

Gary Cohen's Hearing
"Two Weeks Until Enrollment: Questions for CCHIO"
Before
Energy & Commerce Committee
Oversight & Investigations Subcommittee

September 19, 2013

Attachment 1—Additional Questions for the Record

The Honorable Marsha Blackburn

- 1. I'm very concerned about reports we've seen that the Labor Department is issuing additional regulations to target self-insured plans. What communication do you have with them or within your own agency about this? And furthermore, what data do you have that suggests more regulation is needed?**

Answer: While CMS regularly confers with the Department of Labor on a variety of issues, I am not familiar with the reports to which you refer. The Department of Labor is the primary regulator of self-insured plans, and questions related to that topic are best directed to that Department.

The Honorable G.K. Butterfield

- 1. Mr. Cohen, one of the biggest benefits in the Affordable Care Act was the expansion of Medicaid. After the Supreme Court ruled on the law, states were given the option to expand the Medicaid program to millions of Americans. They were not required to do so – but since the expansion was such a good deal for states, paid for almost entirely with federal funds – it was inconceivable that states would turn down this opportunity to provide health insurance for their low-income residents.**

But Mr. Cohen, my governor in North Carolina turned down this opportunity. This is particularly frustrating for me, because many of my constituents would have benefited if the state had chosen to accept federal funds. Currently in North Carolina alone, there are 720,000 uninsured adults that would have benefited from Medicaid if the state had accepted federal funds to expand their Medicaid program – including many thousands of my constituents.

Mr. Cohen, what do you think about this decision by my governor, and other states that have turned down the Medicaid expansion? What are your thoughts on the advantages of Medicaid expansion?

I fail to comprehend why a governor would choose to leave so many low-income people without insurance. And yet, more than 20 states including North Carolina appear to be declining the Medicaid expansion.

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 and future years, remaining level thereafter.

2. Mr. Cohen, one in four of my constituents are at or below the federal poverty level and 137,000 currently lack health insurance. Many of my constituents will benefit from premium tax credits under ACA to help reduce the cost of health insurance premiums. In fact, the Congressional Budget Office projects 8 in 10 people will benefit from these credits and a recent RAND report said the average Marketplace consumer will reduce their premium by 35 percent.

If I am a single male from Edenton, North Carolina, and I make \$47,000, which is less than 400% of the federal poverty level, then I qualify for tax credits to help cover my insurance cost. Can you explain how those tax credits will benefit my constituents up front when they enroll in the Marketplace?

Answer: In general, under the Affordable Care Act, qualified individuals with incomes between 100 and 400 percent 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 earning 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.

A recent report found that of the estimated 21.9 million uninsured Americans eligible to purchase coverage in the Marketplace, 6.4 million may be able to pay \$100 or less per person per month for the second lowest-cost silver plan in the Marketplace in their state in 2014, after taking into account their available premium tax credits. An additional 4.3 million may be able to pay \$100 or less per person per month by using their premium tax credit to purchase the lowest-cost bronze plan available to them.¹

¹ http://aspe.hhs.gov/health/reports/2013/Uninsured/ib_uninsured.cfm

- 3. With continuous attacks on the ACA from detractors, we have not made it easy to get the word out about the many benefits of the health care law. Navigators and people in the community are critical to education those who can benefit most from the law. This afternoon I am hosting an event on how faith communities can help educate people about the ACA.**

Can you discuss some of the important outreach and support efforts Navigators are providing in disadvantages communities like those in eastern North Carolina? How can community groups, like the faith community, become more involved in educating the uninsured about the Marketplaces?

Answer: In July, CMS finalized a rule outlining the standards for Navigators, in-person assisters, and certified application counselors in the Federally-facilitated and State Partnership Marketplace. Navigators are trained to provide accurate and impartial assistance to consumers shopping for coverage in the new Marketplace, including consumers who are not familiar with health insurance, have limited English proficiency, or are living with a disability.

Consumers can get assistance enrolling in the Marketplace in a number of different ways, including through trained navigators, in-person assistance personnel, or through certified application counselors. The navigator, in-person assister, and certified application counselor programs are critical tools to provide consumers with in-person help. Each assister undergoes a rigorous training process, including privacy training, and is tested to ensure they're prepared to help people enroll in the Marketplace. Thousands of enrollment assisters have been trained by CMS. In addition, community health centers are also playing a crucial role in the enrollment process. There are trained enrollment assisters at nearly every community health center in the country.

