STATEMENT OF

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ON

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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.

[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.