURPHY. So these things will be available to look at in September, but then sales of these plans will start in October, a month later?

Mr. COHEN. Correct, for coverage in January.

Mr. MURPHY. And you feel you will be ready with everybody fully trained and people fully informed of what is available in that month?

Mr. COHEN. Yes.

Mr. MURPHY. All right. Now, I want to ask you also another thing with regard to navigators because there are some concerns I have heard that people who—are people who are involved in some community groups or political groups, they can apply for jobs as navigators?

Mr. COHEN. So the requirements for applying for a grant are set forth in the funding opportunity, not to mention——

Mr. MURPHY. But I am just wondering if there are prohibitions in terms of involvement in other activities that they would not be——

Mr. COHEN. We are hoping that groups that have a demonstrated history of serving their community and serving the people in their community that we are trying to reach will apply for navigator grants.

Mr. MURPHY. So ACORN members could?

Mr. COHEN. I can't speak to any particular group——

Mr. MURPHY. Well, but they wouldn't prohibit them, right?

Mr. COHEN. They can apply——

Mr. MURPHY. OK.

Mr. COHEN [continuing]. And their application will be reviewed and we will be making decisions——

Mr. MURPHY. Well, given that they are community groups, I am concerned about data confidentiality and HIPAA laws, et cetera, certainly, if they are discussing their own health with navigators. What assurance do you have in place and what penalties will there be to make sure they do not keep that data, it is only, for example, on government computer systems, they cannot use it for any other purpose? Could you address that issue?

Mr. COHEN. Certainly, thank you. So navigators will be trained on the importance of privacy and security and will be subject to all of the laws and regulations that protect people——

Mr. MURPHY. Are there other specific criminal penalties if they use this data for their own purpose?

Mr. COHEN. There are.

Mr. MURPHY. And are they allowed, as community groups, to accept donations from insurance companies and other private groups?

Mr. COHEN. The prohibition is against receiving compensation for enrolling people in coverage.

Mr. MURPHY. I understand. But if they get donations in a general sense, are they permitted to do that?

Mr. COHEN. I think——

Mr. MURPHY. You are not sure?

Mr. COHEN [continuing]. I would need to understand better what the—what type of donation and what the purpose of it would be——

Mr. MURPHY. Could you look into that, please, and get back to us?

Mr. COHEN. I would be happy to.

Mr. MURPHY. I understand your concern. That is an important concern for all of us on those things, too.

I also have a final question with regard to do you think you have enough funding at this point, not future budgetary things, to take care of your enrollment of people in these exchanges?

Mr. COHEN. For fiscal year 2013 we have enough funding and we have—the President's budget requests additional funding for fiscal year 2014.

Mr. MURPHY. Thank you. My time has expired.

I will now recognize Ms. DeGette for 5 minutes.

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

Mr. Cohen, the chairman talked to you about this hypothetical person, Mary Smith, who is a registered insurance broker or something. And she can't be a navigator while she is selling insurance. That is because it would be a conflict of interest, correct?

Mr. COHEN. That is right.

Ms. DEGETTE. But if she, with all her qualifications, decided not to represent any insurance companies and not to do that, she could become a navigator, correct?

Mr. COHEN. She could.

Mr. DEGETTE. Because then she wouldn't have a conflict of interest, right?

Mr. COHEN. That is right.

Ms. DEGETTE. Now, what about these community groups? On the community groups, as I recall when we did the Medicare Part D prescription drug benefit, we also had a number of community groups helping sign seniors up for that. Is that right?

Mr. COHEN. Correct.

Ms. DEGETTE. And that was kind of a similar situation because it involved asking citizens—in this case, senior citizens—to sort out a number of plans and then apply online, right?

Mr. COHEN. That is true.

Ms. DEGETTE. And so really you did have to have trained individuals, whether from community groups or other places, helping folks do this, right?

Mr. COHEN. You did.

Ms. DEGETTE. OK. Now, I am glad that you have a lot of confidence that on October 1, 2013, consumers are going to be able to sign up for these exchanges. I want to ask you about the States, including my State of Colorado, which are going to either run their own marketplaces or their marketplace in partnership with the Federal Government. There are 24 of them. What is your view about the state marketplaces, how are they coming along?

Mr. COHEN. So I am very encouraged by the progress the States have been making. We work with them on literally, you know, a daily and weekly basis. We are in close contact with the people at the exchanges and also at the state Medicaid agencies because that is a very important part of this as well. I think it is fair to say that there are some States that started earlier in the process and some States that started a little bit later. So we are looking very carefully at the progress that each of the States are making and our commitment is that there will be a functioning marketplace in every State on October 1. So we have been working with the States to make sure that we provide the support that is needed to make that happen.

Ms. DEGETTE. And what about the States that got a late start? Are you giving them extra effort to help them get their exchanges up and going?

Mr. COHEN. That is correct.

Ms. DEGETTE. OK. Now, can you give us a sense—the Chairman and I have talked a lot about the importance of doing this oversight—what are the milestones and benchmarks we should be looking at to measure CCIIO's progress over the next few months?

Mr. COHEN. So I think—and we provided you, I think, with a timeline for what is supposed to be happening and what will be happening over the next several months. I think the keys are that we are on schedule and on track with the IT build that were doing, which is clearly an important part of this. And as I mentioned, we have achieved a big milestone earlier this month with the QHP Submission process. The federal data hub is going to be moving—is in testing now but will be continuing testing through the summer. And so I think it is just important to take a look at each of the steps along the path and make sure that we are on track. But I am very optimistic and confident of where we are at this point.

Ms. DEGETTE. Now, Mr. Cohen, a couple of months ago at a conference you said, "it is only prudent to not assume everything is going to work perfectly on day one and to make sure that we have got plans in place to address things that may happen." You also said that as we get closer to October 1, "we will be in a position to better know which contingency plans we actually have to implement." That seems a little in contrast to what you are saying this morning. Can you explain what that comment meant and if that means that HHS is not going to be ready to implement the law?

Mr. COHEN. I would be happy to, and I think, you know, sometimes when things get reported, the context gets a little lost. So——

Ms. DEGETTE. I have never noticed that before.

Mr. COHEN. I was speaking specifically not about whether we would be ready and in operation October 1; I was speaking really, Congresswoman, to some of the comments that you made in your opening statement, that we know that when big programs begin, sometimes things aren't perfect on day one and you have to make improvements. And it is only prudent to be prepared for the things that might happen that you could do better. And we are, like all federal agencies, subject to guidelines that are published by the National Institute of Standards and Technology for when you do an IT project. And so you have to be prepared with mitigation strategies in case something doesn't work exactly the way you expected. But we will be up and operational October 1. I don't have any question about that.

Ms. DEGETTE. Could you tell us about how you are developing those mitigation strategies and are those coming along?

Mr. COHEN. Yes. So it is really a constant process of you—as you do the build—and I am not the expert on IT—but as you do the build, you do testing, you see how things are going, you come up with strategies for how you are going to deal with—for example, suppose we get a lot more applications that come in on day one than we planned for. So you have to have redundancy; you have to be prepared for that eventuality.

Ms. DEGETTE. Right.

Mr. COHEN. So those are the types of things that we are doing.

Ms. DEGETTE. Thank you.

Mr. MURPHY. OK. The gentlelady's time has expired.

I now recognize the gentleman from Texas for 5 minutes, Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman.

So Mr. Cohen, let's go back to AHIP quote about which contingency plans you actually have to implement now. The Secretary was here last week and I asked her about contingency plans and she said there are no contingency plans. Everything will be ready. So which is it? Everything will be ready or you are planning for contingencies?

Mr. COHEN. Everything will be ready but we are also planning for anything that, when we go into operation, if the situations come up that we need to address, we will be ready to address those situations and make sure that the experience for American consumers is as seamless and as good as it can be.

Mr. BURGESS. Well, the Committee would benefit, actually, from seeing some of those contingencies. Let me just ask you this: would it be fair to say that closing the enrollment on the Pre-Existing Condition Insurance Plan, was that a contingency?

Mr. COHEN. Closing enrollment on the Pre-Existing Condition Plan was something that we did because it was the prudent thing to do in light of the fact that we had a certain amount of money, $5 billion, to spend on that program——

Mr. BURGESS. So that was a contingency plan to close enrollment in PCIP that this committee was unaware of last year?

Mr. COHEN. I think we were looking very carefully at the expenditures of the program and we were committed as careful stewards

of the money that had been appropriated us to do whatever was needed to live within the money——

Mr. BURGESS. Yes, but here is the point: I mean the Secretary comes in and says there are no contingency plans; you are telling me that a year ago there was a contingency plan to deal with the Pre-Existing Conditions program. We need to know.

Mr. COHEN. Well, I didn't say that. I didn't say that. I said——

Mr. BURGESS. Well, it sounded like you said that. And if we take a context, which we will, that is how it will be reported by your friends in the press over here.

Look, we have got to level with each other. I mean people are going to be counting on you to do your job on January 1. And you have raised questions; your main health IT guy at the same AHIP conference where you spoke, he raised questions about whether that federal hub will be ready. And then you look at what happened in the Pre-Existing Condition Plan, there is a word that goes around. I learn new words in this town all the time. Some of them I can say here in committee; some of them I can't. But the word that keeps coming up is de-scoping. So are you actively discussing de-scoping, reducing the scope of the Affordable Care Act when the rollout occurs?

Mr. COHEN. No.

Mr. BURGESS. I mean I am reminding you, you are under oath so——

Mr. COHEN. Yes.

Mr. BURGESS [continuing]. When we call you back in here next year to talk about this, there is no plan to narrow the scope of the Affordable Care Act?

Mr. COHEN. We intend to implement fully the Affordable Care Act. We have announced already some portions that will be put off to 2015. But at this point, I don't anticipate any de-scoping of the Affordable Care Act now.

Mr. BURGESS. And yet, you look at the people who wanted to sign up for the preexisting program and in their parlance they have been de-scoped out the availability of that program, have they not?

Mr. COHEN. Well, the Preexisting Condition program was always meant to be temporary. And the circumstances of those people really point to exactly why we needed the Affordable Care Act——

Mr. BURGESS. Yes, but you know what——

Mr. COHEN [continuing]. Because those people were not able to get health insurance coverage at all——

Mr. BURGESS. Building a bridge doesn't do you any good if it doesn't get to the other side, and these people now fall into this 8-month chasm and that is a problem.

Now, the SHOP exchanges that were much extolled as a virtue of the Affordable Care Act and now those are going to be delayed—well, not really delayed but you will only have one choice because the competition that was advertised amongst these plans.

Mr. COHEN. Well——

Mr. BURGESS. And I think that is what Senator Rockefeller was talking about. Wait a minute. This was a serious missed-at fire.

Mr. COHEN. Let's be clear. Employers will have a choice. They can choose among the plans that are available in the SHOP. And we believe that employers will have more choice under the Afford-

able Care Act than they did before. The 1-year transition to—affects only employees' choice and whether employers can offer more than one plan to their employees in the federally facilitated marketplace.

Mr. BURGESS. Again, I would just offer the observation that sounds like a narrowing in scope to at least to me. Maybe it doesn't to other people, but it does to me.

So let me ask you a question about taking the money from the Prevention Fund. Did someone in your department make the decision to take the money from the Prevention Fund to fund these navigators?

Mr. COHEN. Within CCIIO, no.

Mr. BURGESS. So who made the decision?

Mr. COHEN. The Secretary.

Mr. BURGESS. So can you perhaps talk a little bit about how your department has been using the money that the Secretary moved from the Prevention Fund?

Mr. COHEN. The portion of the Prevention Fund money that CCIIO is using goes to the $54 million funding opportunity announcement for navigator grants.

Mr. BURGESS. So are you going to take other money from the Prevention Fund?

Mr. COHEN. I am not aware of that at this point, no.

Mr. BURGESS. But it is the Secretary who has the transfer authority under the law, so unless she were to level with us—and I promise you, she didn't last week—unless she were to level with us about what the future plans are, you would have no way of knowing; we would have no way of knowing. That secret is locked up with the Secretary.

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

Mr. MURPHY. The gentleman's time has expired.

I will now recognize Mr. Waxman for 5 minutes.

Mr. WAXMAN. Thank you, Mr. Chairman.

It is so amazing to me that the Republicans are complaining that money was taken from the prevention program to help pay for the implementation of the Affordable Care Act after the Republicans denied the Administration funds to implement the Affordable Care Act. It is like the kid who killed his mother and father and then said you have to care for me because I am an orphan. They are the ones who are impeding this legislation from being implemented and forcing the Administration to make these kinds of choices. But they are now making a conscious choice to take the Prevention Public Health Fund to pay for a short period of time for this Preexisting Condition Insurance Program that is supposed to go out of existence at the end of this year.

This Preexisting Condition Insurance Program, or PCIP, was part of the Affordable Care Act. It isn't something the Republicans authored into law; it was part of the Affordable Care Act that they voted against. And in February of this year, CCIIO, your agency, announced that enrollment would be suspended to ensure that the program's funds, which were capped, would be able to pay the claims of existing enrollees. This is what happens when you cap a program. They want to cap Medicare; they want to cap Medicaid.

That means if you run out of money, you run of services. Well, why was this decision made?

Mr. COHEN. Well, you stated it, Congressman. When we had a certain amount of money that was authorized for the program, our number one priority, obviously, was to make sure that those people who were already enrolled in the program got continuity of care until the end of the year.

Mr. WAXMAN. So we are talking about 107,000 enrollees. Isn't that correct?

Mr. COHEN. It is at least that many, yes.

Mr. WAXMAN. OK. These individuals will be able to receive their benefits until the end of this year. Is that correct?

Mr. COHEN. Correct.

Mr. WAXMAN. OK. And am I correct that the PCIP program was always meant to be a temporary bridge to full ACA implementation in 2014 when insurers would be barred from discriminating against people with preexisting conditions?

Mr. COHEN. That is right.

Mr. WAXMAN. OK. And will those uninsured individuals who cannot get access to the PCIP program now be able to get access to affordable quality healthcare coverage when the ACA goes fully into effect in January?

Mr. COHEN. That is right. Insurers won't be able to turn them away and they won't be able to charge them more just because they are sick.

Mr. WAXMAN. It is to be quite amazing that the Republican suddenly want to champion a program for a few months which is a bridge until people get to what is a much more sane way to handle the matter. People in this preexisting program until the end of the year, we don't pay all their expenses, do we? They have to buy their insurance?

Mr. COHEN. That is right.

Mr. WAXMAN. And is that going to be the same price as other people's insurance, or that——

Mr. COHEN. Under the PCIP program, it is about the price of other people's insurance today, unlike state high-risk pools where the cost to enrollees is typically much higher.

Mr. WAXMAN. We talked about the Affordable Care Act being fully implemented in 2014, but many key benefits and protections from the law are already in place. And I want to ask you how Americans are already benefiting from the law. The ACA prohibits insurers from denying coverage for children with preexisting conditions right now, isn't that correct?

Mr. COHEN. That is right.

Mr. WAXMAN. And how many children are there with preexisting health conditions?

Mr. COHEN. As many as 17 million.

Mr. WAXMAN. Seventeen million people. We didn't have to create a fund for them; we just said they have to be covered right now; the others will be covered in January.

Mr. COHEN. That is right.

Mr. WAXMAN. Covered without being discriminated against. The law also bans annual lifetime coverage limits, isn't that correct?

Mr. COHEN. It did.

Mr. WAXMAN. And when did this ban going to affect?