In North Carolina, one such assister organization is the North Carolina Community Care Networks. North Carolina Community Care Networks, Inc. are consortia that total more than 100 organizations who will work to inform consumers statewide, with particular focus in areas where there is a higher concentration of uninsured. These networks will be serving to reach out, inform, educate and help enroll North Carolinians, and include organizations in the legal rights, faith-based, agricultural, and aging communities.

For community groups that are interested in becoming more involved in educating people about their coverage options, CMS has official resources available at www.marketplace.cms.gov, including training to become a Certified Application Counselor (CAC), FAQs about eligibility and enrollment, and Census information and research to help target the uninsured.

- 4. Mr. Cohen, on August 29th, fifteen Members of this committee requested detailed documents and briefings from the 51 organizations approved as Navigators. I recognize that in July CMS finalized a rule which set standards for Navigators and established robust and demanding criteria for approval.**

Can you walk us through some of the stringent standards including the strict privacy and security standards the Navigators must meet in order to be approved?

Would you say that the review demanded by some on this committee was duplicative and unnecessary after the thorough process of evaluating Navigators at CMS?

Do you believe the duplicative and unnecessary efforts from some of the members of this committee obstructed the ability of Navigators to move forward with their obligations to help people access affordable health care?

Answer: To be eligible to receive a Navigator grant, as required in the Affordable Care Act, an applicant had to demonstrate that it had existing relationships or could readily establish relationships with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan. In addition to the rules set forth in the law, funding announcement, and regulations, like other entities and individuals seeking to conduct business with the Federal Government, recipients of Navigator grants were subjected to a robust screening process before the grants were awarded.² Awardees must also meet any licensing, certification, or other standards prescribed by the state or Marketplace, if applicable, so long as these state Navigator standards do not prevent the application of Title I of the Affordable Care Act. Fourteen states with Federally-facilitated Marketplaces have set additional requirements for Navigators.³

These groups are trying to do the same type of work they have done in their communities for years and in some cases, decades, and it's unfortunate that they are the subject of inquiries that suggest they are doing something wrong by helping people in their communities enroll in health care coverage. This type of scrutiny risks creating an insinuation that well-respected organizations and institutions--like food banks, large state universities and United Way chapters--have somehow done something inappropriate--before they've spoken to a single consumer. It is disappointing that their resources and attention have been diverted at this critical time.

- 5. In a few weeks, it will be easier than ever before for North Carolinians and all Americans to shop for health insurance. Consumers will be able to go online, fill out a streamlined application, and sign up for health care coverage all in one sitting. And they will no longer be disqualified due to preexisting conditions or other arbitrary criteria.**

Can you explain options for consumers with additional questions, including accessing the toll-free call center or meeting face to face with a Navigator?

Answer: Educating consumers and businesses about the benefits that Marketplaces have to offer is the first step toward helping them take advantage of those benefits. We know quite a bit about the uninsured Americans we need to reach—many have never had health insurance, so the transaction of selecting, applying, and enrolling in health coverage will be unfamiliar to them. According to a CMS analysis of the 2011 American Community Survey, 20 percent of uninsured adults have not completed high school. To effectively reach these populations about their new health insurance options,

² Entities and individuals are not eligible for a Federal grant, including a Navigator grant, if they are on the Excluded Parties List of entities or individuals who have been suspended or debarred by any Federal agency. Suspensions from receiving Federal grant money of up to one year may be issued based on indictments, information, or adequate evidence involving environmental crimes, contract fraud, embezzlement, theft, forgery, bribery, poor performance, non-performance, or false statements. Debarments from receiving Federal grant money for a longer period of time may be issued based on convictions, civil judgment or fact-based cases involving environmental crimes, contract fraud, embezzlement, theft, forgery, bribery, poor performance, non-performance, or false statements, as well as other causes. This careful screening will help to ensure that individuals or organizations that pose a risk to the Federal Government are not awarded Federal Navigator grants.

³ The states are Arkansas, Florida, Georgia, Indiana, Iowa, Louisiana, Maine, Montana, Nebraska, Ohio, Tennessee, Texas, Virginia, and Wisconsin. See <http://www.commonwealthfund.org/Blog/2013/Jul/Will-State-Laws-Hinder-Federal-Marketplaces-Outreach.aspx>.

information should be provided in multiple ways, including by trusted people connected to the community in an appropriate manner.

Consumers who have additional questions regarding the application process for the Health Insurance Marketplace will be able to contact our toll-free call center, which is open 24 hours a day and can be reached at 1-800-318-2596. The toll-free call center can respond to requests in 150 languages. Additionally, consumers can use the Find Local Help tool on Healthcare.gov⁴ to find a Navigator or other similar in-person assisters in their area who can offer additional help in applying for coverage.

⁴ Available at <https://localhelp.healthcare.gov/>

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Tim Murphy

1. When did HHS make the decision to increase funding for the Navigator Program?

Answer: HHS announced additional funding on August 15, 2013.

2. Would states like California, who have their own marketplace and its own Navigator Program and are operating under the rules of the Federal Government, be under the same guidance, rules or regulations as an insurance agent?

Answer: Agents and brokers in all states, including SBM states, are licensed by the state's department of insurance. There are very specific state laws governing the practices, training requirements and continuing education requirements for agents and brokers. The State-based Marketplaces are training agents and brokers about how to use their Marketplace websites and what the Affordable Care Act requirements are, etc., and registering those that have taken their training and passed the exam so they can sell through the Marketplace.

The Affordable Care Act requires Marketplaces to establish a Navigator program to help consumers understand new coverage options and find the most affordable coverage that meets their health care needs. HHS wrote the regulations creating conflict of interest, training, certification, and recertification, and meaningful access standards for Navigators in the Federally-facilitated and State Partnership Marketplaces, and to non-Navigator assistance personnel in State Exchanges that are funded through Federal Exchange Establishment grants. Navigator responsibilities are defined by the Federal regulations, which can be supplemented by state law or the departments of insurance as long as those state requirements do not prevent the application of Title I of the Affordable Care Act. The states have entered into grant arrangements with Navigator entities, are funding them through various non-Federal funding streams (state appropriations, private foundation grants, etc.) during this first year, and have developed training programs and certification requirements consistent with Federal law and regulations, but separate from the licensing requirements for agents and brokers. CMS regulations specifically prohibit Navigators from serving as agents and brokers; Navigators are subject to different conflict of interest requirements and Navigators are prohibited from receiving compensation from issuers in connection with enrolling consumers in coverage.

3. Please provide us with the information regarding which states require criminal background checks and which ones do not.

Answer: Consumers can get assistance enrolling in the Marketplace in a number of different ways, including through assisters such as trained navigators, in-person assistance personnel, or through certified application counselors. We understand that thirteen State-based Marketplaces perform some type of background checks on Navigators and/or the other types of assisters listed above: California, Colorado, Connecticut, the District of Columbia, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Oregon, Rhode Island, Vermont, and Washington have and will continue to perform background

checks on Navigators and assisters. In terms of the Federally-facilitated Marketplace, we understand that Arkansas and Iowa will apply background checks to Navigators, and Illinois, Georgia, Florida, Indiana, Montana, Ohio, Tennessee, Utah, and Wisconsin will apply background checks to Navigators and the other types of assisters listed above.

4. How can our staff get the appropriate training to be able to answer questions and help our constituents?

Answer: CMS training materials and presentations are publicly available at <http://marketplace.cms.gov/training/get-training.html>. CMS is happy to work with your staff to ensure you have the necessary information to help your constituents find and enroll in health coverage.

The Honorable Steve Scalise

1. Please provide the name of any Navigator entity that has dropped out of the Program due to scrutiny.

Answer: Several Navigator grantees chose to terminate their grant after grants were awarded in mid-August. In particular, Cardon Healthcare and West Virginia Parent, Training, and Information, Inc., indicated that heightened scrutiny of the Navigator Program factored into part of the reasons for rescinding their grant. An additional grantee, Children's Hospital Medical Center (OH), cited additional restrictions placed by the state legislature as a barrier to their participation in the grant program.

The Honorable Gregg Harper

1. Can you please describe the budget review process for the grant applicants and whether or not it included additional payment for each enrollee that they sign up?

Answer: A budget review is the process of reviewing the line-item (object class) budget (and accompanying budget justification/narrative) submitted as part of a grant application, including Federal funds requested and any required matching or cost sharing, in order to identify unallowable costs and anomalies, ensure proper categorization of costs, verify rates, and check arithmetic accuracy.