Mr. COHEN. In September of 2010.

Mr. WAXMAN. And how many Americans are benefiting from this provision of the Affordable Care Act?

Mr. COHEN. Approximately 105 million.

Mr. WAXMAN. The ACL also ends some of the insurance industry's most harmful abuses, including policy rescissions. Mr. Cohen, for folks who aren't experts in the insurance industry, tell us: what are these rescissions?

Mr. COHEN. So insurance—before the Affordable Care Act, insurers often had a policy of what is called post-claim underwriting. So they would wait to see if someone got sick and started having a lot of health claims, and then they would go back to look at their application and see if they could find something in the application that maybe was mistakenly entered that was incorrect. And then they would say we are going to take way your policy retroactively so that we don't have to pay for any of those claims.

Mr. WAXMAN. So when Republicans voted against the Affordable Care Act, they were voting to let the insurance companies do this rescission, which is taking away your insurance coverage when you needed even though you paid for it.

Mr. COHEN. That is correct.

Mr. WAXMAN. Thank you.

Mr. MURPHY. The gentleman's time has expired.

I now recognize Mr. Scalise for 5 minutes.

Mr. SCALISE. Thank you, Mr. Chairman. I appreciate you having in this hearing.

Thank you, Mr. Cohen, for coming. Yesterday, I was in my district before I flew back here to D.C. and there was a panel on the healthcare law that was held at a local hospital in my district. And, you know, I was one of the people that was speaking on that panel. And there were a number of people in the healthcare industry, people that have insurance. And it just seemed to be an underlying theme that continued to go through that room that nobody is ready for this law. Nobody knows how it is going to work for them, and most people are really concerned that the good healthcare they have they are in jeopardy of losing. And again, this is something I hear all the time when I am back in my district talking to small businesses, talking to families who have healthcare that they are now having real concerns about whether or not they are going to be able keep that. I mean are you out of touch with this or do you hear these real concerns? And I talked to my colleagues from other States and they are hearing the same things. I mean are you hearing these things?

Mr. COHEN. I mean I think it is important to keep in mind that for the many millions of Americans who have healthcare through their employer who—that employs more than 50 people, they are largely unaffected by the Affordable Care Act.

Mr. SCALISE. Well, I will give you an example. I met recently with the owner of Whole Foods. They have something like 30,000 employees. This is a very large company, a very well-respected company nationally. They have healthcare that their employees really like. Their employees actually get to vote on the benefits. It is a very highly successful plan. They have managed to control

costs, they beat the industry average, and yet they still provide a plan that their employees like. And under the current law, from what they see, their plan is not even eligible. Their 30,000 plus employees that have good healthcare they like our right now at risk of losing that coverage. You know the old promise if you like what you have, you can keep it? It was broken to those 30,000. That was one example. I mean, are you even aware of that?

Mr. COHEN. Well, I can't speak to—specifically to——

Mr. SCALISE. You ought to find out about it.

Mr. COHEN [continuing]. That example. What I can——

Mr. SCALISE. A real-life example of a real company that is a well-respected company that has good healthcare their employees really like and they are right now at risk of losing it because of this law.

Mr. COHEN. But I can't——

Mr. SCALISE. Well, I want to walk you through some specific things that we have been seeing, you know, and start with the Pre-Existing Condition Insurance program. You all did actually stop taking new enrollees in that program, right, because it ran out of money?

Mr. COHEN. We stopped taking new enrollees to make sure we wouldn't run out of money.

Mr. SCALISE. All right. So the Early Retiree Reinsurance Program, that was supposed to last until 2014. I think it was discontinued in 2011, is that right?

Mr. COHEN. Well, I think the success of that program showed the great need for it and——

Mr. SCALISE. So enrollments closed on it? It was so successful that somebody can't get in it right now?

Mr. COHEN. We are paying out claims now only based on money that is coming back to us.

Mr. SCALISE. So can someone enroll in it today?

Mr. COHEN. Enroll in it today, no.

Mr. SCALISE. No. So they can't enroll in it. Some requirements for Small Business Health Options Program were delayed, is that correct?

Mr. COHEN. The SHOP will be operating in October. The one provision that is put off——

Mr. SCALISE. But did you delay some of those provisions?

Mr. COHEN. One aspect of the SHOP, which is the employee choice we had——

Mr. SCALISE. That has been delayed. The CLASS program—that was supposed to be Obamacare's long-term care program—that was actually repealed by Congress, wasn't it?

Mr. COHEN. That is not one of mine so——

Mr. SCALISE. No, it is not one of anybody's anymore because it got repealed by Congress it was so bad. And hopefully, none of this is yours anymore because we could repeal the whole thing.

But I want to hit one more of them. The 1099 requirement that we were hearing horror stories about that was getting ready take effect, again, part of Obamacare. The horror stories were so bad that Congress, Republican and Democrat alike, agreed to repeal that, too, right?

Mr. COHEN. That is my understanding. Well, again that is the——

Mr. SCALISE. But it is not your problem anymore either because we repealed that. So there are five examples right there, five examples, some fairly small components, but then you are here telling us that probably the largest component that you are going to have to deal with, and that is these exchanges, they are going to be ready. You think they are going to be fine in a couple of months when it is time for them to come online, yet I just gave you five examples of programs that were either delayed, closed enrollment because they weren't ready for primetime, or just outright repealed because they were so bad. But then you are going to tell us that the biggest part is going to be oK?

Mr. COHEN. We are on track and I can just point to the successes that we have had so far in developing systems——

Mr. SCALISE. I just highlighted five examples of failures. In fact, I don't know if you know this, one of the lead architects of Obamacare, Senator Baucus just last week said, "I just see a huge train wreck coming down," and he is not even running for reelection. But, I mean, he just said that last week. I mean, do you dispute what he said last week about the healthcare law being a huge train wreck coming down?

Mr. COHEN. We are on track and on schedule——

Mr. SCALISE. On track. The problem is there is a train coming at you on that track——

Mr. COHEN. We——

Mr. SCALISE. According to one of the architects—that is what I mean. I voted against it. Somebody that actually was helping push this thing through said it is about to be huge train wreck——

Mr. COHEN. We will be ready to help millions of Americans enroll in quality affordable health——

Mr. SCALISE. I hope you are ready to help the millions of Americans that are about to be dealing with this train wreck that is coming because again, when you talk to real people out there in the real world—big and small—they don't know how they are going to be able to keep the healthcare they like for their employees. And that is a big concern of mine.

I yield back.

Mr. MURPHY. The gentleman's time has expired.

I now recognize Mr. Tonko for 5 minutes.

Mr. TONKO. Thank you, Mr. Chair. Mr. Cohen, thank you for appearing before the subcommittee today. And the Affordable Care Act's Prevention and Public Health Fund have been subject to ongoing attacks since their inception under the Affordable Care Act. The Republicans have repeatedly sought to repeal or drain those funds. They argue that it is a slush fund and that the resources are being used inappropriately to pay for public health lobbying efforts.

Let's take the opportunity to set the record straight on exactly how the Prevention Fund is or isn't being used. I know the Prevention Fund isn't under your supervision but can you give us a general overview of the HHS agencies and public health programs and activities that have been and will be supported through the fund?

Mr. COHEN. So I would be happy to try, Congressman. That is not directly my area and I would be happy to get back to you with information on that. But I do know that the Prevention Fund has

been used extensively in tobacco cessation and wellness programs and in other programs designed to get preventive care to people. And with respect to the work that we are doing, we know that when people have health insurance, they get preventive care and they get care for the illnesses that they do have earlier and they get better treatment and it is more cost-effective.

So I think that the use of the Prevention and Public Health Fund to help stand up these exchanges and make sure that people know about them and take advantage of the benefits they have to offer is really, you know, right within the scope of what the fund is intended to do.

Mr. TONKO. Thank you. And do state and local governments receive any of the dollars?

Mr. COHEN. I don't know the answer to that. I am sorry.

Mr. TONKO. Is there a way you can check and get back to us, please?

Mr. COHEN. Absolutely. Be happy to, yes.

Mr. TONKO. And is any of the Prevention Fund being used by its grantees to support local lobbying efforts?

Mr. COHEN. No, not that I am aware of. But again, I can check into that and get back to you.

Mr. TONKO. And what is the Department's policy on the use of federal grant dollars for lobbying activities?

Mr. COHEN. It is not permitted.

Mr. TONKO. OK. With respect to using this fund to help implement the Affordable Care Act and implement the health insurance marketplaces, I understand that you and the rest of the Administration are in a very difficult position. Because Republicans in Congress have refused to provide any funding to support this critical program and help the implementation work smoothly, HHS was forced to leverage and reallocate existing resources to provide short-term and immediate funding. So my question is, can you please explain to us how the Secretary has used her transfer authority to help implement the Affordable Care Act?

Mr. COHEN. The Secretary has used the statutory authority that she has to transfer funds within HHS. She has used some funding from the Prevention Fund, as you mentioned, and she has used some funding from a nonrecurring expense fund particularly for IT projects. And those are the sources that she has used in addition to the implementation fund that was contained in the Affordable Care Act.

Mr. TONKO. And the IT projects that you are talking about would——

Mr. COHEN. That is the work that we are doing to get the marketplaces ready for October.

Mr. TONKO. For October 1. And how will HHS ensure that programs supported by the Prevention Fund won't be negatively impacted due to the reallocation, if you will, of the funds?

Mr. COHEN. Well, I mean, obviously the President's budget for 2014 requests additional funding for the work that we are doing. So the hope is that going forward we will get that funding and will be able to rely on that rather than having to use any funding under the Prevention Fund.

Mr. TONKO. I thank you for your response. The Prevention Fund is a significant, smart, and worthwhile investment obviously in improving health situations for customers and reducing costs. It is unfortunate that you had to reallocate some of these funds to pay for implementation. I think is unfortunate that my Republican colleagues have been so unwilling to provide the basic funding requested by the Administration to implement the healthcare laws.

So, you know, I appreciate the insight that you have provided today. If you can get back to us with some of those other concerns, that would be appreciated. But, you know, this down payment is the effort to provide for a better outcome and to achieve the ultimate goals of the Affordable Care Act.

So with all of that, I thank you——

Mr. COHEN. Thank you.

Mr. TONKO [continuing]. For your response here.

And with that, Mr. Chair, I will yield back.

Mr. MURPHY. Thank you. The gentleman yields back.

I now recognize Mr. Harper for 5 minutes.

Mr. HARPER. Thank you, Mr. Chairman.

Mr. Cohen, thank you for allowing us this opportunity on very important issues that we need to discuss.

And I want to follow up a little bit on what the gentleman from Louisiana just asked you about the Pre-Existing Condition Insurance program, the fund, where you had to stop enrollment. I was under the impression that it was stopped because the money was exhausted, but you said that you stopped so you wouldn't run out of money. Would you explain that in a little more detail?

Mr. COHEN. Sure. As with any program like this, claims come in and have to get paid out over a period of time, so we have to project forward for the people that we have enrolled in the program now. We need to make sure that we can cover their costs.

Mr. HARPER. Your anticipated or projected or expected costs——

Mr. COHEN. For the rest of the year. So we look at how much we are spending and how much we have, and obviously, we know that we can't go beyond what has been appropriated. So that was the basis for the decision.

Mr. HARPER. Right. How much money was left when it was closed when enrollment was stopped?

Mr. COHEN. I would have to go back and get you those precise numbers. I don't——

Mr. HARPER. Can you provide that information to us?

Mr. COHEN. Yes, I would be happy to. I don't want to misstate it so I would like—I would prefer to go back and get you that information.

Mr. HARPER. Preexisting, I think everybody here is always concerned about preexisting. But even before the implementation of this, the largest insurer in my home State already provided preexisting coverage for dependent children up to age 25, not quite 26, but 25.

Mr. COHEN. Yes.

Mr. HARPER. And those things were there and available. But what I want to know is you said there was not enough money left so you had to stop, but isn't this money that we are talking about today that Ms. Sebelius has available to her under the Preventive

Care, could not some of that have been—instead of used for navigators or something else? Didn't she have the authority to transfer some of that money that was available to her, the billions of dollars available to her to help prop this program up for preexisting?

Mr. COHEN. That is not something that we have looked at, Congressman, but I am sure we can——

Mr. HARPER. Well, I don't know that I need you to provide an answer. We know that is the truth. She has the ability; that money is available. I mean the money is almost like a slush fund for her to use. And so we are going to do what should have been done, which is to take this money that is there available to use to help these people that are sick and to help those with preexisting. I mean some of this money has been used for a pet neutering project. And some others we used for lobbying efforts regarding soda taxes. I mean that is unconscionable that we would use money for something like that but yet deny care to those that are in most need.

So I would encourage you to, even now, as this is going on, there are funds available within the program that could be shifted over to preexisting but we are going to take care of it with legislation today. It is interesting that even though some on the other side have been very critical, there are many health advocacy groups, patient advocacy groups that support this bill that is going to come up for a vote later today.

Now, I would like to talk now for a minute about the sequester impact if we could. We have had this Administration cancel White House tours but yet have concerts that cost over $400,000 of taxpayer money. We have had an Easter egg roll. We are going to have, I guess, another congressional White House Christmas Ball. All these things are done. TSA talking about long waits at the airport even though they ordered $50 million worth of new uniforms before the sequester kicked in.

So I think the public realizes the political gamesmanship that is taking place in this. So I want to know what you have done, as far as the sequester, how that has impacted you and if there is anything there that we should expect as far as furloughs or impact on patient care?

Mr. COHEN. Within CMS, we have been working very hard to avoid the necessity for furloughs. We are under a hiring freeze so I can't hire. I can't replace people who leave, which is a serious issue for me in terms of trying to run a program. If people move on to other jobs, I can't hire to replace them. And there have been—we have applied the sequester according to the advice that we have been given across the board, as we are required to do.

Mr. HARPER. OK. I am almost out of time. But are you telling me, then, that this Administration is furloughing air-traffic controllers vital to public safety in this country but yet you are not furloughing anybody in your agency?

Mr. COHEN. Well, in effect we are because we can't replace people who leave. So we are——

Mr. HARPER. But that is not the same. I mean we are talking about at least a 15 percent furlough of current air-traffic controllers resulting in delays and perhaps safety concerns, but yet this has been a selective political item by the Administration.

I yield back.

Mr. MURPHY. The gentleman yields back. I now recognize the gentleman from Texas, Mr. Green, for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman.

And I share my colleagues' concern, but when that sequester was passed, it was passed by a huge bipartisan vote. And, you can't vote for something and the say, oh, I wish it weren't happening because it is happening whether it be at CMS or TSA or anywhere else.

But let me get to the health exchanges. I have a question related to exchanges' important goal and I think we both share in sharing that part of the successful implementation of the Affordable Care Act, people have access to the care they need. Your agency has released a series of letters to issues relating to Qualified Health Plans, QHPs and the insurance exchanges and the essential community partners. In your letter, you state CMS urges issuers to offer provider networks with robust ECP participation. Do you agree that is important that ECPs such as community health centers be considered as an integral part of the Qualified Health Plans networks?

Mr. COHEN. Yes. Yes.

Mr. GREEN. And is CMS encouraging that?

Mr. COHEN. We are.

Mr. GREEN. I have another related question but I will submit that for the record.

And on the topic of premiums we heard repeatedly last month concerns about the potential rate increases under the Affordable Care Act, the concern that there will be some people, mainly healthier young men, who will pay higher premiums under the Affordable Care Act than they pay in an individual market. I would like to understand more detail. First, can you tell us a bit about how rates are structured for different groups in the individual market now based on factors such as age, sex, and health status?