Navigators are required to perform a number of activities including education and enrollment assistance. As part of the grant application process, each Navigator grantee organization had to submit a budget and detail how they intended to achieve the scope of work of the grant award. While some of the successful Navigator applicants proposed paying per-enrollee in their applications, those organizations agreed to forgo that system during the post-award budget negotiations. Through the Navigator's execution of the cooperative agreement, the Navigators must follow that agreement irrespective of what they included in their proposed budget.

As part of the standard Federal grant management process, we looked at the applications' budgetary narratives and conducted cost analyses to determine if the estimated costs for items like employee salaries, supplies, travel, etc. are allowable and reasonable. Additionally, through our post-award monitoring, we can ensure that the actual costs the grant recipients incur for items like employee salaries are allowable and reasonable. We followed the standard cost analysis process that is used

throughout HHS and the Federal Government to ensure that the awardees' costs are allowable and reasonable. There is no additional payment made to Federally-facilitated Marketplace Navigator grantees for enrolling individuals in coverage offered through the Marketplaces. However, State-based Marketplaces, which run their own assister and Navigator programs, may pay-per-enrollee.

2. Which states are paying some portion of compensation for each enrollee that they sign up? What additional amounts are they being paid per enrollee?

Answer: There are a few states conducting pay by enrollment; California is an example.

In California, the payment is going to the organization, not to the individual enrollment assisters. The organizations will then pay the individual assisters based on whatever contract they have with them.

Some Marketplaces are holding back a percentage of their funds (10-20 percent) to use as bonus funds, in essence, for those entities whose assisters have enrolled the most individuals/families/businesses in plans.

3. Are any state Navigator programs going door to door? If so, which ones?

Answer: Navigator grantees have been instructed that they should not be going door-to-door to provide assistance with enrollment; however, they may choose to go door-to-door to conduct outreach and education activities such as passing out flyers.

4. Is it HHS' position that Navigators can use money awarded to them in the grant to make robo calls?

Answer: Navigator grantees should not be making robocalls. If a grantee proposed to undertake such activities in their original application, CMS grant project officers would work with grantees to help them understand that this activity should not be conducted.

The Honorable Pete Olson

1. How many Navigator entities are there? Of those entities, how many have hired people for the Navigator position or currently have people in place to be Navigators to fulfill these requirements?

Answer: There are currently 102 Navigator grantees. Each grantee has either current staff or new staff hired to perform Navigator activities. Most grantees have Navigators working on the ground; however, a few grantees are still going through either the Federal training or state requirements before beginning their work as a Navigator.

The Honorable Morgan Griffith

1. Do you believe that one Navigator can enroll 11,500 people, which averages out to 31 people per day?

Answer: Sometimes applicants overestimate the number of people they will realistically be able to reach. However, an unrealistic estimate did not, of itself, eliminate an applicant from consideration. Applications are not scored based solely on the number of consumers the applicant indicated that they would serve in their project abstract. Applicants generally submit well-thought-out project plans. Applicants are approved to receive a Federal Navigator grant based on their project narrative explaining how they will implement their proposal in accordance with their proposed budget. Grant project officers work with all grantees to discuss issues within their application, including estimates of consumers potentially served that are not realistic.

The Honorable John Dingell

1. Please explain why in 2012, insurers were less likely than in previous years to request rate increases of 10 percent or more.

Answer: I believe increased transparency has helped to reduce the number of rate increases of 10 percent or more. Under the Affordable Care Act, insurance companies are now required to justify a rate increase of 10 percent or more, shedding light on arbitrary or unnecessary costs. Since this rule was implemented,⁵ the number of requests for insurance premium increases of 10 percent or more have plummeted from 75 percent in 2010⁶ to 43 percent in 2011 to 26 percent in 2012 and an estimated 14 percent in the first quarter of 2013⁷, and Americans have saved an estimated \$1.2 billion on their health insurance premiums, thanks to review of all rate increase requests.⁸

2. Please elaborate on your expectation that the consumers will have more and better information because of the structure of the marketplaces.

Answer: Answer: Consumers will be able to select an insurance plan with confidence that it will cover key health care services when they need them. All non-grandfathered policies in the individual and small group markets will cover essential health benefits, which include items and services in ten statutory benefit categories.⁹ Additionally, non-grandfathered health plans in the individual and small group markets will provide coverage in one of several standardized tiers. These tiers will allow consumers to compare plans with similar levels of coverage, which, along with comparing premiums, provider networks, and other factors, will help consumers make more informed decisions.