Mr. COHEN. Yes. So in the market today, issuers are allowed to vary rates depending on the health status of a person, whether they are sick and they were expected to have higher costs. They are allowed to charge women more than men and treat being a woman as a preexisting condition.

Mr. GREEN. OK. So older and sicker people pay more and women pay more for healthcare right now?

Mr. COHEN. That is right.

Mr. GREEN. How would the rates be structured under the Affordable Care Act go into effect?

Mr. COHEN. Health status won't be able to be used as a factor. Gender won't be able to be used as a factor. Age still can be used as a factor but the impact is limited compared to what it is today. And where you live is—can be used as a factor.

Mr. GREEN. So under the Affordable Care Act, the risk will be pooled insurance cannot charge more for women and those with underlying health conditions. They are limited on how they can charge older people more than younger people, is that correct?

Mr. COHEN. That is correct.

Mr. GREEN. And I know there are groups like young healthy males that look like they might pay higher premiums. My understanding is a number of factors that mitigate these premium in-

creases. First, many of these individuals may qualify for Medicaid, so they will be able to receive coverage without paying premium, is that correct?

Mr. COHEN. Yes.

Mr. GREEN. In addition, the Affordable Care Act now allows young adults to remain on their parents' healthcare until 26?

Mr. COHEN. Correct.

Mr. GREEN. And that was part of the Affordable Care Act?

Mr. COHEN. It was.

Mr. GREEN. And as I recall, being here in 2009, there was not a Republican vote for moving that to 26 years old. But anyway, let me go on.

What about those who are not on Medicaid or their parents' health plan? Am I correct that they qualify for tax credits or premium assistance that will reduce their insurance costs?

Mr. COHEN. Correct, up to 400 percent of the federal poverty level.

Mr. GREEN. OK. And to what extent will this mitigate the impact of premium increases?

Mr. COHEN. It will be significant.

Mr. GREEN. OK. Finally, individuals under the age of 30 may purchase so-called young and invincible plans on health insurance and exchanges. I know I used to think that way when I was in my 20s but since I joined Medicare last year, I know I am not. Can you tell me how these plans will work and how they will reduce cost?

Mr. COHEN. Absolutely. So that is a high-deductible plan which means that for your typical doctor's visit, it won't cover it, but if something serious were to happen to you—you become ill or in an accident—it will cover you. And those plans, we expect, will be very affordable for younger people.

Mr. GREEN. OK. The Affordable Care Act contains a lot of new tools like rate review and the medical loss ratios. I come from the State of Texas and we typically don't regulate anything in health insurance except policies, and to be one of the best reforms in the Affordable Care Act was the 80 percent loss ratio. Because as an employer of small business years ago, I was not sure that the premiums we were paying were coming back into medical benefits. But we only had 13 employees and we didn't have a choice. But now, that small employer will know that 80 percent of their premiums will come back into medical benefits.

Mr. COHEN. That is exactly right. And insurers have to pay back over $1 billion in rebates to consumers and businesses in 2012 because of that program.

Mr. GREEN. Well, and again, like I said, that seemed like one of the best reforms, although there a lot of things in there. And again, you don't need to say this but I also know that we tried to work on that bill in our committee and we did have a markup. And again, I didn't expect many Republicans to vote for it and none of them did. But there were a lot of good things in the Affordable Care Act that people have talked about on a bipartisan basis for decades.

And I realize I am out of time. Mr. Chairman, thank you.

Mr. MURPHY. The gentleman's time has expired. I will now go to the gentleman from Texas, Mr. Olson, for 5 minutes.

Mr. OLSON. I thank the chair.

And good morning, Mr. Cohen.

Mr. COHEN. Good morning.

Mr. OLSON. And I know I don't have to say this but I am going to say it anyway. I have been elected three times by the people of southeast Texas, my home—Texas 22—to be the Member here in Congress, their Representative. And quite frankly, they are frightened, and I don't use that word lightly. But they are frightened about Obamacare and what it is going to do to their healthcare. Will it become more expensive? Will they have access? Will they keep it? Many promises have been made and many have already been broken. They want and deserve answers to my questions. So I ask you to respect them and directly answer the questions I ask.

In a prior life, I spent 9 years as a staffer in the United States Senate. I know what a filibuster looks like. And I haven't seen one today, so thank you for that. But if I smell a filibuster I will abruptly interrupt and ask the questions. So thank you for that.

But I am confused. I mean last week right here in this room the Secretary said that there are no contingency plans for the state-based exchanges changes. And yet, Mr. Cohen, you today are saying there are some plans. So are there plans, contingency plans, or aren't there plans? Yes or no.

Mr. COHEN. We will be ready to operate October 1 of 2013. We are preparing for the eventuality that different parts of the system that we are building may not work perfectly and may need to be improved, and those are the kinds of plans that we are working on. We are doing testing and we are doing everything that we can to make sure that everything works as well as possible. But we know that in any large project——

Mr. OLSON. OK. That is great, sir. It sounds like you are preparing for the worst and planning for the best—hoping for the best. Is that correct, yes or no?

Mr. COHEN. We are——

Mr. OLSON. Preparing for the worst but hoping for the best.

Mr. COHEN [continuing]. We are realistic in our planning and we will be ready.

Mr. OLSON. OK. One further question, sir. I have talked to many family businesses back home about Obamacare and its impact on their businesses. These guys provide health insurance to their employees, and every single one of them that I have talked to, every single one has told me, Congressman, I provide healthcare for my employees because it is good for my business, it is a recruiting tool, retention tool, but I have to compete in the market. If this thing goes down, it will cost me anywhere between, I have heard, $5,000 to $9,000 per employee per year. If the healthcare bill comes to pass and the exchanges don't work out, I will dump my people in the exchanges, because I will pay a $2,000 or $3,000 fine that is more beneficial for business. They are not going to be the first one to pull the trigger. They are waiting because they want to do it for their employees. But they will have to because the market will demand them to. Are you prepared? Have you gotten out in American heard this complaint or concern from small businesses?

Mr. COHEN. Yes, I have spoken to small business owners and representatives of small business associations. I think it is important to keep in mind that the offer rate for small businesses of health insurance has been declining dramatically over the past decade and more because it is not affordable. And that was before there ever was an Affordable Care Act. I think there are a number of very important provisions in the law that will make coverage more affordable for small businesses, one of which certainly is the tax credit that is for eligible employers that can pay up to 50 percent of the cost of providing healthcare to their employees.

Mr. OLSON. Again, sir, every business I have talked to in this situation has said they are planning to drop their healthcare insurance. that is in stark contrast to what you are saying here. I know what you are saying, but again, the bottom line on Americans' minds is there are going to be changes. People will lose their healthcare because of Obamacare.

And one final question. My State of Texas is going to go on the federal exchange, and so obviously enrollment on October 1, full on go on January 1. One of the problems with D.C. is our eagerness is to impose a one-size-fits-all solution to all of our problems. It won't work, the state exchanges. My parents live in Vermont; they retired up there. And I can assure you that Vermont's challenges are much different than Texas' challenges. Heck, Texas has a one-size-fits-all problem within the State.

I mean, the Rio Grande Valley there has a high epidemic of diabetes. West Texas has a high epidemic of skin cancer compared to the rest of the State. Urban environments have more asthma, more issues in that area. So how do you address these differences? Will the federal exchanges address the differences between States?

Mr. COHEN. Congressman, I think you know that Texas has one of the highest uninsured rates in the entire country. And the Affordable Care Act and Medicaid expansion and the exchanges offers an opportunity to Texas to get a lot of those people enrolled in coverage. And we welcome Texas' involvement with us and a partnership with us as many, many, many states have to develop a marketplace that is best suited to the needs of the people in Texas.

Mr. MURPHY. The gentleman's time has expired.

Mr. OLSON. And I yield back. Thank you, sir.

Mr. MURPHY. Thank you.

I now turn to the gentlelady from Florida, Ms. Castor, for 5 minutes.

Ms. CASTOR. Well, thank you, Chairman Murphy and Ranking Member DeGette, for calling this hearing because I think it is very important that we have substantial oversight of the implementation of the Affordable Care Act. The good news is that, so far, families across America have seen vast improvements already even before the marketplaces are set up and people are enrolling in health insurance. You know, some of the ones that are popular in my community, young people aged 26 now can stay on their parents' insurance. That has meant a meaningful change to over 3 million young people across America.

Medicare has gotten better; it has gotten stronger. Whether it is your prescription drugs that are more affordable or those new pre-

ventive services when you go in for checkups, that is a very meaningful change for our parents and grandparents.

And then the one that doesn't get as much attention but should are the rebates that have come back from insurance companies. In the State of Florida alone, 1.2 million Florida families have gotten an insurance rebate because of the terms of the Affordable Care Act that say, you know, when you pay your premiums and your copay, that money should go to actual healthcare and health insurance rather than profits and marketing and CEO salaries. That has brought back to the State of Florida $123 million right back into the pockets of Florida families at a time when they could really use those extra couple hundred dollars. So thank you for that.

And now we are on the cusp of such a positive change for families across America, so many that have not had access to those important doctor visits or being able to call the nurse and get the checkups that they need or, with a chronic condition, get the significant health services that they need.

So, Mr. Cohen, I want to ask you about the outreach efforts, especially the navigators. We have talked little bit about that already today. This is going to be a very substantial effort as HHS begins the outreach rollout, how you inform families about signing up, how you educate families and small businesses about their insurance options. I know that some are concerned that some of the Affordable Care Act dollars are going to fund these outreach efforts, but how else are we going to educate everyone? I think it is all hands on deck. We need the insurance companies here. We need community groups, community health centers, doctors, nurses, and what I hear at home is everyone is ready to join in this effort.

But could you talk about—kind of set the stage for this? We have 50 million uninsured in this country. People are hungry for information, wouldn't you agree? Could you talk about, right here at the outset, what you are going to be doing in the coming months?

Mr. COHEN. Thank you. I would be happy to. First of all, as you mentioned, the $54 million for grants to community organizations and church groups and Indian tribes and other groups to serve as navigators, we are allocating that money based on the number of uninsured in each State. So we are going to try to put that money where we need it the most.

In addition to that, there is going to be sort of a media campaign, just sort of to get people to understand more about the law and the benefits that it can bring to them. And we will be directing people to go online to healthcare.gov where, beginning in June, the call center will be up and healthcare.gov will have changed its focus to really be a consumer site that will be there to provide information to consumers and help them get ready for the steps that they will need to take beginning in October for enrollment.

And as you mentioned, I am hearing a tremendous amount of excitement out there in the community from foundations, from the insurance companies that, obviously, have a real incentive to get people to come buy their products. So I think there is going to be a—really a multifaceted effort to make sure that people know what is in store for them.

Ms. CASTOR. And looking at the States that have such high numbers of uninsured—California, Texas, New Mexico, Florida—in

Florida we have between 20 and 25 percent are uninsured, do not have health insurance. So these are going to be critical areas. In many of those areas, English is not the first language. Could you talk about American citizens that don't—your outreach in bilingual and diverse communities?

And then, I do think it is important to have insurance agents and brokers involved. If I have a large outreach event with the community health centers, doctors, nurses, and I have the brokers there, they are not a navigator——

Mr. COHEN. Right.

Ms. CASTOR [continuing]. But can they participate in those kinds of outreach efforts?

Mr. COHEN. So thank you. So on the language side, one of the qualifications for being a navigator is that you be able to serve people, you know, in cultural and appropriate ways. And we definitely are expecting to get applications from groups that are specifically going to target specific groups that are not English-language proficient.

We are working very closely with the agent broker community. I have had a number of meetings with their trade associations and with the agents and brokers directly, and we have come up with a way for agents and brokers to easily be able to enroll people through the marketplaces, and we are definitely expecting that they will play a very significant role, particularly with regard to small business where—as they do today.

Ms. CASTOR. Thank you very much.

Mr. MURPHY. The gentleman's time has expired.

I am curious, are you asking for perhaps a written statement on that? Because I think the chair would like to know that as well to help our people who may be in other groups.

Ms. CASTOR. Yes, Mr. Chairman. I think it is very important. All hands on deck here for enrollment.

Mr. MURPHY. So you will get back a written response to the committee on that?

Mr. COHEN. Sure.

Mr. MURPHY. Brief one? Thank you very much.

I now recognize the gentleman from Virginia, Mr. Griffith, for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman. I was a little bit surprised that you said people that you talked to, there is excitement out there. The excitement that I am finding in my district is kind of like the excitement that Mr. Olson found in his district in Texas, is that people are scared and they are concerned. And I have got businessmen who come to me and say I don't know what I am going to do. Do I lay off some of my employees in order to get down under 50? What do I do?

Of course, the Commonwealth of Virginia, which I represent, has indicated that they are going to have all of their part-time employees go under 29 hours so that they won't have to cover them on insurance. And it is becoming kind of interesting to see because you have people who were promised if you like your insurance, you can keep it. But just recently, I think within the last 48 hours, a proposal passed in the State of Washington out of the Senate—it is probably not going to pass the House—but it passed out of the

State of Washington where they currently cover employees down to 20 hours, but they are going to take their state employees and move them into the exchanges is the proposal. Under the plan, they would give them $2 per hour bonus and pay that would help defray the premium cost but they won't be able to keep the insurance they had. And I wonder what your thoughts are on that, that folks are being forced out of the plans they like because the States—and look, let's face it. If the States can't afford it, a lot of businesses can afford either. The States are doing things that are pushing people away from either the number of hours they work or the insurance that they like and that they had.

Mr. COHEN. Well, first of all, the law does provide that grandfathered plans are not subject to most of the provisions of the Affordable Care Act. So it is possible for employers to keep the plan that they like. If they had a plan in place before and it is not changed significantly, they can keep the insurance that they have.

Mr. GRIFFITH. Well, the employer can keep it, but in this case, they are looking at moving the employees off of that plan and into the exchanges because it will save the State of Washington $120 million.

Mr. COHEN. Well, obviously I don't know specifically what is happening in Washington. I think there are a great number of factors that go into employers' decisions about how many hours their employees work and how many employees they employ. Healthcare is certainly one of those. But we know that under the existing system, which has been broken, employers have found it difficult or impossible to get affordable coverage, particularly with a small employer. Just one employee who has a serious illness can drive the cost for that employer to the point where the employer can no longer afford to provide that coverage. That can no longer happen under the Affordable Care Act.

Mr. GRIFFITH. Well, let me tell you what is going on. I will tell you the excitement that you reference is excitement of the negative, not excitement of the positive. And I am going to quote now from the Olympian—their .com or their online publication—because they go on to cite "worker-friendly lawmakers"—and talk about that same bill, but this person was opposed to that bill—"worker-friendly lawmakers such as Democratic Senator Karen Fraser of Thurston County called the bill "premature." Why you ask? Again quoting Senator Fraser, "because the precise benefits available under the exchanges are still unknown." She said there is a chance that some workers could not afford coverage and plunge their families into poverty.

Now, that is a Democratic State Senator in the State of Washington who fears putting state workers into the exchanges because they won't be able to afford the coverage. How can you tell the American people and how can you tell Senator Fraser that she is wrong and that she has no reason to be fearing. Is that the kind of excitement that your hearing? Because that is the kind of excitement I am hearing in my district, and, obviously, Senator Karen Fraser of the State of Washington, a member of the Democratic Party, has that same fear coming to her from her constituents. How do you respond to that, sir?

Mr. COHEN. Well, I don't know about her particular concerns, but what I do know is that under the Affordable Care Act, tax credits will be available to people that will make insurance coverage more affordable beginning in 2014 than it is today.

Mr. GRIFFITH. And that argument was made on the floor in the State of Washington and Ms. Fraser wasn't convinced.

Thank you, sir. I yield back my time.

Mr. MURPHY. The gentleman yields back. I now recognize the gentleman from North Carolina, Mr. Butterfield, for 5 minutes.

Mr. BUTTERFIELD. Thank you very much, Mr. Chairman.

Thank you, Mr. Cohen, for coming to be with us today. Hopefully, you have brought with you some very important information that we can all benefit from.

As you may know, I represent a very low-income district in North Carolina. In my whole State we have about 1 ½ million people who are uninsured. About ⅓ of those, 500,000 of those, are poor people. And about 10 percent of those live in my congressional district. And so I have listened to the questions and answers here today and I can tell you that in my district—I can't speak for other districts—but in my district there is a lot of excitement about the Affordable Care Act. The people that I represent are looking forward to it, including businesspeople. Those who are rational, those have taken the time out to study the benefits of the Affordable Care Act for their business, once they understand it, most if not all of them are ready to embrace it.

But I want to just take a few minutes to drill down on the navigator program, because you know and I know that that is so critically important. I see the navigator program as community-based individuals who will go out into the community and go to untraditional places: barbershops, and beauty salons, and even knock on doors to find people who would qualify for the exchange. Is that correct?

Mr. COHEN. That is exactly right.

Mr. BUTTERFIELD. These are not elitist, these are not people who will sit behind a desk and push some buttons. These are people who will actually beat the pavement and go out and find people, first of all, to inform them about the benefits of the program.

Mr. COHEN. That is right. And ideally, people who already have a track record and a history of helping people in those communities.

Mr. BUTTERFIELD. Will this include knocking on doors, canvassing neighborhoods?

Mr. COHEN. Absolutely.

Mr. BUTTERFIELD. All right. And when a door is knocked on and an individual is found who would potentially qualify for the program, what happens next? I guess there is an informational session with the individual. But once the navigator determines that this individual qualifies for assistance for the tax credits, what happens next? Do you take them by the hand and take them to some central location and process a claim?

Mr. COHEN. I mean, ideally, the easiest way to get people signed up is online. So ideally, navigators would help folks who may not have access to a computer at home, you know, go to the community

organizations location and help them through an online process which could be done——

Mr. BUTTERFIELD. Well, let's divide into two pieces. Let's say the citizen has a computer in their home. Will the navigator actually stay in the home, assist the individual with the application online?

Mr. COHEN. They can help them walk through the application, exactly.

Mr. BUTTERFIELD. At the request of the individual?

Mr. COHEN. Of the person, of course.

Mr. BUTTERFIELD. Yes. And if the citizen does not have access to a computer, then the navigator will enable the individual to go to an office?

Mr. COHEN. Ideally, or people can apply—there is a paper application and people can apply with a paper application. So a navigator could sit down with someone across the kitchen table and go through the application and do it that way as well.

Mr. BUTTERFIELD. Then will the navigators see it through to completion? Is there a procedure for making sure that the individual follows through?

Mr. COHEN. There can be a procedure for the navigator finding out whether—what the result of it has been.

Mr. BUTTERFIELD. All right. Now, from what I can gather, if an individual—let's say a single, healthy, childless adult who makes $20,000 a year—and that individual would qualify for tax credits through the exchange. But an individual who makes $10,000 year who is single and childless and healthy would qualify for Medicaid. But if a State has declined the expansion of Medicaid, the 10,000 individual will have no access to insurance. Is that correct?

Mr. COHEN. They can still go into the exchange.

Mr. BUTTERFIELD. Even if they are under 100 percent of the federal poverty line?

Mr. COHEN. They could then—those people won't be getting a tax credit. You are correct.

Mr. BUTTERFIELD. But can anyone under 100 percent of poverty go into exchange?

Mr. COHEN. Yes.

Mr. BUTTERFIELD. So if makes $50 a year in income, if they have the capacity to pay for the exchange, they can go into it?

Mr. COHEN. Correct.

Mr. BUTTERFIELD. So if a family member wanted to assist that low-income individual, they could do that?

Mr. COHEN. They could do that.

Mr. BUTTERFIELD. All right. All right. Thank you very much. I yield back.

Mr. MURPHY. The gentleman yields back.

I will now go to the gentleman from Ohio, Mr. Johnson, for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman. Mr. Cohen, has your office done any analysis of the healthcare law, Obamacare's impact on premiums?

Mr. COHEN. No.

Mr. JOHNSON. You haven't?

Mr. COHEN. No analysis in the sense that——

Mr. JOHNSON. That is great. We are going to have a fun session here then. So are premiums going up or down for the average consumer? You testified earlier that millions of Americans that don't currently have insurance are going to have insurance in October under the law.

Mr. COHEN. Right.

Mr. JOHNSON. For the average consumer that has healthcare today, are their premiums going up or down?

Mr. COHEN. I think we have to wait and see when the plans submit their rates——

Mr. JOHNSON. But that is not what the President promised. The President promised that supporters would see lower costs. So are people going to see increases or decreases in their premiums?

Mr. COHEN. I think at this point we have to wait and see what—how the rates come in for 2014. Over time, people absolutely will see lower costs. As we see more competition in the system, a broader risk pool, and if you look at the overall healthcare costs that people have to absorb, giving tax credits, lower cost-sharing, they will see lower costs.

Mr. JOHNSON. Well, who is going to see lower cost? What demographics are going to see lower costs? Is it going to be the young? Is it going to men? Is it going to be women? Is it going to be seniors? Who is going to see lower costs?

Mr. COHEN. Well, we know that women today can be charged up to 50 percent more than men just because they are women. So yes, women will see lower costs. And we know that older people can be charged often 5 or 6 times as much because of their age, and that is going to be limited. So they will see lower costs.

Mr. JOHNSON. Are anybody's premiums going up?

Mr. COHEN. I think we have to wait and see what the rates look like when they come in.

Mr. JOHNSON. That is a theme that has persisted in this law. Wait and see. Pass it, and then let's see what happens down the road. Well, I tell you what, that is a dangerous way to navigate a ship like America's economy.

You know, you also write that these programs will keep premiums in the individual and small group markets reasonably priced. What is a reasonable price? Surely, you have got some idea what a reasonable price is?

Mr. COHEN. You know, sitting here today, I don't have an answer to the question. We can certainly come back. I think what I can say is that we know that over the last couple of years, health insurance premiums have been going up at a lower rate than they have been for decades before. I mean, health insurance premiums are going up by double digits year after year after year. And that hasn't been the case——

Mr. JOHNSON. But the American people were promised two things.

Mr. COHEN [continuing]. Over the past couple of years.

Mr. JOHNSON. They were promised that if they like their current coverage, they could keep it, and that cost would be lowered. You have just confirmed to me that you don't know that to be true anymore. You don't know. You are having to wait and see.

Mr. COHEN. For 2014. Over time, you know——

Mr. JOHNSON. Well, I just asked you that. Were premiums going up or down and you said you don't know.

Mr. COHEN. For 2014 we have to wait and see——

Mr. JOHNSON. OK. Let's look out longer than that. Are premiums going up or down?

Mr. COHEN. I expect that premiums will go down relative to what they would have been——

Mr. JOHNSON. For who?

Mr. COHEN [continuing]. Without the Affordable Care Act.

Mr. JOHNSON. For who?

Mr. COHEN. For everyone.

Mr. JOHNSON. For everyone?

Mr. COHEN. If not for the Affordable Care Act, they will be going up higher.

Mr. JOHNSON. OK. So then you must know then what defines some reasonable cost. If you know they are going down or you think they are going down, you have got some idea of what that range is. What is reasonable?

Mr. COHEN. The primary factor that goes into what a healthcare premium is is the cost of medical care, and we all know that. That is the primary driver of healthcare costs. So in order to have premiums go—truly go down, we need to address the cost of medical care. And the Affordable Care Act and the Administration have a number of different ways of——

Mr. JOHNSON. Well, we have a very different——

Mr. COHEN [continuing]. Doing that. As far as my program is concerned——

Mr. JOHNSON. We have a very different understanding of what is driving the cost of healthcare, because in my opinion, what is driving that cost of healthcare up is the bureaucracy that has now set itself up in Washington to oversee ⅙ of our economy. I have only got a little bit of time left.

On the application, one of the questions that the applicants are asked is, do you think the employer's coverage is affordable? Do you think the employer's coverage is affordable? Why do you ask this?

Mr. COHEN. It is——

Mr. JOHNSON. What is affordable healthcare in your opinion?

Mr. COHEN. It is defined in the statute. The question is asked because it is one of the eligibility requirements and it is defined in the statute as up to—depending on what your income level is, up to 9.5 percent of your income.

Mr. JOHNSON. So affordable in your opinion is 9.5, which is almost 10 percent of a person's income for healthcare.

Mr. COHEN. It is not my opinion. It is what is in the law.

Mr. JOHNSON. But what is your opinion of what is affordable?

Mr. COHEN. I don't have an opinion.

Mr. JOHNSON. Well, that is good. Got you. I yield back.

Mr. MURPHY. The gentleman's time has expired.

I now go to the gentlelady from Illinois, Ms. Schakowsky, who is recognized for 5 minutes.

Ms. SCHAKOWSKY. Well, Mr. Cohen, it is not surprising that from the Republican side of the aisle the relentless drumbeat of opposi-

tion to the Affordable Care Act, or Obamacare as I proudly say, goes on after 33 efforts to repeal the entire bill.

But I would challenge my colleagues on the other side to go out and explain to at least some of their constituents—for example, the parents of children with preexisting conditions—that they want to take away insurance to them, that annual and lifetime coverage limits should be reinstated, that the rescissions of policies should, once again, go into place, that all the preventive health services without cost-sharing ought to go back into effect, that the young people that are on their parents' policies, forget it, they are off. You explain that to them, that the medical loss ratio requiring insurance companies to actually pay for health coverage should be changed, and tell women that we think you should be discriminated against. That is a good idea, that about, I don't know how many billions of dollars we collectively pay more in health insurance.

And so, you can list 5 problems with the program and we can list many, many more good things. And we would like to work with each other to try and correct them rather than just complain. No, the program is not perfect.

I wanted to ask you. We are just months away now from full implementation of Obamacare's coverage, and the Administration has requested additional resources to implement the law and those requests have been ignored. And it seems to me the refusal of my Republican colleagues to appropriate HHS adequate resources to help implement the law is limiting our efforts to inform Americans about Obamacare's exciting new coverage options.

And let me just say that when the Part D was put into effect, $600,000 was spent by the Bush Administration for blimps to talk about—just for blimps alone. So could you explain how CCIIO would use additional resources that the Administration has requested to implement the law, and how might the refusal to appropriate adequate resources hinder the ability of consumers to know about October 1?

Mr. COHEN. Thank you, Congresswoman. We certainly would welcome the ability to provide more grants to navigators out there in the community. We welcome the ability to do more outreach ourselves to—as you know, there has been a lot of misinformation about this law. People, you know, really do need to understand the benefits of it and what it can do for them. And so with the President's budget request, we certainly could use that money to do more outreach into the community and make sure that people understand what the law is and how it can benefit them.

Ms. SCHAKOWSKY. You know, and I would just like to say to my colleagues, you talk about the fear in the districts. And to the extent that there are some problems with the bill, if we could sit down and work together and figure out how to make it better, but a lot of that fear is the misinformation that has been quite deliberately sent out. You watch Fox; it is hard not to be scared about Obamacare and what it might do to you. So I would suggest that the fear-mongering that is going on about this law, which has now been upheld by the United States Constitution that will bring up to 30 million people of the United States of America to be able to have healthcare, that will help us join the community of nations in

the world that declare that healthcare is a right of the citizens of their countries. You know, we could use the help. All of us could use the help. All Americans could use the help to perfect this legislation.

And I yield back.

Mr. MURPHY. Thank you. The gentlelady yields back the balance of her time.

I now recognize the gentleman from Colorado, Mr. Gardner, for 5 minutes.

Mr. GARDNER. Thank you, Mr. Chairman.

Thank you, Mr. Cohen, for your time with us this morning. And my colleagues said that there is fear-mongering on this bill but I would just like to point out that I read an article the other day that the roofers union backtracks on Obamacare and wants repeal or reform of the bill. So I don't think this is right wing fear-mongering. I think when you have a union that is very concerned about Obamacare and wants its repeal or reform, I think that is where we have significant concerns that must be addressed.

Mr. Cohen, are you familiar with Richard Foster, the actuary of Medicare?

Mr. COHEN. I know who Richard Foster is, sure.

Mr. GARDNER. Are you familiar with testimony that he gave before the House of Representatives Budget Committee a year ago or so?

Mr. COHEN. Generally, but not specifically, no.

Mr. GARDNER. In that testimony he talked about the two central promises of the healthcare law that were unlikely to be fulfilled: one, that the bill will not hold costs down; and two, that it won't let everybody keep the current insurance if they like it. Would you agree with that assessment?

Mr. COHEN. Well, I think, as I said, I do believe that costs will be down relative to where they would have been without the Affordable Care Act——

Mr. GARDNER. So that is an increase then.

Mr. COHEN. Well, if medical costs increase, then the cost of insurance is going to increase. But at least——

Mr. GARDNER. So that the promise——

Mr. COHEN [continuing]. People will have——

Mr. GARDNER [continuing]. Was made that it would keep costs down.

Mr. COHEN. Well, it will keep costs down relative to what they would have been without the law and at least people will have the security——

Mr. GARDNER. So what you are saying is that we will expect, then, costs to increase?

Mr. COHEN. At least people will have the security of knowing that if they have a serious illness, their care will be paid for, which they don't have today.

Mr. GARDNER. We are talking about cost increases.

Mr. COHEN. Well, for someone who has never been able to have health insurance before, to talk about an increase——

Mr. GARDNER. What about the person who has health insurance. Are they going to experience cost increases?

Mr. COHEN. I think it is going to depend on the individual situation. There are factors that will cause costs to go down; there are tax credits that are available.

Mr. GARDNER. Are you insured through the federal system or do you have outside insurance?

Mr. COHEN. I am insured through the federal system.

Mr. GARDNER. Has your insurance gone down or gone up?

Mr. COHEN. You know, I don't even remember what happened. I think we had a small increase this year.

Mr. GARDNER. So——

Mr. COHEN. But we have had lower increases in the last 2 years than we have had for a long time before that.

Mr. GARDNER. So what kind of——

Mr. COHEN. The fact that health insurance goes up is not new. I mean, that is—health insurance has been——

Mr. GARDNER. But I think the promise that was——

Mr. COHEN [continuing]. Going up year after year after year after year.

Mr. GARDNER [continuing]. Made in the healthcare bill, if I am not mistaken, the promise was made that this would lower the cost of healthcare.

Mr. COHEN. Well, I think it will relative to where it would have been without the law.

Mr. GARDNER. So this is kind of like the Washington two-step when we say we are cutting budgets but you are actually decreasing the rate of an increase. Is that what you are saying Obamacare has done?

Mr. COHEN. I am saying that I believe that healthcare insurance—and if you look at the total out-of-pocket costs that people have to absorb—will be lower than it would have been without the law, yes.

Mr. GARDNER. So that is an increase in costs because if it is going to be——

Mr. COHEN. It may or it may not be, depending on——

Mr. GARDNER. What is an acceptable increase? I mean——

Mr. COHEN. I mean for——

Mr. GARDNER [continuing]. What are you anticipating under this healthcare bill?

Mr. COHEN. For women who have had to pay 50 percent more than men, you know, the effect will be to reduce their costs. For people who have had to pay out-of-pocket for all that medical care——

Mr. GARDNER. But reduce their cost, even though their costs increase from year to year? It is just what you are saying is that, oh, it might not increase as much.

Mr. COHEN. I think it is going to depend on a number of factors, including the underlying costs of medical care.

Mr. GARDNER. Well, let me ask you this then: will Obamacare reduce the cost of healthcare?

Mr. COHEN. It will relative to what it would have been without the law, yes.

Mr. GARDNER. But you are saying then that healthcare will increase?

Mr. COHEN. That will depend on factors that are external to the Affordable Care Act. It will depend on——

Mr. GARDNER. Well, maybe——

Mr. COHEN [continuing]. The costs of healthcare.

Mr. GARDNER [continuing]. I am not asking my question very clear.

Mr. COHEN. Yes.

Mr. GARDNER. Will healthcare costs be less next year after the implementation of this bill?

Mr. COHEN. I think that will depend on——

Mr. GARDNER. Yes or no.

Mr. COHEN. I can't answer the question. I don't know what is going to happen next year.

Mr. GARDNER. So we don't know whether or not the——

Mr. COHEN. I don't know what is going to happen to the underlying cost of medical care.

Mr. GARDNER. Well, what about insurance——

Mr. COHEN. What doctors charge——

Mr. GARDNER [continuing]. That people——

Mr. COHEN [continuing]. What hospitals charge, what——

Mr. GARDNER. Well, what about insurance that people like? If they have their insurance and they want to keep it, are they going to be able to?

Mr. COHEN. They can if they are in a grandfathered plan and the plan doesn't change significantly, they can keep that coverage and it is not affected by the Affordable Care Act.

Mr. GARDNER. So you are saying that, right now, people across this country who have been told they are not going to be able to keep their insurance, they are being misinformed?

Mr. COHEN. They are misinformed if they don't understand that if they are in a plan that was grandfathered, as many people are, that they could keep that coverage, then yes, they are misinformed.

Mr. GARDNER. So if the employer switches the plan because of this healthcare bill, then they get to keep their old healthcare?

Mr. COHEN. Employers can keep their employees in a grandfathered plan and not be affected by the provisions of the Affordable Care Act, yes.

Mr. GARDNER. Do you know which plans were grandfathered? And if the healthcare bill requires them to change the plans, though, doesn't that mean that they are going to lose the healthcare?

Mr. COHEN. No, no, no, the healthcare law doesn't require them to change the plans. That is the whole point of being grandfathered. You don't have to change it if you are in a grandfathered plan.

Mr. GARDNER. So these employers will never have to change their healthcare plan that they are offering?

Mr. COHEN. As long as the plan does not change significantly in terms of the benefits that they offer. If they keep the benefits the same——

Mr. GARDNER. Or what is required by the healthcare bill.

Mr. MURPHY. Time is expired.

Mr. COHEN. Then, they can keep a grandfathered plan and they don't have to comply with the provisions of the Affordable Care Act. That is what grandfathering means.

Mr. MURPHY. Thank you. The gentleman's time is expired.

Now, I will recognize the gentleman from Missouri, Mr. Long, for 5 minutes.

Mr. LONG. Thank you, Mr. Chairman.

And Mr. Cohen, thank you for being here today. But I have got to say that if Rod Serling walked through that door right there, I wouldn't be surprised because he could walk in here and say you have now entered the Twilight Zone. There cannot be so much difference in interpretation, I don't think, other than it is inexplicable. It is Twilight Zonish if that is a word. We have friends of mine on the other side of the aisle, a good friend that just spoke a minute ago, Ms. Schakowsky. She, to paraphrase her, said on the Republican side of the aisle, there is relentless drumbeat of opposition to the President's healthcare plan. And my other very good friend over there, Gene Green, said something to the effect of people across America have seen vast improvements in their healthcare. And I think from the questions you have seen today, that is not what some of us are hearing.

So I want to start with a couple of yes-or-no answers if I may on some things some Democrats have said, see if you agree with them. Democratic Senator Max Baucus said, "I just see a huge train wreck coming down because of bumbling implementation." Yes or no, do you agree with that?

Mr. COHEN. I do not agree with that.

Mr. LONG. Let's move to another Democrat Senator. Let's move to Tom Harkin. Senator Tom Harkin—and Mr. Cohen, yes or no—do you agree with Senator Harkin that this Administration should not be raiding the Prevention Fund for funding exchange expenditures?

Mr. COHEN. Congressman, I really am not going to express a view on that. That is not a decision I made. It is not——

Mr. LONG. You can't answer a yes-or-no question——

Mr. COHEN. I can't answer——

Mr. LONG [continuing]. Whether you agree with a statement——

Mr. COHEN. I can't answer that——

Mr. LONG [continuing]. That a Democrat Senator made?

Mr. COHEN. I can't.

Mr. LONG. You can't——

Mr. COHEN. I don't have——

Mr. LONG [continuing]. Or you don't want to——

Mr. COHEN. I——

Mr. LONG [continuing]. Or you don't know if you agree——

Mr. COHEN. I don't have a view.

Mr. LONG. You don't have a view whether you agree with a statement that a Senator made?

Mr. COHEN. I don't.

Mr. LONG. I really don't know what to say. I guess I will wait for Rod Serling to come through the door.

Mr. COHEN. That would be the second coming of Rod Serling I think. I think he passed away——

Mr. LONG. The way things have been going here, I wouldn't doubt it. I mean I could see it happening.

This morning, according to POLITICO Pro's whiteboard, Senator Tom Harkin blasted HHS Secretary Kathleen Sebelius at a hearing this morning. It was after we had started this hearing—blasted Sebelius for using Prevention Fund money to pay for insurance navigators saying the Obama Administration is treating preventive care as an afterthought. To quote the Senator, "I am sorry to say this Administration just doesn't get it." And this is a Democrat. This is not the Republican's drumbeat. First of all, it was a $5 billion raid last year on Prevention Funds, Harkin said, referring to the payroll tax extension Barack Obama signed into law last year that cut $5 billion from the Prevention Fund. This year, it is another $332 million raid. It is sort of like the Prevention Fund is sort of an afterthought.

I am going to ask you one more time. Do you agree with Senator Harkin that this Administration should not be raiding the Prevention Fund for funding exchange expenditures, yes or no?

Mr. COHEN. You know, I would have been happy if Congress had appropriated funding for us to do the work that we need to do and, you know, that didn't happen. And so the Secretary made decisions under her authority. And I don't have an opinion one way or the other as to those decisions, no.

Mr. LONG. Who would you direct me to? Let's say for a minute that I have staff that come to me and say we are a little confused. What is our healthcare going to cost starting 2014? What government agency would you direct me to to get their questions answered, what they are going to be paying for their healthcare next year, my staff?

Mr. COHEN. Well, if your staff is covered by the federal program, then I think the information that they would want to get would be from the program that administers their healthcare.

Mr. LONG. What government agency?

Mr. COHEN. FEHB or whoever—whatever coverage they have.

Mr. LONG. OPM maybe?

Mr. COHEN. Could be.

Mr. LONG. Well, we have tried relentlessly because I have—well, you laugh at it but——

Mr. COHEN. No, no——

Mr. LONG [continuing]. My staff is not laughing and it is a very serious concern for me. When you have staffers on this Hill that have got college educations, some of them have law degrees, and they are living two and three people to an apartment because the cost of living up here to get by, and they come to me with a legitimate question on what they are going to be paying next year. They are thinking about leaving government service. They are thinking about taking jobs other places. It is a very serious thing so we have tried and tried and tried to get the answer on what they are going to be paying. OPM cannot tell us.

Mr. COHEN. No, and I don't mean to minimize that, Congressman. I was only smiling because I can't help with OPM obviously. I wish I could but I can't.

Mr. LONG. I gave Rod Serling 5 minutes and he didn't make it, so I yield back.

Mr. MURPHY. The gentleman's time is expired.

And I recognize the gentlewoman from North Carolina, Mrs. Ellmers, for 5 minutes.

Mrs. ELLMERS. Thank you, Mr. Chairman.

And thank you, Mr. Cohen, for being with us today. I do have to go back and just reiterate some of the points that have already been made and get some clarification from you. Going back to the closing of the Pre-Existing Insurance program. When was that closed?

Mr. COHEN. It was closed for the federal program in February and for the state programs in March.

Mrs. ELLMERS. OK. And so those individuals who would be utilizing those dollars for their preexisting condition coverage will not be able to do so until January 1?

Mr. COHEN. The existing enrollees are unaffected but new people who would be coming into the program will not be able to come into the federal—into the PCIP program unless we are able to—yes, until January.

Mrs. ELLMERS. After January——

Mr. COHEN. January they can——

Mrs. ELLMERS [continuing]. As it is right now.

Mr. COHEN. As it is right now, correct.

Mrs. ELLMERS. OK. You know, this is the confusing part about it because especially my colleagues across the aisle continuously try to paint us—us meaning Republicans here on the other side—as the ones who are interfering with anyone getting preexisting coverage and looking at it from an unsympathetic standpoint. However, this program has been cut off and they support that, and here we are attempting to pass legislation to actually help those individuals. I am just——

Ms. SCHAKOWSKY. So are we. Will the gentlewoman yield?

Mrs. ELLMERS. This is my time. You had your time.

You know, I am perplexed by that and you clarified that for me. I just want to make sure that we have clarified that we are talking about months of time that individuals will go without that care.

Also, for clarification purposes, in the discussion that you were having with Mr. Johnson and then also with Mr. Gardner, you stated that as of January 1, 2014, that healthcare premiums will go down. Is that correct?

Mr. COHEN. No, what I think I said—what I believe is that, first of all, we don't know yet what premiums are going to be for coverage in January of '14 because plans are just now submitting those rates to their state insurance departments for approval to the exchanges of—with respect to——

Mrs. ELLMERS. OK. But, sir, that was not the promise. The promise that was made continuously when this was being implemented, that healthcare premium costs would go down. And so I am asking you under oath today, as you see it—you are no longer standing behind that statement? You are now saying that we do not know and probably more than likely we wil see healthcare insurance premiums going up. Is that correct?

Mr. COHEN. No, that is not correct. What I think I said was that for 2014 we need to wait to see how the rates come in, and over

time, I believe that the Affordable Care Act will result in lower overall cost of——

Mrs. ELLMERS. And what——

Mr. COHEN [continuing]. Healthcare for people——

Mrs. ELLMERS. OK. Sir, what do you base that on? Because CBO has done a culmination of studies, which showed—and I will just cite North Carolina—that North Carolina healthcare premium rates will go up by 61 percent. So what are you basing your data on? And if you do have studies that show this, I would like for you to submit them to the Subcommittee.

Mr. COHEN. I am basing it on the increased competition that will exist in the new marketplace compared to what we have today where, in many States——

Mrs. ELLMERS. But that could exist——

Mr. COHEN [continuing]. There——

Mrs. ELLMERS [continuing]. With or without the Affordable Care Act going into effect. You know, we in Congress could enact many pieces of legislation and are working on just that, to help increase competition——

Mr. COHEN. Well——

Mrs. ELLMERS [continuing]. Among the healthcare providers.

Mr. COHEN. Well, it could, Congresswoman, but in most States today—in many States today, the individual and small group markets are dominated by one carrier that has 60, 70, 80, even 90 percent of the market. That is the reality today.

Mrs. ELLMERS. And that could be——

Mr. COHEN. And that is what we are——

Mrs. ELLMERS [continuing]. Easily remedied.

Mr. COHEN [continuing]. Going to change.

Mrs. ELLMERS. That could be easily remedied with legislation. We don't need this massive takeover of healthcare, increasing rates by 61 percent for those who I represent in North Carolina. There again, I would really hope that you would be able to gather some data, because again under oath you are saying, 'I am incredibly unclear as to what will happen with healthcare rates as of 2014.'

Mr. COHEN. For most Americans, the millions of Americans who are covered by insurance through their employer that is in a large group, they are not going to see an effect from the Affordable Care Act one way or another——

Mrs. ELLMERS. OK. Well, my time is up——

Mr. COHEN [continuing]. So that their——

Mrs. ELLMERS [continuing]. And I don't understand even what you base that on.

Mr. MURPHY. If I could ask the gentleman, you asked a question about while he was under oath about prices going up or not going up and you didn't get a chance to answer that question, so I am going to give you a moment to answer that question with regard to you previously stated about prices not going up, you said you couldn't guarantee that and you were going to elaborate on that statement.

Mr. COHEN. I think——

Mr. MURPHY. Do you recall?

Mr. COHEN [continuing]. We have lost the thread.

Mr. MURPHY. All right.

Ms. DEGETTE. Mr. Chairman, let me ask.

Mr. Cohen, did you ever say that——

Mrs. BLACKBURN. Mr. Chairman, I think I am next in the queue——

Mr. MURPHY. It is.

Mrs. BLACKBURN [continuing]. If you don't mind before you go to a second round.

Ms. DEGETTE. I would ask unanimous consent to—listen, the previous questioner advised the witness he was under oath and then asked him a question and refused to let him finish answering that question, and I think that is inappropriate for this hearing.

Mr. MURPHY. No, I just asked if he would like——

Ms. DEGETTE. And so, Mr. Chairman, I think that the witness should be allowed to complete his answer.

Mr. MURPHY. I just did that and——

Mr. COHEN. Well, I am not sure what the question was——

Ms. DEGETTE. Right.

Mr. COHEN [continuing]. That is my problem.

Mrs. ELLMERS. I will be more than happy to restate my question if that will help.

Mr. MURPHY. Can I ask if you could submit that question——

Ms. DEGETTE. I think it is——

Mr. MURPHY [continuing]. For the record and——

Ms. DEGETTE [continuing]. Wrong for members of this committee to try to put the witnesses in a perjury trap——

Mr. MURPHY. That is why I am——

Ms. DEGETTE [continuing]. When they come in here——

Mrs. ELLMERS. No, ma'am.

Ms. DEGETTE [continuing]. And they are trying to help this committee——

Mrs. ELLMERS. No, ma'am.

Ms. DEGETTE [continuing]. Understand.

Mrs. ELLMERS. I am clearly restating that the gentleman is under oath and that he was not answering the question was——

Ms. DEGETTE. Well, get him——

Mr. MURPHY. Order here. What I would like to ask is if the gentlelady would submit that question and we will ask Mr. Cohen——

Mr. COHEN. I would be happy——

Mr. MURPHY [continuing]. To submit it for the record.

Mr. COHEN [continuing]. To answer for the record. Thank you.

Mr. MURPHY. That way we will be sure what exactly what you were asking, Ms. Ellmers, and sure of your answer.

Mr. COHEN. Thank you.

Mr. MURPHY. Thank you so much.

Recognize the gentlelady from Tennessee for 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

And sir, you have been patient with us and we do appreciate it.

I want to go to your statement you made I think in response to Mr. Harper's question about over time you thought the insurance cost would come down. And this is something that I always watch very closely because I am out of Tennessee, and you are probably familiar with the program TennCare, and I know I have worn out all of my committee members here talking about TennCare and

asked Secretary Sebelius about it repeatedly. And I just want to let you know that it seems from what we have found, what I have found in my research—and I have been working on this since we got TennCare—as a test case for Hillarycare in 1995. And bear in mind, it quadrupled in cost over a 5-year period of time.

But sir, what we found is there is no example where these near-term expenses are going to yield a long-term savings in healthcare. And if you do have those examples, I would love to see them because through all of this debate of Obamacare, nobody has been able to show one, not with public option care, not with guaranteed issue, not with community rating, not with any of this in New Jersey or Tennessee or Hawaii or anywhere else, not with any of these CMS waiver programs. There is no example where you decrease cost, you increase access, and you get better outcomes. So if you can prove us wrong on that, then, you know, feel free to bring forward an example. Do you have an example?

Mr. COHEN. Congresswoman, I think for the person today who doesn't have health insurance coverage and doesn't know how they are going to pay their medical bills and worries about going into bankruptcy because their child is sick, I think for that person, a lot of this discussion is really irrelevant. And we—and that is what we are going to change.

Mrs. BLACKBURN. OK. Let me ask you this. I want to ask you a question about the navigators. Is it true that the navigators cannot have healthcare or health insurance experience?

Mr. COHEN. No.

Mrs. BLACKBURN. That is not true?

Mr. COHEN. That is not true.

Mrs. BLACKBURN. OK. Because that has been part of the understanding that is out there.

Also, on your increased competition theory, I have got to tell you, what we have seen in Tennessee when you have government control, when it is government control, that is what runs people out of the marketplace.

Mr. COHEN. Well, this isn't government control. This is a commercial marketplace with——

Mrs. BLACKBURN. I beg to differ——

Mr. COHEN [continuing]. Private insurance carriers——

Mrs. BLACKBURN [continuing]. With you. Let me——

Mr. COHEN [continuing]. Providing coverage to people.

Mrs. BLACKBURN [continuing]. Give you a few examples of what is happening in Tennessee. Yesterday, of course, the rate filings in Maryland shows that small group coverage increases are going to go up 145 percent. And we have got examples in Tennessee that we have been polling our companies for this year and next year. This year, they are going up anywhere from 26 percent to 132 percent. We are seeing 40 and 50 percent increases expected for next year. In the young adult population, the survey we have here at Energy and Commerce Committee is looking at 145 to 185 percent. Families have already seen their insurance go up $3,000 per family since this law was passed. So what do I tell people that are coming to my town halls and saying but the President promised my premium was going to go down $2,500 a year. What do we tell these people?

Mr. COHEN. I think you tell them that they should shop on the marketplace to find the plan that is best for their family and is the most affordable for them. And that is what we expect to be able to provide for people.

Mrs. BLACKBURN. But it is going to cost them more.

Mr. COHEN. I think healthcare costs have been going up year after year after year long before we ever had Obamacare, so it has nothing to do with—the fact that the costs go up——

Mrs. BLACKBURN. The percentage is——

Mr. COHEN [continuing]. Isn't——

Mrs. BLACKBURN [continuing]. Greater, and I think that you probably are aware of that. Do you believe that the increases are tied to the taxes and the mandates in Obamacare? Do you believe that that is any of the driver?

Mr. COHEN. The impact of the taxes on healthcare premiums is very small by all accounts.

Mrs. BLACKBURN. $165 billion is small?

Mr. COHEN. The impact on premiums of the taxes is very small.

Mrs. BLACKBURN. You think that $165 billion of new taxes has a small impact on premiums. What do you call——

Mr. COHEN. And——

Mrs. BLACKBURN [continuing]. Large?

Mr. COHEN. And we are going to have——

Mrs. BLACKBURN. How would you classify small and large?

Mr. COHEN. We have a reinsurance program that is going into effect that is estimated to reduce premiums from what they otherwise would have been by 10 or 15 percent.

Mrs. BLACKBURN. Let me ask you a little bit about that. I would like to know if you find it odd or ironic that we are now subsidizing insurance purchase while at the same time we are making insurance more expensive by the mandates and taxes that are being piled on this? Thus, we have got increasing subsidies and we are putting taxpayers on the hook for even higher federal spending. Do you find that odd or ironic?

Mr. COHEN. I think that Americans are paying for the cost of uncompensated care today. When people show up at the emergency room and they don't have coverage and they get treatment, those costs have to be passed on to all——

Mrs. BLACKBURN. So you are comfortable——

Mr. COHEN [continuing]. Businesses——

Mrs. BLACKBURN [continuing]. With the costs going up?

Mr. COHEN [continuing]. So we are going to——

Mrs. BLACKBURN. I yield back.

Mr. COHEN. We are going to move to a system where we have much more insurance coverage. We are going to spread the cost over more people, and that will be to the benefit of all Americans.

Mr. MURPHY. I thank the gentlelady from Tennessee. I might also add on that issue of uncompensated care, I hope that is an area you will submit more questions for the record so we will have those.

I ask unanimous consent that the written opening statements of members be introduced into the record of those who wish that. And without objection, the documents will be entered in the record.

And in conclusion, I would like to thank all the witnesses and members that participated in today's hearing, which would be you, Mr. Cohen. I remind members they have 10 business days to submit those other questions for the record, and I ask that Mr. Cohen will respond promptly to our questions.

I appreciate you being here today. I am sure we will be seeing you again soon. Thank you very much.

Mr. COHEN. Thank you.

Mr. MURPHY. The committee is adjourned.

[Whereupon, at 12:05 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Attachment
Gary Cohen's Additional Questions for the Record
Energy & Commerce, Subcommittee on Oversight & Investigations Hearing
"The Center for Consumer Information and Insurance Oversight and the Implementation of the Patient Protection and Affordable Care Act"
April 24, 2013

The Honorable Fred Upton

1. **You were questioned repeatedly on the impact of the PPACA on the premiums paid for health insurance—have you or any individuals at CCIIO conducted any research or analysis of the impact of the PPACA on premiums?**

Answer: Issuers have just started to send in their applications for participating in the Marketplaces. We will not know their premium rates for 2014 until after those applications are certified. Likewise, we will not know what premiums outside the Marketplace will be until they are published in each state.

Beginning next year, many individuals will newly receive comprehensive coverage at an affordable price thanks to reduced out-of-pocket costs, premium subsidies, and consumer protections. In addition, the Affordable Care Act has many provisions that help stabilize premiums as new entrants come into the market, such as risk adjustment, reinsurance, and risk corridors. For example, the medical loss ratio (MLR or 80/20) rule, which is already in effect, will help keep premiums lower.

There have been studies that have made educated guesses about health care costs, but estimates are just that – estimates. In addition, many of these estimates focus on premiums, not the actual out-of-pocket expenses people are going to pay for their plans. Many of these studies do not consider these factors in their projections. Because of the Affordable Care Act, people are going to be able to buy comprehensive insurance without discrimination based on gender or pre-existing conditions. Many of those people will qualify for lower costs on their premiums through tax credits to help them buy insurance, and everyone will benefit from increased transparency and competition both inside and outside of the Marketplace.

2. **Have you had any discussions with representatives from a health insurance company, or industry representative, discussing the impact of the PPACA on premiums? Identify those individuals and the substance of those conversations.**

Answer: CMS is working continuously with many stakeholders, including health insurance issuers, state departments of insurance, and consumer groups. Our regulations, which were made available for public comment, as well as our guidance materials are available to all stakeholders. In addition, our regulations and guidance materials discuss provisions that help stabilize premiums for issuers, such as risk adjustment, reinsurance, and risk corridors. All our regulations and guidance are available to the public on our website: http://www.cms.gov/cciio/index.html.

3. **You were asked about the effects of sequestration on your office, and you indicated that you were in a "hiring freeze." Yet, several job openings are posted online for CMS. Explain this discrepancy. What was the last date a new employee was hired for CCIIO and does CCIIO plan to hire any additional staff in 2013?**

Answer: CMS is under a hiring freeze for most of our accounts including Federal Administration, our main administrative discretionary account. CCIIO FTEs are funded from the following accounts: 1) Federal Administration, 2) Pre-Existing Condition Program (PCIP); 3) Early Retiree Reinsurance Program; 4) Consumer Operated and Oriented Plan (CO-OP) Program; and 5) Exchange Planning and Establishment Grants (1311). Of these accounts, CCIIO is able to fill 23 vacancies currently available under Exchange Planning and Establishment Grants (1311). The remaining accounts are under a freeze, thus, no vacancies are available.

4. **Have any CCIIO employees been furloughed in 2013?**

Answer: No.

The Honorable Marsha Blackburn

1. **Pursuant to the Patient Protection and Affordable Care Act (PPACA), an employer must extend affordable health care coverage to basically all of its full-time "employees." Under the Internal Revenue Code, a leased employee is an individual who is formally hired (and paid) by a third-party leasing agency and to provide service on behalf of the agency's client, typically on a full-time basis. Moreover, the individual's work is under the "primary direction and control" of the client (often called the "service recipient").**

   In the proposed regulation for the shared employer responsibility provisions of PPACA, the definition of "employee" indicates that a leased employee will not be treated as the employee of the service recipient, meaning that the service recipient is not required to offer the individual health-care coverage. However, the preamble to the proposed regulation creates an ambiguity as to whether a leased employee may, in some instances, be considered the employee of the service recipient under the common law standard since his/her work is directed and controlled by the service recipient. Can you provide any further guidance as to which entity would be required to offer/provide this type of employee health care coverage?

Answer: CMS is not in a position to comment on the interpretation of proposed regulations issued by the Internal Revenue Service (IRS).

2. **Recent pronouncements from CCIIO regarding the offer and purchase of the pediatric dental essential health benefit (EHB) have created confusion in the marketplace. Specifically, I understand that inside the federally facilitated exchange (FFE), the pediatric benefit must be offered but its purchase is not required. Outside the FFE, CCIIO staff has made statements that the purchase is mandated—even for childless adults. Can you provide some clarity on CCIIO's view of the outside the FFE marketplace that is regulated by the state?**

Answer: Several provisions of the Affordable Care Act affect the coverage of pediatric dental essential benefits. Section 2707(a) of the Public Health Service Act requires issuers in the individual and small group markets inside and outside the Marketplaces to offer essential health benefits (EHB) as defined in section 1302 of the Affordable Care Act. EHB requirements apply to health insurance issuers, which must offer certain benefits; they are not requirements for individuals or families to obtain coverage for a particular benefit.

In the EHB Final Rule, CMS provided a clarification regarding situations in which issuers outside the Marketplaces would not be found to be non-compliant with the requirement to offer EHBs if the issuer is reasonably assured that the applicant has obtained the pediatric dental EHB through a Marketplace-certified stand-alone dental plan. With respect to issuers inside a Marketplace, however, section 1302(d)(4)(F) of the Affordable Care Act allows issuers to omit pediatric dental coverage if there is a stand-alone dental plan offering the pediatric dental essential benefit in that Marketplace. Thus, the different issuer requirements in the Affordable Care Act lead to different consumer experiences inside and outside of the Marketplaces.

3. **Will the federally facilitated exchanges (FFEs) have information and a link to products providing supplemental coverages, such as stand-alone vision plans (SAVPs), similar to what was recently provided for in state-based exchanges?**

Answer: For 2014, CMS does not plan to provide links to stand-alone vision plans or other ancillary products in Federally-facilitated Marketplaces.

4. **PPACA requires that out-of-pocket maximum cost-sharing limits – equal to those applied to high-deductible plans in any given year – apply to all group health plans beginning in plan year 2014. A recent FAQ released by the Departments of Labor, Health and Human Services, and Treasury ("Affordable Care Act Implementation (Part XII), February 20, 2013) proposes an interim policy for the 2014 plan year only, meant to ease the transition to PPACA standards for health plans that use multiple service providers to administer benefits (e.g. one third party administrator for major medical benefits, another for prescription drugs). The interim policy could result in enrollees paying twice the maximum out-of-pocket costs set by PPACA (where a plan has two different administrators) or potentially unlimited out-of-pocket costs (where a plan does not have an out-of-pocket maximum for prescription drugs). Such a policy would be unduly burdensome to individuals with rare diseases and would result in overwhelming costs for these highly vulnerable patients. Any advantages the interim policy creates by easing the transition for insurers are far outweighed by the significant risks it poses to patients and patient care. Can you please explain how this interim policy aligns with the policy goals envisioned by PPACA?**

Answer: As noted in the Frequently Asked Questions (FAQs) that you reference, CMS recognizes that plans may currently utilize multiple service providers to help administer benefits (such as one third-party administrator for major medical coverage, a separate pharmacy benefit manager, and a separate managed behavioral health organization). In such situations, separate plan service providers often impose different levels of out-of-pocket limitations and may utilize different methods for crediting participants' expenses against any out-of-pocket maximums. These processes will need to be coordinated under section 1302(c)(1) of the Affordable Care Act, which may require new regular communications between service providers.

The February 20, 2013 FAQs state that only for the first plan year beginning on or after January 1, 2014, where a group health plan or group health insurance issuer utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums under section 2707(a) or 2707(b) of the Public Health Service Act, the Departments will consider the annual limitation on out-of-pocket maximums to be satisfied if both of the following conditions are satisfied:

(a) The plan complies with the requirements with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); and

(b) To the extent the plan or any health insurance coverage includes an out-of-pocket maximum on coverage that does not consist solely of major medical coverage (for example, if a separate

out-of-pocket maximum applies with respect to prescription drug coverage), such out-of-pocket maximum does not exceed the dollar amounts set forth in section 1302(c)(1).

Accordingly, any separate out of pocket maximum in 2014 would be limited to the amount set forth in section 1302(c)(1), although plans may choose to make it lower. However, existing regulations implementing Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibit a group health plan (or health insurance coverage offered in connection with a group health plan) from applying a cumulative financial requirement or treatment limitation, such as an out-of-pocket maximum, to mental health or substance use disorder benefits that accumulates separately from any such cumulative financial requirement or treatment limitation established for medical/surgical benefits. Accordingly, under MHPAEA, plans and issuers are prohibited from imposing an annual out-of-pocket maximum on all medical/surgical benefits and a separate annual out-of-pocket maximum on all mental health and substance use disorder benefits.

The Honorable Diana DeGette

1. **There is a concern relative to the consistent application of rules on dental plans inside and outside of the Exchanges. In Colorado alone, over 15,000 children presently have dental coverage through plans in the small group market.**

   Recent communications from the Center for Consumer Information and Insurance Oversight (CCIIO) regarding the offer and purchase of the pediatric dental essential health benefits have resulted in some confusion. Specifically, on the Colorado Exchange, the pediatric benefit must be offered but its purchase is not required. Outside the exchange, the purchase is mandated (even for childless adults) and responsibility for the reasonable assurance that an individual has purchased the pediatric dental benefit of purchase rests with the major medical carrier.

   This lack of equitable treatment inside and outside exchanges may preclude children from receiving access to important oral services, as required by the Affordable Care Act. Can you clarify whether CCIIO will provide equitable treatment for the pediatric dental benefit which is so important to health of Colorado's children?

Answer: Several provisions of the Affordable Care Act affect the coverage of pediatric dental essential benefits. Section 2707(a) of the Public Health Service Act requires issuers in the individual and small group markets inside and outside the Marketplaces to offer EHBs as defined in section 1302 of the Affordable Care Act. EHB requirements apply to health insurance issuers, which must offer certain benefits; they are not requirements for individuals or families to obtain coverage for a particular benefit.

In the EHB Final Rule, CMS provided a clarification regarding situations in which issuers outside the Marketplaces would not be found to be non-compliant with the requirement to offer EHBs if the issuer is reasonably assured that the applicant has obtained the pediatric dental EHB through a Marketplace-certified stand-alone dental plan. With respect to issuers inside a Marketplace, however, section 1302(d)(4)(F) of the Affordable Care Act allows issuers to omit pediatric dental coverage if there is a stand-alone dental plan offering the pediatric dental essential benefit in that Marketplace. Thus, the different issuer requirements in the Affordable Care Act lead to different consumer experiences inside and outside of the Marketplaces.

The Honorable Ben Ray Luján

1. **The Affordable Care Act called for the creation of Consumer Operated and Oriented Plans or CO-OPs, which will be offered on the health insurance exchanges as nonprofit insurance providers to compete with other carriers in the individual and group markets. This February, the co-op that will operate on my home state's exchange, New Mexico Health Connections received its certificate of authorization from the state insurance Superintendent, making it the first new health insurance company licensed by the state in 8 years. The progress of New Mexico Health Connections has been remarkable-they have announced that they will be ready to offer policies beginning on October 1 when the state exchange first opens for business-and they couldn't have done it without the help of CCIIO.**

   The Co-op was initially underwritten with a $6 million loan from the Centers for Medicare and Medicaid Services that will be repaid within 5 years and has taken advantage of another $64 million line of credit with CMS to be repaid in 15 years. In our current fiscal climate, these co-ops present a terrific investment opportunity for the federal government. These startup funds can be utilized to expand the reach of co-ops to bring more Americans into an affordable plan that promises to bring sorely needed competition to the individual health insurance market. Best of all, the co-ops have plans in place to become self-sufficient and fully re-pay the federal government for its contribution.

   Mr. Cohen, could you please further discuss the federal government's role in funding these co-ops and how you foresee the role of the government in sustaining them into the future? I am particularly interested in opportunities for CCIIO to further expand the reach of the co-ops as they go online and seek to provide health coverage for additional customers.

Answer: We are pleased to have established the CO-OP Program, authorized by section 1322 of the Affordable Care Act, to foster the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets.

To date, 24 private, nonprofit entities have been awarded loans to establish CO-OPs across 24 states. Because such funds are considered to be obligated when the awards are made upon execution of a loan agreement, loan or grant awards issued to CO-OPs prior to enactment of the American Taxpayer Relief Act are not subject to or affected by the rescission.

CMS will continue to provide assistance and oversight to these CO-OPs as they work to achieve program milestones, receive licensure from their respective state Departments of Insurance, qualify as a Qualified Health Plan, and prepare to participate in new Health Insurance Marketplaces.

While CMS no longer has the authority to make loan awards to new borrowers, it can provide additional funding to existing borrowers, including funds for expansions to new states. CMS is currently accepting and reviewing these applications submitted by existing borrowers.

The assessment process for additional funding is rigorous. The available program funds will be prioritized first to ensure the viability of the existing business plans, and secondly to fund modifications to business plans for the purpose of expanding to new states. Expansion requests will be reviewed by both a contractor and CMS against the same scoring criteria as were the original loan applications. Preference will be given to expansions that align with the program goal of increasing consumer choice in states that may otherwise face limited issuer competition in their Health Insurance Marketplace.

CMS will closely monitor CO-OPs to ensure they are meeting program goals and will be able to repay loans. To ensure strong financial management, CO-OPs are required to submit quarterly financial statements, including cash flow and enrollment data, receive site visits, and undergo annual external audits. This monitoring is initially conducted by CMS and will continue concurrently with the financial and operational oversight by state insurance regulators once the CO-OP is approved for state licensure. We look forward to our continued collaboration with these CO-OPs to provide more options for Americans as they access health insurance coverage in the new Marketplaces.

2. **I represent a very rural state in which patients sometimes have to drive several hours just to speak with their health care providers. There are no requirements in the Exchange final rules that specify the minimum distance for access to providers or minimum time frames in which to access the providers. However, guaranteeing network adequacy is a particularly important issue for individuals with ESRD, given that such individuals' lives depend on their ability to access dialysis treatment at least three times each week. Peer-reviewed literature (e.g. in the American Journal of Kidney Disease) has confirmed that increased drive time is correlated with diminished health outcomes for ESRD patients. These same studies have shown that a significant majority (3 out of 4) of ESRD patients currently have drive times that are within 30 minutes.**

   I understand, due to the geographic variability of many states, a single standard distance or time frame for all providers may prove to be difficult. On the other hand, network adequacy is a key indicator with respect to proper plan design, particularly in the case of individuals with significant health needs. Unfortunately, as the NAIC noted in a December 19, 2012 letter to CMS, "State insurance regulators continue to have questions regarding how the prohibition on discriminatory benefit design is to be defined and enforced" and "need more clarity on what is a 'discriminatory benefit design." Would HHS consider issuing clarifying regulatory language to provide, in the case of individuals with significant health needs, that plans may not contain network adequacy criteria that are more restrictive than those established under the state benchmark plan?

Answer: The Exchange Establishment Final Rule (77 FR 18310), 45 C.F.R. § 156.230 requires QHP issuers to develop provider networks that (1) include essential community provider described in 45 C.F.R. 156.235, and (2) are sufficient in number and types of providers,

including providers that specialize in mental health and substance abuse service, to assure that all services will be accessible without unreasonable delay.

Health plan network adequacy is an area reviewed by many state departments of insurance today; consistent with CMS' overarching commitment not to duplicate state work in carrying out its responsibilities with respect to a Federally-facilitated Marketplace, CMS will implement a tiered approach to network adequacy reviews. In states with sufficient authority and means to evaluate health plan network adequacy consistent with the Federal regulatory standard, CMS will use a state's review as part of its evaluation. In states without such authority, CMS will rely on an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting agency. Unaccredited issuers will be required to submit an access plan as part of the QHP Application. The access plan must demonstrate that an issuer has standards and procedures in place to maintain an adequate network consistent with § 156.235(a).

CMS intends to monitor consumer access to providers, including specialists, during the coverage year, and will work closely with states in which an FFM is operating.

In addition, as part of the certification process in FFMs CMS will work to ensure that potential QHPs do not employ discriminatory benefit designs. Specifically, CMS will use an outlier test to identify potential QHPs with relatively high cost sharing for benefits like specialist visits and prescription drugs. More information about CMS's approach for reviewing both network adequacy and benefit designs is included in the 2014 Letter to Issuers, available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.

3. **As a strong supporter of one of the ACA, I am eager to see that the law is implemented properly. As the exchanges begin enrolling people this fall, I want to be sure that my constituents have access to all of the important care and services they need. I understand that the recent Essential Health Benefits rule may inadvertently restrict access to care for patients suffering from rare diseases. Exactly how will you ensure that my constituents suffering from these diseases are not inadvertently discriminated against by qualified health plans in the exchanges?**

Answer: The EHB Final Rule at 45 CFR 156.125 outlines non-discrimination standards for issuers offering EHBs. The regulation provides that an issuer's benefit design, or the implementation of its benefit design, may not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. In guidance issued on April 5, 2013, entitled, *Letter to Issuers on Federally-facilitated and State Partnership Exchanges,* CMS further detailed the steps it will take to review plans for discriminatory benefit design as part of the Qualified Health Plan (QHP) certification process in Federally-facilitated and State partnership Marketplaces.

4. **One of the goals of the ACA was to ensure that none of our constituents fell through the cracks of our complex healthcare system. Congress enacted a number of protections into the bill to ensure patients have access to the care they need. As the exchanges open for business later this year, I want to be sure that we continue to keep those promises to**

patients, particularly those who suffer from rare diseases. Many of these patients require specialized care. What are you doing to ensure that qualified health plans operating in the exchanges will have robust networks of providers so that my constituents are not left with few or no options for treatment for their rare diseases?

Answer: CMS finalized network adequacy standards in the Exchange Establishment Final Rule (77 FR 18310), in sections 45 CFR 155.1050 and 45 CFR 156.230. The Final Rule states that a QHP issuer must maintain a provider network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay. In addition, QHP issuers must meet the requirements to include essential community providers in accordance with 45 CFR 156.235 and meet the network adequacy provisions of section 2702(c) of the Public Health Service Act. The standards articulated are a floor. Nothing prohibits states from applying more stringent standards or protections across their markets. New Mexico has elected, and has been conditionally approved, to run a State-based Marketplace. As a result, New Mexico will review plans for compliance with network adequacy standards.

5. **I understand that the Essential Health Benefits Rule that was recently issues by HHS allows qualified health plans to employ "reasonable medical management techniques," but that issues could not use such techniques "in a manner that discriminates on the basis of membership in a particular group..." One Such technique that is often used is to place certain medications into 'specialty tiers' with higher cost-sharing for patients. I am concerned that this may cause undue harm to rare disease patients. How will you ensure that this will not happen to the most vulnerable rare disease patients?**

Answer: CMS' implementing regulations neither require nor prohibit prescription drugs being covered on any particular tier, if a plan chooses to use a tier system in its formulary. Instead, the rule requires the plan to offer at least the greater of one drug in every USP category and class or the number of drugs in each USP category and class offered by the EHB-benchmark. However, the EHB Final Rule at 45 CFR 156.125 outlines non-discrimination standards for issuers offering EHBs, which apply to all EHBs including prescription drug benefits. The regulation provides that an issuer's benefit design, or the implementation of its benefit design, may not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Lastly, the Final Rule requires that plans have an exceptions procedure for enrollees to request and gain access to a clinically appropriate drug not covered by the health plan.

The Honorable G.K. Butterfield

1. **As you may know, the Republican-controlled North Carolina General Assembly passed and Governor Pay McCrory signed a bill called the "No NC Exchange/No Medicaid Expansion." The decision by the legislature and Governor defies logic. The Federal government will pay 100 percent of the cost of expanding Medicaid for three years and then pay 90 percent after that. This shortsighted decision continues to exclude single, childless adults who make less than 100 percent of poverty-some 500,000 people. Some estimate it may be as high as 650,000. What will the individuals who fall into that category be forced to do when they become sick? And doesn't that decision by the Governor and General Assembly essentially force those individuals who do not qualify for Medicaid to go to an emergency room where they will likely not be able to afford the bill once they are treated?**

Answer: CMS agrees that expanding Medicaid has financial and social benefits for states, with the Federal Government covering 100 percent of the cost of covering Medicaid for newly eligible low-income adults under age 65 for the first three years and no less than 90 percent in following years. This expanded coverage would dramatically reduce uncompensated care in emergency rooms and other care settings, lowering the financial burden on hospitals, providers, employers, and patients.

CMS continues to work with states on Medicaid-expansion implementation. There is no deadline by which a state must notify the Federal Government of its intent to expand its Medicaid program, and states may choose to expand Medicaid at any time. However, while states have flexibility regarding how they implement the Medicaid expansion, Federal match rates for medical assistance for newly eligible individuals are statutorily tied to specific calendar years: states will receive 100 percent support for the newly eligible adults in 2014, 2015, and 2016; 95 percent in 2017, 94 percent in 2018, 93 percent in 2019; and 90 percent in 2020, remaining at that level thereafter.

2. **Say a 35 year old single man from Rocky Mount, North Carolina who doesn't smoke and is just above the poverty line is searching for health insurance under the Marketplaces in 2014. If our Governor had been wise enough to expand Medicaid, he would have had that option. But on the exchange, my constituents will get a tax credit to keep his premiums at around 2% of their income. Is that correct? Will this credit enable individuals to access more comprehensive coverage with lower premiums than exist currently?**

Answer: Yes. In general, under the Affordable Care Act, qualified individuals with incomes between 100 and 400 percent of FPL, who are not eligible for certain health insurance coverage through their employer, Medicaid, Medicare, or certain other types of coverage , and who purchase insurance coverage through the Marketplaces, are eligible for tax credits to reduce the cost of coverage. The amount of the tax credit is based on a benchmark premium: the premium for the second-lowest-cost silver plan (a plan that provides EHBs and has an actuarial value of 70 percent) available in the Marketplace where the individual is eligible to purchase coverage. The amount of the tax credit also varies with the individual's income, such that the premium for

the benchmark plan for an individual earing 100-133 percent FPL would be capped at 2 percent of the individual's household income. CMS expects that these tax credits, coupled with the Affordable Care Act's insurance market reforms, will enable access to affordable, comprehensive insurance without discrimination based on gender or pre-existing conditions.

3. **In all my conversations with state and local officials in my Congressional District and across my state of North Carolina, I emphasize how important it is that everyone who doesn't have insurance knows they will be required to enter the insurance marketplace. HHS has developed an "exchange navigator program" designed to help guide people through the process. Can you please explain how the navigators will measure progress and if you feel that the resources made available for the program are sufficient?**

Answer: On April 9, 2013, CMS published a Funding Opportunity Announcement (FOA) making up to $54 million available in cooperative agreements to fund Navigators in Federally-facilitated and State Partnership Marketplaces, including North Carolina, with a minimum amount of $600,000 available per Federally-facilitated or State Partnership Marketplace service area. This funding will be sufficient to provide Navigator services in the states that will have Federally-facilitated or State Partnership Marketplaces. Navigator cooperative agreement applications are due on June 7, 2013. The President's Fiscal Year (FY) 2014 Budget includes $574 million, or a total program level over $800 million when accounting for user fees, for Marketplace outreach activities, primarily the call center, Navigator grants, and other enrollment assistance, with a smaller portion allocated to the website, print communications and other awareness activities.

As a condition of their cooperative agreement awards, Navigators in the Federally-facilitated and State Partnership Marketplaces must agree to cooperate with any Federal evaluation of the program and must provide required quarterly and final progress reports. The reports will outline how cooperative agreement funds were used, describe program progress, describe any barriers encountered including how potential conflicts of interest were mitigated and process for handling non-compliant staff or volunteers, describe how the program ensured access to culturally and linguistically appropriate services, and detail measurable outcomes including how many staff and volunteers completed training and became certified Navigators and how many consumers were served.

4. **I understand the navigators will provide help to customers through the eligibility and enrollment process. For a low income, African American from Roanoke Rapids, North Carolina with hereditary medical issues, will the navigators be able to provide suggestions about the best plans to fit their health care and financial needs?**

Answer: Navigators will help consumers through the eligibility and enrollment process, but will not make eligibility determinations and will not select qualified health plans (QHPs) for consumers or enroll applicants into QHPs. That said, Navigators may play an important role in facilitating a consumer's enrollment in a QHP by providing fair, impartial, and accurate information that assists consumers with submitting the eligibility application, clarifying the distinctions among QHPs, and helping qualified individuals make informed decisions during the health plan selection process.

In addition, Navigators will maintain expertise in eligibility, enrollment, and program specifications and will conduct public education activities to raise awareness about the Marketplace. Navigators will provide information and services in a fair, accurate, and impartial manner, including information that acknowledges other health programs such as Medicaid and CHIP. Navigators will also provide referrals for enrollees with questions, complaints, or grievances about their health plan, coverage, or a determination under such health plan or coverage to appropriate State agencies, such as any applicable office of health insurance consumer assistance or health insurance ombudsman. Navigators must provide information in a manner that is culturally and linguistically appropriate to the needs of the population served by the Marketplace, including individuals with limited English proficiency, and must ensure accessibility and usability of Navigator tools and functions for individuals with disabilities.

5. **If I live in Durham, North Carolina and have been diagnosed with a pre-existing condition but missed the February cutoff for enrollment in the Pre-existing Condition Insurance Program (PCIP), what are my insurance options until the implementation of the Marketplace in 2014?**

Answer: Starting in 2014, health insurance issuers will no longer be able to discriminate against Americans with pre-existing conditions. All Americans – regardless of their health status or pre-existing conditions – will finally have access to quality, affordable coverage. On October 1, 2013, Americans with pre-existing conditions will be able to apply for affordable health insurance coverage through the new Health Insurance Marketplace.

Marketplaces will be up and running and ready to serve all Americans, including those with pre-existing conditions, on October 1st of this year. Until then, a variety of options may be available to those with pre-existing conditions who are not enrolled in PCIP. For example, they may be eligible for Medicaid or a state high risk pool. Individuals with pre-existing conditions may visit http://finder.healthcare.gov to explore their health care options.

6. **As you know, states like North Carolina originally intended to establish a state-federal partnership health insurance exchange but at the last minute decided to rely on the federal government to operate the exchange. Is implementation for Federal Marketplaces in states like North Carolina still on track?**

Answer: Implementation of the Federally Facilitated Marketplaces is on track, and on October 1, 2013, consumers will be able to apply for coverage and premium tax credits, receive an accurate eligibility determination, compare QHPs and choose the plan that best fits their needs. CMS has released the final model single streamlined application after extensive testing for consumer usability. The infrastructure for the data hub, which will facilitate data exchange between consumers and relevant government agencies, has been completed and testing has been successful. CMS met its April 1st deadline for allowing issuers to submit QHP applications, and states have successfully used the Hub in testing. We expect each of these systems to be fully operational and interoperable by open enrollment on October 1.

7. **It is my understanding that waiver process for employers and ensures was simple, fair, and transparent. Do waivers continue to be granted at a high rate and in a timely manner?**

Answer: The Affordable Care Act was clear that restricted annual limits on EHBs would be permitted until 2014 to prevent changes that would increase premiums or reduce access. The waiver policy adheres to the law without creating a blanket rule that exempts many more health insurance issuers and group health plans from the new protections against restricted annual limits. Most health insurance issuers and group health plans determined that they could comply with the new policy that restricted annual limits to no less than the following: $750,000 for plan years between September 23, 2010 and September 22, 2011; $1.25 million for plan years between September 23, 2011 and September 22, 2012; and $2 million for plan years between September 23, 2012 and December 31, 2013. However, health insurance issuers and group health plans were able to apply for and receive a waiver if they could show that the prohibition against restricted annual limits would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies. Plans that received waivers have been required to let their enrollees know that they received waivers from the new protections in the law. This balanced approach reflects our goal of not disrupting coverage while expanding consumer protections as we move toward full implementation – and a full prohibition of annual limits – in 2014. The deadline for plans to apply for these waivers was September 22, 2011, and we stopped issuing waivers on January 6, 2012. A list of the waivers is available at: http://www.cms.gov/CCIIO/Resources/Files/approved_applications_for_waiver.html. All annual limit waivers expire for the plan or policy year that begins on or after January 1, 2014.

8. **Some states (e.g. California) have enacted legislation to prohibit treatment limits from exceeding the corresponding limits imposed by the state benchmark plan and would generally prohibit a plan from making substitutions of the benefits required to be covered. Do you believe the EHB Final Rule will comport with such legislation? Would HHS consider clarifying regulatory language to provide, in the case of individuals with significant health needs, that plans may not contain treatment limits which exceed the corresponding limits imposed by the benchmark plans or make substitutions of the benefits required to be covered under the benchmark plan?**

Answer: State requirements that are more stringent than the Federal requirements would not be preempted by the EHB Final Rule unless such requirements prevent the application of Federal law. Accordingly, states have significant latitude to impose requirements with respect to health insurance coverage that are more consumer-protective than the Federal law, including with respect to benefit substitution under EHBs.

9. **Can you please describe how much, and what type of information will be available to consumers when they are ultimately able to make coverage choices in the health insurance marketplace? Will it look like Medicare Part D? Or perhaps Medicare Advantage?**

Answer: To access the Marketplace, consumers can visit HealthCare.gov, which will guide them to the appropriate application – state applications for State-based Marketplaces, or the single, streamlined HHS-developed application in states with a Federally–facilitated Marketplace or State Partnership Marketplace.

After an applicant receives an eligibility determination, the applicant will then either proceed to the Plan Compare section of the Marketplace website, or to the State-specific process for Medicaid or CHIP enrollment, depending on the final eligibility determination.

In the Plan Compare section of the Federally-facilitated Marketplace website, eligible applicants will be able to learn more about available QHP options and compare the plans based on a number of factors including price, benefits, and quality. Applicants will be able to compare plans across metal levels and also within a metal level. For example, an applicant can compare three different "silver" level plans or they may want to compare a "silver" plan to a "gold" and a "bronze" to learn what each plan offers for them and at what cost. Applicants will be able to review information for each plan such as: monthly premium (after any applicable premium tax credit); deductible; out of pocket maximum; co-pay amounts; and dental options available. Applicants will also be able to easily link to a summary of benefits and coverage, provider directories, and other plan details. This consumer-driven tool will allow applicants to easily compare the QHPs available to them, helping them make the best decision for their and their family's needs.

The Honorable Paul Tonko

1. **The implementation of the Affordable Care Act will extend federal parity protections from Mental Health Parity and Addiction Equity Act to more than 62 million Americans. However, given the lack of clarity stemming from the delay of the Obama Administration in issuing final parity regulations, it remains to be seen whether the American people will enjoy the full protections of mental health parity consistent with the spirit of MHPAEA as the ACA goes into full effect in 2014. Last week, Secretary Sebelius testified that a final Mental Health Parity regulation would be finished by the end of the year. Can you provide us with any more details on when to expect a final parity rule?**

Answer: As you note, the Administration has committed to releasing a MHPAEA Final Rule this year. I expect that the regulation will specify an effective date. Until the Final Rule is issued, the Interim Final Rule implementing MHPAEA, which was published in the Federal Register on February 2, 2010, remains in effect.

2. **While it is promising new that final parity regulations will be released this year, I fear that it will be too late for insurance plans to implement for their 2014 plan year. Can you specifically tell us whether the administration expects final parity rules to be in force for their 2014 plan year, consistent with the roll out of the ACA?**

Answer: See response to question 1.

3. **Along with promulgating a final rule, there are significant concerns that the administration is not doing enough to enforce the interim final regulations that are already in place. Just this week, an employee from CCIIO was quoted in an article in CQ Weekly, speaking in front of representatives of the health insurance industry that mental health parity was, "an area where we plan on setting the dials pretty low." I find this attitude to be very troubling. Can you please explain what was meant by this statement and speak generally to the Administration's posture towards MHPAEA enforcement?**

Answer: The Department of Labor, the Department of Health and Human Services (HHS), and the Department of the Treasury (the Departments) are committed to full implementation and enforcement of MHPAEA, including the provisions of the interim Final Rules that were published on February 2, 2010. The President and his Administration are fully committed to promulgating a MHPAEA Final Rule in 2013. We share your interest in ensuring that group health plans, health insurance issuers, health care providers, and consumers are provided the guidance necessary to realize the full benefits of the law.

The Department of Labor and the Department of the Treasury generally enforce the requirements for private, employment-based group health plans, but do not have enforcement authority under MHPAEA over health insurance issuers. Under the Public Health Service Act section 2723(a), states have primary enforcement authority over health insurance issuers with respect to the provisions of title XXVII of the Public Health Service Act, including MHPAEA. HHS (through

CMS) has enforcement authority over the issuers in a State if the State notifies CMS that it has not enacted legislation to enforce or is not otherwise enforcing, or if CMS determines that the State is not substantially enforcing, a provision (or provisions) of title XXVII of the Public Health Service Act. CMS also has direct enforcement authority with respect to non-Federal-Government plans. The Department of Labor and the IRS have enforcement authority over private group health plans.

The Departments recognize that many States have existing insurance laws requiring parity for or requiring coverage of mental health or substance use disorder benefits and that it can at times be difficult to understand how the Federal MHPAEA requirements interact with such provisions of State law. The Departments regularly work with state regulators through the National Association of Insurance Commissioners and on an individual basis to ensure that states understand MHPAEA and its implementing regulations and are aware of their enforcement responsibilities. In addition, the Departments communicate regularly with state regulators, health plans, issuers, providers, consumer organizations, and congressional staff to discuss MHPAEA implementation issues.

Beginning in 2014, many Americans will experience expanded access to mental health and substance use disorder benefits. Section 2707(a) of the Public Health Service Act and section 1302 of the Affordable Care Act provide that health insurance coverage in the individual and small group markets must include coverage for 10 categories of EHBs. One of those categories is mental health and substance use disorder services, including behavioral health treatment. HHS issued a Final Rule related to EHBs on February 25, 2013. Under this Final Rule, starting in 2014, all individual policies and small group plans sold both inside and outside a Health Insurance Marketplace must provide mental health and substance use disorder benefits in compliance with the requirements of the MHPAEA interim Final Rule. In addition, large group health plans will continue to be subject to MHPAEA.

In preparation for 2014, many states have reached out to HHS with questions concerning how to structure the benefits within EHB-benchmark plans to comply with MHPAEA. For benefit years 2014 and 2015, states selected "base-benchmark plans" from four types of health plans, including the largest plan by enrollment in any of the three largest small group insurance products in a state's small group market. Because EHB-benchmark plan benefits are based on 2012 plan designs, and include state-required benefits that were enacted before December 31, 2011, some of the benchmark plan summaries may not reflect requirements effective for plan years starting on or after January 1, 2014. Therefore, HHS has been informing stakeholders that, when designing plans that are substantially equal to the EHB-benchmark plan, beginning in 2014, issuers may need to conform plan benefits, including coverage and limitations, to comply with these requirements and limitations, including compliance with the requirements of the MHPAEA interim Final Rule. State regulators have appreciated HHS's guidance on MHPAEA at this crucial stage, especially given that all individual policies and small group plans sold both inside and outside a state marketplace must comply with states' EHB-benchmark plans in 2014.

4. Can you describe in step-by-step detail the current investigation and enforcement procedures that your office goes through when it receives a complaint about parity violations?

Answer: Plans subject to MHPAEA may be regulated by different entities, depending on the type of plan. States have primary regulatory authority over health insurance issuers, unless a state is not enforcing a Federal law, in which case CMS is required to enforce the law. This enforcement structure has been in place since the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). CMS also enforces MHPAEA requirements for non-Federal Governmental plans. The Department of Labor and the Department of the Treasury generally enforce the requirements for private, employment-based group health plans, but do not have enforcement authority under MHPAEA over health insurance issuers. If CMS receives a complaint about a MHPAEA violation, we investigate it and take enforcement action as appropriate to ensure that the law protects consumers as intended. CMS and other Federal agencies work closely with plans, state departments of insurance, and issuers to ensure any MHPAEA violations are corrected.

The two primary methods in which consumers and providers contact CMS with inquiries about MHPAEA are a toll-free phone number (1-888-393-2789) and an email address (phig@cms.hhs.gov). The caseworkers within CCIIO's Consumer Support Group, who have received MHPAEA training, gather information about the consumer's or provider's issue and answer basic questions about the law.

In addition to following up on inquiries and complaints, the Departments of Health and Human Services, Labor and the Treasury (the Departments) have released fact sheets and interpretive guidance to increase the public's understanding of this complex law. For example, the Departments issued Frequently Asked Questions (FAQs) regarding MHPAEA on December 22, 2010, and November 17, 2011, to address several common questions from stakeholders. These FAQs reflect the Departments' interpretation of the requirements in the interim Final Rule and applicable Federal law. Also, HHS has posted a fact sheet on MHPAEA. Both resources are available at: http://www.cms.gov/cciio/index.html.

5. When these investigations of parity violations are concluded, are the results of these investigations made public? If not, why?

Answer: The results of the Department's investigations of parity violations are not made public at this time. The Department recognizes stakeholders' desire for more transparency and will coordinate to formulate methods to disseminate information on parity compliance.

6. Will you commit to releasing more of the information regarding the administration's parity investigations so that insurers and patients will have greater clarity as to when parity violations have been committed?

Answer: The Department appreciates the need for insurers and patients to have greater clarity as to when parity violations have been committed, specifically regarding the Administration's parity investigations. We will coordinate to develop a process to disseminate information on

parity compliance so that stakeholders will have additional information on the enforcement efforts of the Department.

The Honorable Gene Green

1. **Congress' intent with the ECP provision was to ensure sufficient access to safety net providers, including Community Health Centers among others. I want to ensure that as this rolls out, your agency is continuing to monitor the extent to which these plans do contract with ECPs and that your agency updates its guidance accordingly-especially if QHPs are offering untenable or limited contracts to safety net providers who wish to contract with them.**

   In fact, as ACA implementation rolls out it will be vitally important to link access to coverage and ensure people can see access the important primary and preventative care services they need (and avoid unreasonable delays to care). And so, Congress' intent was that any willing safety net provider should be able to contract with any Qualified Health Plan-especially those providers who are open to all, such as Community Health Centers, and who are located in areas where there are already sever barriers to accessing primary and preventative care. Looking forward to how this will roll out-both in terms of the contracting requirements for this current year and also in terms of continued guidance for the future, can you tell me how your agency will be monitoring this issue, what would be considered "robust participation"-since the 10% contracting requirements could mean just one single provider, which certainly would not be robust-and what your plans are for updating this guidance down the road?

Answer: For the 2014 coverage year, CMS will implement a threshold-based approach to evaluating the inclusion of essential community providers, or ECPs, in QHP provider networks. QHP provider networks may satisfy the regulatory requirement at 45 CFR 156.235 in one of three ways.

First, an issuer's networks may satisfy the safe harbor standard. To qualify for this standard, an issuer's QHP application must demonstrate that at least 20 percent of available ECPs in the plan's service area participate in the issuer's provider network(s). In addition to achieving 20 percent participation in available ECPs, the issuer must offer contracts prior to the coverage year to at least one ECP in each ECP category in each county in the plan's service area, and all available Indian providers.

Second, an issuer's networks may qualify for the minimum expectation standard. To satisfy the minimum expectation standard, an issuer's must demonstrate that at least 10 percent of available ECPs in the plan's service area participate in the issuer's provider networks. The issuer must also submit as part of the QHP application a narrative response describing how the issuer's provider networks, as currently designed and after taking into account new 2014 enrollment, provides an adequate level of service for low-income and medically underserved enrollees. This narrative justification should address the needs of specific underserved populations, including individuals with HIV/AIDS, American Indians/Alaska Natives, and low-income and underserved individuals seeking women's health and reproductive health services.

For an issuer that does not meet either the safe harbor standard or the minimum expectation, CMS will expect the application to include a narrative justification describing how the issuer's provider

network(s) will provide access for low-income and medically underserved enrollees and how the issuer plans to increase ECP participation in the issuer's provider network(s) in future years.

To assist issuers in identifying available ECPs, CMS published a non-exhaustive list of available ECPs based on data maintained by CMS and other Federal agencies, including provider names, contact information, and ECP type. CMS also published a list of providers who offer dental services to assist issuers of stand-alone dental plans.

CMS intends to monitor ECP participation during the coverage year to ensure that medically underserved and other consumers have adequate access to ECPs, and will continue to solicit feedback from the ECP community. As indicated in the 2014 Letter to Issuers, CMS may modify network adequacy and ECP standards in future years based on program experience.