3. Please submit additional information on why in the 16 states for which we have data, our preliminary rates for health insurance in the marketplaces, 19 percent are less expensive than predicted.

Answer: We are already seeing evidence that the Marketplace is encouraging plans to compete for consumers, resulting in affordable rates. In the sixteen states¹⁰ for which data are available, the preliminary rate for the lowest-cost silver plan in the individual market in 2014 is, on average,

⁵ Health Insurance Rate Review – Final Rule on Rate Increase Disclosure and Review: <http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf>

⁶ <http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/rate-review09112012a.html>

⁷ <http://aspe.hhs.gov/health/reports/2013/rateIncreaseIndvMkt/rb.cfm>

⁸ http://aspe.hhs.gov/health/reports/2013/acaannualreport/ratereview_rpt.cfm

⁹ Essential Health Benefits: <http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28362.htm>

¹⁰ The states are: California, Colorado, Connecticut, District of Columbia, Maine, Maryland, Nevada, New Mexico, New York, Ohio, Oregon, Rhode Island, South Dakota, Vermont, Virginia, and Washington.

19 percent less expensive than the estimate based on projections by the Congressional Budget Office (CBO).¹¹ Outside analysts have reached similar conclusions. A recent Kaiser Family Foundation report found that “while premiums will vary significantly across the country, they are generally lower than expected,” and that fifteen of the eighteen states examined would have premiums below \$320 per month, which CBO projections imply would be national average premiums.¹²

4. Please submit additional information on why some insurers submitted bids to participate in the marketplace only to revise these bids and reduce their prices when other insurers’ rates came in lower.

Answer: Some insurers lowered their proposed bids when they were finalized. In Washington, D.C., some issuers have reduced their rates by as much as 10 percent.¹³ In Oregon, two plans requested to lower their rates by 15 percent or more.¹⁴ I believe this can at least partially be attributed to the competitive nature of the Marketplace.

5. Please submit additional information on why nearly half of consumers will likely be able to pay \$100 or less per person for coverage in 2014.

Answer: Under the Affordable Care Act, advanced payment of the premium tax credits will be available to help eligible individuals and families afford insurance coverage through the Health Insurance Marketplace beginning January 1, 2014, and states may expand Medicaid eligibility for low-income adults. There are currently 41.3 million eligible uninsured Americans.¹⁵ According to a September 2013 report, in the 25 states projected to expand Medicaid, a total of 23.2 million people, or 56 percent of the 41.3 million eligible uninsured, may qualify for Medicaid, CHIP, or tax credits to purchase coverage for \$100 or less per person per month. If all states expanded their Medicaid programs, 78 percent of the 41.3 million eligible uninsured, or 32.1 million people, would qualify for Medicaid, CHIP, or tax credits to purchase coverage for \$100 or less.¹⁶

6. Please elaborate on the fact that eight and ten marketplace consumers are expected to qualify for subsidies to make health coverage more affordable.

Answer: CBO has projected that about eight in 10 Americans who obtain coverage through the Marketplaces will qualify for assistance to make their insurance more affordable, an estimated 20 million Americans by 2017.¹⁷ A family’s eligibility for these affordability programs depends on its family size, household income, and access to other types of health coverage.

¹¹ ASPE Research Brief: Market Competition Works: Proposed Silver Premiums in the 2014 Individual and Small Group Markets Are Substantially Lower than Expected – see:

http://aspe.hhs.gov/health/reports/2013/MarketCompetitionPremiums/ib_premiums_update.pdf

¹² <http://kaiserfamilyfoundation.files.wordpress.com/2013/09/early-look-at-premiums-and-participation-in-marketplaces.pdf>

¹³ <http://hbx.dc.gov/release/dc-health-link-applauds-aetna-decision-cut-rates>

¹⁴ http://www.oregonlive.com/health/index.ssf/2013/05/two_oregon_insurers_reconsider.html

¹⁵ This number, based on the 2011 American Community Survey (ACS), is the estimate of Americans who are citizens or legal residents under the age of 65 and therefore eligible for coverage either in the Marketplace or through Medicaid. Some of these were eligible for Medicaid or CHIP coverage prior to 2014 but were not enrolled.

¹⁶ http://aspe.hhs.gov/health/reports/2013/Uninsured/ib_uninsured.cfm

¹⁷ http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf