HEARING ON IMPLEMENTATION OF HEALTH INSURANCE EXCHANGES AND RELATED PROVISIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

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HEARING ON IMPLEMENTATION OF HEALTH INSURANCE EXCHANGES AND RELATED PROVISIONS

WEDNESDAY, SEPTEMBER 12, 2012

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The subcommittee met, pursuant to call, at 3:20 p.m., in Room 1100, Longworth House Office Building, the Honorable Sam Johnson presiding.

[The advisory of the hearing follows:]

HEARING ADVISORY

Chairman Herger Announces Hearing on Implementation of Health Insurance Exchanges and Related Provisions
Wednesday, September 5, 2012
UPDATE: NEW TIME

ALL OTHER DETAILS OF THE HEARING REMAIN THE SAME.

House Ways and Means Health Subcommittee Chairman Wally Herger (R–CA) today announced that the Subcommittee on Health will hold a hearing to examine implementation of health insurance exchanges as authorized by the Democrats' health care law (P.L. 111–148 and 111–152). **The hearing will take place on Wednesday, September 12, 2012, in 1100 Longworth House Office Building, beginning at 2:30 PM.**

In view of the limited time available to hear from witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing. A list of witnesses will follow.

BACKGROUND:

The Democrats' health care law calls for the creation, operation, and regulation of health insurance exchanges. The health care law states that exchanges must meet minimum operational standards, provide for the certification of qualified health plans (QHP), and facilitate Medicaid and plan enrollment.

The health care law requires states to establish exchanges, in accordance with federal law and subsequent regulations, by January 1, 2014. Eligibility for premium and cost-sharing subsidies, which are financed through cuts to Medicare and tax increases on families and employers, are tied to enrollment in a QHP offered in state-established exchanges. If a state is unwilling or unable to establish an exchange, the law authorizes the Secretary of Health and Human Services (HHS) to establish a federal exchange within the state. States have until November 16, 2012, to declare their intentions.

Open enrollment in the exchanges begins on October 1, 2013. Plans are required to be certified as a QHP prior to open enrollment. Additionally, enrollment is predicated on the establishment and operation of information technology infrastructure, referred to as the data hub, to accurately and reliably transmit sensitive personal data. Prior to open enrollment, states, insurers, and other federal agencies need to conduct tests with the data hub, to ensure citizenship, income, plan enrollment, and other data necessary for eligibility determinations can be transmitted accurately and securely. This is clearly a significant undertaking.

However, to date, the Obama Administration has failed to publish final regulations to guide states, employers, and health plans as to what will be expected of them when open enrollment begins, including regulations on mandated benefit packages, new insurance regulatory mandates, expected enrollee costs, and much of the exchange-related information. Instead, the Administration has often relied on "bulletins," which are not enforceable by law and are issued without first conducting a rigorous cost-benefit analysis.

Between 2012 and 2022, the Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) estimate exchanges will process more than $1 trillion in premium and cost-sharing subsidies. Additionally, exchanges are also responsible for facilitating Medicaid enrollment, which CBO and JCT estimate will result in an additional expenditure of more than $640 billion.

In announcing the hearing, Chairman Herger stated, **"In just over a year, the Democrats' health care law is slated to begin funneling more than $1.6 trillion in taxpayer and Medicare beneficiary and provider-funded subsidies through state-based insurance exchanges. However, the necessary regula-**

tions for exchange operation, plan design, and eligibility still have not been finalized by the Obama Administration, leaving many to question whether political motivations are delaying the release of much-needed guidance for states, employers and health plans. Such uncertainty threatens to saddle stakeholders with higher costs and also increases the risk of waste, fraud, and abuse. Given this massive undertaking, the hearing will allow the subcommittee to hear about the progress and the pitfalls associated with this unprecedented expansion of government into America's health care system."

FOCUS OF THE HEARING:

The hearing will focus on the implementation status of health insurance exchanges and related regulations.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on September 26, 2012**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

Mr. JOHNSON. We are going to bring the subcommittee to order. We have got two guys in here, the two most important ones in the whole Congress.

Let me say our thoughts are with the Health Subcommittee chairman Wally Herger as he continues to recover in California from a hip replacement surgery and a recent bout with the flu, and I speak for all of us when I say we wish him well and hope for a speedy recovery.

We are here today to discuss implementation of Obamacare insurance exchanges and related provisions, and I want to thank our witnesses for your flexibility so we will be able to hold the hearing today, and thank you for sticking around. I appreciate it.

In the interests of time and to accommodate our witnesses, I ask unanimous consent that my opening statement be made part of the record. Do you agree to that?

Mr. THOMPSON. Absolutely.

Mr. JOHNSON. And Mr. Stark isn't here yet, so, without objection, I would ask that you make his opening remarks part of the record as well.

Mr. THOMPSON. Absolutely.

Mr. JOHNSON. Thank you, appreciate that.

Today we are joined by five witnesses, and given the home State ties, I will yield to the gentleman from Pennsylvania to introduce our first witness. Go ahead.

Mr. GERLACH. Thank you, Chairman Johnson, for giving me the opportunity to introduce my fellow Pennsylvanian, Insurance Commissioner Michael Consedine. Last year Michael was appointed by Governor Tom Corbett to serve as our insurance commissioner for the Pennsylvania Insurance Department and was confirmed by the Pennsylvania Senate back in April of last year.

The Insurance Department of Pennsylvania administers the laws of the Commonwealth as they pertain to the regulation of the insurance industry in order to protect insurance consumers. Given that Pennsylvania is the fifth largest insurance market in the United States and the 14th largest insurance market in the world, Michael certainly has his work cut out for him when you add it to the implementation of the State exchanges under the Affordable Care Act.

Throughout his legal career he has concentrated his practice on regulatory and corporate matters involving insurance entities and consumers. From 1995 to 1999, he served as department counsel for the Pennsylvania Insurance Department where he represented the department in an array of litigation proceedings and on transactional filings, including major corporate restructurings. He has also practiced law with the firm of Saul Ewing in Philadelphia, where he was a partner and vice chair of its insurance practice group.

He is a graduate of James Madison University as well as the Widener University School of Law, and given his vast experience and knowledge in the industry, he is an important asset to our Commonwealth. So we want to welcome him to the panel today and thank him for testifying on this important matter.

Yield back. Thank you, Mr. Chairman.

Mr. JOHNSON. Thank you.

Also testifying today are Neil Trautwein, vice president and employee benefits policy counsel at the National Retail Federation. Thank you for being here. Dan Durham, executive vice president of policy and regulatory affairs at America's Health Insurance Plans; Jim Blumstein, professor of constitutional law and health law and policy at Vanderbilt Law School, director of Vanderbilt's Health Policy Center; and Heather Howard, director of State Health Reform Assistance Network and lecturer in public affairs at Princeton University's Woodrow Wilson School of Public and International Affairs.

Thank you all for being here. You will each have 5 minutes to present your oral testimony, and your entire written statement will be made a part of the record.

[The Opening statement of follows: The Honorable Pete Stark]

The Honorable Pete Stark

Opening Statement

Ways and Means Health Subcommittee Hearing

September 12, 2012

I thank my colleague Mr. Johnson for joining us as Chairman today at the Health Subcommittee. He is filling in for Chairman Herger who recently underwent hip replacement surgery and is home convalescing. We all wish him a quick recovery.

Today's hearing is a chance to look at the Administration's ongoing efforts to implement the Affordable Care Act (ACA), a law that will finally bring our nation up to speed with every other modern nation in the world by ensuring that all our citizens have access to quality, affordable health care.

Unfortunately, politics have overtaken reason with regard to the Affordable Care Act.

It appears that the goal of my Republican colleagues today is not to actually monitor implementation of the law, but to instead attack the Obama Administration. That's obvious when you look at their hearing announcement, which states that this is a hearing on implementation of health insurance exchanges as authorized by *"the Democrats' health care law."* Last time I looked, the ACA was a law for all Americans, not just Democrats. Certainly, its benefits are accruing to Americans of all political stripes.

I'm not aware that there is a party affiliation test for the more than six million young adults who have been able to obtain or maintain coverage through their parents' health insurance plans or the countless consumers with private insurance who have received more than $2 billion in rebates or lower premiums thanks to the ACA's rate review provisions. Nor for the small businesses who have obtained tax credits to make coverage more affordable for their workers. Likewise, 5.3 million of Medicare beneficiaries – Republicans, Independents, Libertarians, Democrats, Green Party members and others – have obtained $4.1 billion in drug coverage. In 2012 alone, 18 million beneficiaries received at least one free preventive service, thanks to the ACA.

It strikes me that the timing of this hearing is all wrong. States have until November 16, 2012 to declare their intentions with respect to exchanges. Before then, we cannot obtain a clear picture of who is where with respect to state versus federal exchanges.

In terms of needing regulations for market reforms and other provisions, time and again, the written testimony of the majority's witnesses today says – quite carefully – IF we don't have regulations early in 2013, THEN it will be a problem. I agree. Regulations are needed well in advance of the deadline for submitting plans for review and taking other actions to prepare for the initial open enrollment periods in the exchange in October 2013. Again, if we are in this situation next Spring, a hearing would be a good idea. But, near as I can tell, the Administration has gone to great lengths to seek input in the pre-regulatory process from the very sectors and stakeholders before us today so that the actual regulations will be informed by the concerns of these communities. I guess the lesson here is that they are damned if they do, and damned if they don't.

With regard to the development of health insurance exchanges, whether the Administration is doing a good job seems to depend entirely on the perspective of the questioner. Based on the data I've seen, it looks like things are moving forward fairly smoothly. To the extent regulations aren't final yet, it appears to me that is directly related to the lengths to which the Administration has gone to solicit and consider input from a variety of stakeholders – states, insurance companies, employers and others. My Republican colleagues, on the other hand, would have you believe it is utter chaos.

The law was explicitly drafted with the flexibility to permit and even encourage states to develop their own exchanges. But, the statute always acknowledged that not every state will have the ability or desire to pursue that route. Recognizing that, the law established a federally facilitated exchange to ensure that all Americans -- in every state -- have access to the benefits of reform.

In implementing this model, HHS has gone out of its way to be flexible and accommodate state needs. For example, while the law envisioned states establishing their own exchanges or defaulting into a federal exchange, HHS developed a new "partnership" approach that permits a joint federal-state model. This new approach will enable states to share duties with the federal government, either on a temporary basis or in perpetuity. It's my understanding that a number of states are actively working with HHS on this approach.

So where do we stand on exchange implementation? The final regulations were published on March 27, 2012. States have until November 16th, 2012 to declare their intention with regard to whether they will pursue a state-based exchange, a partnership or instead have HHS operate in their respective states. Even with that date more than two months away, 13 states and the District of Columbia, representing one-third of the US population, have submitted letters of intent to pursue state-based exchanges. Since enactment of the law, 49 states applied for anc received $1 million federal planning grants, 29 states have moved ahead to receive exchange establishment level 1 grants, and another six states have both level 1 and level 2 establishment grants.

When I listen to people talk about this topic, it becomes clear that it is impossible for the Administration to meet everyone's concerns. This is a balancing act, and one I'd submit they are doing rather well up on a very high wire.

At the same time that one group complains about the lack of a final rule on a particular provision, they simultaneously laud the Administration for providing advance bulletin information on another provision so that interested parties can provide input before getting locked into the official rule-making process.

Today's hearing isn't timed to provide clarity. It is designed to present a false sense of confusion. Despite efforts by reform opponents to sow the seeds of doubt, I am confident that we are on track to begin coverage-based exchange by January, 2014.

With that, I look forward to hearing the testimony of our panel today.

Without further ado, Commissioner Consedine, you are welcome to begin.

STATEMENT OF THE HONORABLE MICHAEL CONSEDINE, COMMISSIONER, OFFICE OF THE COMMISSIONER, DEPARTMENT OF INSURANCE, HARRISBURG, PENNSYLVANIA

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

Thank you for that introduction, Representative Gerlach.

Good afternoon, distinguished members of this committee. My name is Michael Consedine, and I am Pennsylvania's insurance commissioner. As some of you may know, I had the privilege of presenting testimony in front of your colleagues on the Committee on Energy and Commerce in March of last year about our experiences in Pennsylvania with the first year of the implementation of the Affordable Care Act. In that testimony I described Pennsylvania's early experiences with the ACA as traversing a path that was marked by a lack of clear direction and troubling indications of the terrain ahead.

Unfortunately, in the 18 months that have followed, very little has changed. We still lack clear direction, and the flexibility promised us has not materialized, something that at this point poses a significant barrier to our ability to make informed decisions on issues that could impact the lives of millions of Pennsylvanians.

To date, the Department of Health and Human Services has failed to issue numerous regulations regarding how States are to implement the ACA. Most of these outstanding regulations address critical issues on the operation and requirements of key components of the ACA, like health insurance exchanges. The lack of detailed information from HHS has put Pennsylvania and many other States in a very difficult position. We are traveling down a road directionless while knowing the road will soon end. Pennsylvania, like many States, needs final rules and guidance on exchanges in order for us to determine what course is in the best interest for our State.

These concerns and the absence of clear guidance prompted me to write a letter to Secretary Sebelius 2 weeks ago outlining 26 specific questions that we in Pennsylvania felt needed to be answered in order for us to make an informed decision on exchanges. I have submitted a copy of that letter to the committee for inclusion in the record. As of the date of this testimony, HHS has not responded to our letter.

Pennsylvania is not an outlier in feeling directionless on this road. Recently I was asked to chair a National Association of Insurance Commissioners working group charged in part with collectively identifying the universe of unanswered questions and issues with exchanges in order to help other States begin to better understand the impact the operation of a Federal exchange may have on the insurance markets. We have yet to hold our first meeting, but already 22 States have signed up to participate in this working group.

A poorly executed Federal exchange launch and transition from current market rules to the new ACA rules could result in severe market disruptions and a weakening of States' control over their insurance markets. Continuing without answers to these crucial issues is like driving down a winding road at night without headlights. Nothing good will come of it.

As chair of this working group, my hope is that we may provide the needed direction, guidance, and support for all States that are traveling on this road together so that we as regulators can help our States make informed decisions and minimize disruptions to insurance consumers and our markets. We sincerely appreciate the efforts of Congress in aiding us at this critical juncture.

The road to exchange implementation is also a toll road. No matter what exit a State takes, it will cost something. However, without answers to our questions, the total costs are unknown, but seemingly grow every day.

States are also being asked to make a selection of essential health benefits benchmark plan by the end of this month, but no rule, proposed or final, has been released outlining the details of this process. Will a State's selection really be the selection, or can HHS modify a State's choice or, worse yet, override the selection and replace it with another benchmark? At this point no State can answer those questions because there is no regulation. All we know is that the ACA clearly intended for the decision on essential health benefits to be made by the Secretary of Health and Human Services, so at this point any inference that States have binding decisionmaking authority on issues appears to be an illusion.

HHS has been similarly silent on how it intends to pay for a State exchange or what costs States should expect to incur whether entering into a partnership or merely interfacing with a Federal exchange. States are required to live within their fiscal means, which requires thoughtful budget planning. Without answers to these questions, it is impossible for States like Pennsylvania to adequately prepare. These questions are just a few of the many outstanding issues to which States like Pennsylvania need answers if we are to make informed decisions.

In the end, the unfortunate but consistent delay of information from HHS will hurt Pennsylvania individuals and businesses the most. They are the passengers on this journey that is supposed to bring them to a destination of affordable and accessible health care. A poorly implemented Federal exchange, however, will put those passengers at risk. Two years after the ACA's implementation, we see health care premiums in Pennsylvania continue to rise, with no promise of reductions in sight, and we see an increase in the bureaucracy surrounding health insurance regulation. As I told Secretary Sebelius in my letter, Pennsylvania's focus remains on getting health care reform done right, not just done quickly, and certainly not done in a manner that puts Pennsylvanians at risk.

Even though the lack of information from Washington is producing roadblocks to effective exchange implementation in many States, it will not stop Pennsylvania from continuing its own work towards achieving meaningful and sustainable health care solutions in our State.

Thank you very much for the opportunity to testify before you today.

Mr. JOHNSON. Thank you.

[The prepared statement of Mr. Consedine follows:]

TESTIMONY IS EMBARGOED UNTIL 2:30 PM, WEDNESDAY SEPTEMBER 12, 2012

The Committee on Ways and Means, Subcommittee on Health

Statement of Michael F. Consedine,

Pennsylvania Insurance Commissioner

Washington, District of Columbia

September 12, 2012

Good Afternoon Mr. Chair and distinguished members of the Committee. My name is Michael Consedine and I am Pennsylvania's Insurance Commissioner.

As some of you may know, I had the privilege of presenting testimony in front of your colleagues on the Committee on Energy and Commerce in March of last year about our experiences in Pennsylvania with the first year of implementation of the Affordable Care Act ("ACA"). In that testimony, I described Pennsylvania's early experiences with the ACA as traversing a path that was marked by a lack of clear direction and troubling indications of the terrain ahead.

Unfortunately, in the eighteen (18) months that have followed, very little has changed – we still lack clear direction and the flexibility promised us has not materialized, something that at this point poses a significant barrier to our ability

to make informed decisions on issues that could impact the lives of millions of Pennsylvanians.

To date, the Department of Health and Human Services (HHS) has failed to issue numerous regulations regarding how states are to implement the ACA. Most of these outstanding regulations address critical issues on the operations and requirements of key components of the ACA, like health insurance exchanges.

The lack of detailed information from HHS has put Pennsylvania, and many other states, in a very difficult position. We are traveling down a road, directionless, while knowing the road will end soon – January 2014 is right around the bend. Pennsylvania, like many other states, needs final rules and guidance on Exchanges in order for us to determine what course is the best for our state.

These concerns and the absence of clear guidance prompted me to write a letter to Secretary Sebelius two weeks ago outlining twenty-six (26) specific questions that we in Pennsylvania felt needed to be answered in order for us to make an informed decision on exchanges. I have submitted a copy of that letter to the committee for inclusion in the record. As of the date of this testimony, HHS has not responded to our letter.

Pennsylvania is not an outlier in feeling directionless on this road. Recently, I was asked to chair a National Association of Insurance Commissioners ("NAIC") working group charged in part with collectively identifying the universe of unaddressed issues with exchanges in order to help states begin to better understand the impact the operation of a federal exchange may have on their insurance markets. We have yet to hold our first meeting, but already twenty-two (22) states have signed up to participate in this working group. A poorly executed federal exchange launch and transition from current market rules to the new ACA rules could result in severe market disruptions and a weakening of states' control over their insurance markets.

Continuing without answers to these crucial issues is like driving down a winding road, at night, without any headlights – nothing good will come of it. As chair of this working group, my hope is that we may provide the needed direction, guidance, and support for all the states that are travelling on this road together so that we as regulators can help our states make informed decisions and minimize disruptions to insurance consumers and our markets. We sincerely appreciate the efforts of Congress in aiding us at this critical juncture.

The road to exchange implementation is also a toll-road – no matter what exit a state takes, it will cost something. However, without answers to our questions, the total costs are unknown but seemingly growing every day. I will not recount for the Committee every question we have asked HHS, but I'd like to take a few moments to highlight just a few examples of why states like Pennsylvania have struggled to make decisions on exchange implementation.

The final rule on "exchange establishment," one of the few regulations actually released, had approximately 100 references to "future" or "forthcoming" guidance or regulation. To date, I am unaware of any of those regulations being published. States are missing details regarding fundamental aspects of exchange operation, like application requirements, citizen and income verification and appeals processes – the list goes on and on. How is a state expected to develop its own processes to interface with an exchange if the requirements for those functions have not been identified?

States are also being asked to make a "selection" of an essential health benefits benchmark plan by the end of this month, but no rule, proposed or final, has been released outlining the details of this process either. Will a state's "selection" really be the selection or can HHS modify a state's choice or, worse yet, override the

selection and replace it with another benchmark? At this point no state can answer those questions because there is no regulation. All we know is that the ACA clearly intended for the decision on essential health benefits to be made by the Secretary -- so at this point any inference that states have binding decision-making authority on the issue appears to be an illusion.

HHS has been similarly silent on how it intends to pay for a federal exchange or what costs states should expect to incur – whether entering into a partnership or merely interfacing with the federal exchange. Again, how can a state determine the scope of interaction between any one state agency and the federal exchange if we don't know how HHS intends to operate it? One thing is for sure though, interfacing with a federal exchange will require making modifications to states' IT systems – this takes time, and the shorter the time the more costly and resource intensive it will be for a state.

States are required to live within their fiscal means, which requires thoughtful budget planning – without answers to these outstanding questions it is impossible for states like Pennsylvania to adequately prepare. These questions are just a few of the many outstanding issues to which states, like Pennsylvania, need answers if we are to make informed decisions.

In the end, the unfortunate but consistent delay of information from HHS will hurt Pennsylvania individuals and businesses the most – they are the passengers in this journey that is supposed to bring them to a destination of affordable and accessible health care. A poorly implemented federal exchange, however, will put those passengers at risk. Two years after the ACA's implementation, we see health care premiums in Pennsylvania continuing to rise, with no promise of reductions in sight, and we see an increase in the bureaucracy surrounding health insurance regulation. My concern as a state insurance regulator is that we are not driving to the destination promised by the ACA, but instead heading towards a cliff. As I told Secretary Sebelius in my letter, Pennsylvania's focus remains on getting health care reform **done right, not just done quickly, and certainly done in a manner that does not put Pennsylvanians at risk**. Even though the lack of information from Washington is producing roadblocks to effective exchange implementation in many states, it will not stop Pennsylvania from continuing its own work towards achieving meaningful and sustainable health care solutions in our state.

Thank you.

###

ATTACHMENT

Commissioner Consedine's Letter to Secretary Sebelius dated August 23, 2012

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
HARRISBURG

THE COMMISSIONER

August 23, 2012

The Honorable Kathleen Sebelius
Secretary, United States Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Secretary Sebelius,

On June 28, the United States Supreme Court issued its opinion in *National Federation of Independent Business v.* Sebelius, 132 S.Ct. 2566, 2012 WL 2427810, 2012 U.S. LEXIS 4876 (*"NFIB"*). In its review the Court examined the constitutionality of two provisions of the Patient Protection and Affordable Care Act ("PPACA"): the individual mandate to purchase health insurance and the expansion of the Medicaid program. Despite the individual mandate being upheld as a tax, states are now confronted with a series of critical choices relating to the implementation of PPACA, such as whether or not to build a health insurance exchange or expand their Medicaid programs. The changes being made as a result of PPACA are fundamental and potentially disruptive to Pennsylvania's marketplace, which is why we must be mindful of the consequences, both fiscal and policy, associated with any form of implementation by Pennsylvania. In order to be able to provide the Governor with the necessary information to make a prudent and informed decision on these matters we need – in a timely manner – detailed information and substantive responses from the federal government on many outstanding issues relating to health care reform implementation.

To date, HHS has been slow to provide states with detailed and necessary information on a number of key issues affecting health insurance exchanges and other PPACA-related issues. In light of the *NFIB* opinion, an even greater number of questions remain to be answered relating to the optional Medicaid expansion and its impact on exchanges and other provisions of PPACA.

On July 10, Republican Governors sent a letter to President Obama listing some of these outstanding questions. To date, the response received from your agency lacks the clarity we need to make informed decisions on these issues. Significant concerns remain pertaining to what type of burden the operation of an exchange in Pennsylvania will place on our taxpayers and the state's budget, particularly after the first year of operation when federal grant monies are no longer available. Although the goal of the PPACA with respect to expanding coverage is laudable, we are concerned that the expanded government bureaucracy for an insurance exchange as contemplated by the law may not permit a sustainable approach to improving the affordability and accessibility of health care in Pennsylvania.

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Therefore, in order to allow Governor Corbett to carefully evaluate the decisions facing Pennsylvania, we must receive specific answers to the many important questions left unanswered. In order to assist us in providing our Governor with that information, I respectfully request that you provide detailed responses to the following questions in an expedited manner. Although this is not an exhaustive list of questions about the insurance provisions in the ACA, it captures currently recognized questions and primary concerns confronting the Commonwealth the answers to which will help us determine the correct course for Pennsylvania.

1. The preamble to the final exchange establishment rule includes approximately 100 references to "future" or "forthcoming" guidance or rulemaking. Please provide a detailed timeline of when each of these documents will be released.

2. The exchange establishment final rule had a number of key provisions that were issued as "interim final", impacting such areas as eligibility standards, transmission of information on the advance premium tax credit (APTC) and cost sharing reductions (CSR), and the role of agents and brokers. When will HHS be issuing final rules on these topics?

3. Based on informal communications from HHS, states are being encouraged to make a decision regarding Essential Health Benefits (EHB) by the end of the third quarter of this year, though HHS has not issued any rulemaking (proposed or final) addressing the issue. When will such a rulemaking be released; will states have a reasonable period of time after the final rule is issued before they will be expected to declare their intent with regard to EHB?

4. When will HHS release its rulemaking or detailed guidance on the operation of the Federally-Facilitated Exchange (FFE)? When will a rulemaking or detailed guidance be issued on the specifics of a Partnership FFE?

5. What financial costs will a state face if it elects to default to an FFE? Will a state jeopardize any of the federal funding it currently receives if it does not participate in any necessary interfaces to enable an FFE to operate?

6. If HHS operates an FFE or Partnership FFE in the state, may the state charge the exchange or the federal government for the time spent by its staff on exchange matters, and also charge for any other expenses attributable to the FFE or Partnership FFE?

7. If the state enters into a partnership with an FFE, and the state wants to end the partnership because it is determined not to be in the best interest of the state (for financial or other reasons), what are the applicable requirements on the state to continue performing partnership activities?

8. If HHS operates an FFE in the state, what will it do to assure that it is not undermining the market outside of the exchange?

9. What restrictions or limitations, if any, will the operation of an FFE in a state have on that state's insurance regulator's authority to enforce other insurance laws, including consumer protection statutes, that are currently or may be applicable to health insurance companies licensed by the state?

10. When will the rulemaking detailing the operation of the multi-state insurance plans be released?

11. If HHS operates an FFE in the state, will the multi-state insurance plans be required to adhere to all applicable Pennsylvania insurance laws? Will the multi-state insurance plans be required to meet the same standards for qualifications as a Qualified Health Plan that other insurers must meet to be sold through an FFE?

12. Assuming that the state opts to allow HHS to operate either an FFE or a Partnership FFE, and the FFE (or Partnership FFE) is not financially self-sustaining, will the federal government (HHS) commit to not assess the state, or otherwise seek financial support from the state?

13. If a state decides to pursue either a Partnership FFE or state-based exchange, would implementation of either of those options dictate that the state also must expand its Medicaid program in accordance with PPACA?

14. What will be the financial costs borne by a state that performs plan management functions in a Partnership FFE? Will the state be expected to independently finance activities performed pursuant to the partnership agreement? Will HHS provide financial support to states to cover the cost of performing plan management partnership activities?

15. How much autonomy will a state have if it elects to participate in a Partnership FFE? Will states be able to deviate from the anticipated but yet to be released Standard Operation Procedures when performing activities covered under the partnership agreement?

16. Will a state need to access the Federal Data Hub if operating in a Partnership FFE? If yes, will HHS charge a state to access the hub, and how much? If no, will HHS guarantee that a state will never face a charge to access the Federal Data Hub?

17. Will a state be charged to access the Federal Data Hub if it operates a state-based exchange, and how much? If no, will HHS guarantee that a state will never face a charge to access the Federal Data Hub?

18. Is the list of Consumer Assistance activities in a Partnership FFE, as shown in the General Guidance document (issued May 16, 2012), exhaustive? Will the state be expected to independently finance activities preformed pursuant to the partnership agreement? Will HHS provide financial support to states to cover the cost of performing consumer assistance partnership activities?

19. What are the specific expectations of HHS as they relate to the scope and level of in-person consumer assistance a state must provide in a state-operated exchange? In a Partnership FFE?

20. If the state initially defaults to an FFE (or Partnership FFE) and subsequently decides it wants to operate a state-based exchange, what are the requirements and timelines associated with transitioning from an FFE (or Partnership FFE) to a state-based exchange? Will there be federal financial support available to cover the costs associated with the transition?

21. The Insurance Department operates Pennsylvania's Children's Health Insurance Program (CHIP). The proposed methodology for modified adjusted gross income (MAGI) being advanced by HHS will result in families with high incomes being made eligible for free or subsidized CHIP (to give but one example, a family business may have significant net operating loss carryover that results in a negative reported taxable income). The same issue arises with respect to the state Medicaid program. Does HHS plan to revise its methodology to ensure that these programs (and their limited taxpayer funding) remain available for those individuals most in need, and only for those individuals?

22. Will a state be allowed to use a Premium Assistance Program/Health Insurance Premium Payment Program to pay for CHIP (or Medicaid) eligible children to be added to a parent's health insurance policy purchased through an exchange?

23. The MAGI criteria used by the IRS for its calculation of eligibility for APTC and CSR is different from CMS' MAGI criteria to be used for CHIP (and Medicaid) eligibility determinations. Will the IRS, CCIIO, and CMS be comparing the methodologies and either aligning them into a single approach or providing states with a template to be used for each specific type of MAGI determination?

24. In Administrator Tavenner's July 13, 2012 letter to the Republican Governor's Association, she indicated that states do not need to declare whether they are expanding Medicaid eligibility or operating their own exchange in order to receive enhanced funding for IT systems changes. She also indicated that a state would not have to return any funding if it later decides not to take either step. The letter indicated that further guidance would be forthcoming. When will the guidance on this issue be released?

25. Will Pennsylvania be required to convert its CHIP income-counting methodology to MAGI for purposes of determining eligibility if Pennsylvania decides not to expand Medicaid to the optional adult coverage group?

26. Will HHS require a state-based exchange to maintain, for each Qualified Health Plan, a list of participating health providers who are accepting new patients? Will this be a requirement of a state under a Partnership FFE?

We look forward to receiving responses to these inquiries so that we may complete the analysis necessary to permit an informed decision. As has been previously communicated to you by Governor Corbett, Pennsylvania is committed to implementing health reform solutions that work for Pennsylvania – not a one-size-fits-all Washington solution. Given the extent and nature of the questions that remain open, we have determined that at this time it would be imprudent for us to continue extensive planning efforts until we receive answers to these items. Therefore, Pennsylvania will not be expending any of its Level I Establishment grant funding until such a time when the information we require to make an informed decision is provided to us by your Department. Pennsylvania's focus remains on getting healthcare reform done right, not just done quickly. As we await your response, Pennsylvania will be continuing its work towards achieving meaningful and sustainable health care solutions in our state.

Sincerely,

Michael F. Consedine
Insurance Commissioner

Mr. JOHNSON. Did you get an answer from the Secretary?
Mr. CONSEDINE. We did not.
Mr. JOHNSON. Thank you.
Mr. Trautwein, you are now recognized for 5 minutes, sir.

STATEMENT OF E. NEIL TRAUTWEIN, VICE PRESIDENT, EMPLOYEE BENEFITS POLICY COUNSEL, NATIONAL RETAIL FEDERATION, WASHINGTON, D.C.

Mr. TRAUTWEIN. Thank you, Mr. Chairman, Ranking Member Stark, and Members of the Committee. I appreciate the opportunity to appear before you today.

My name is Neil Trautwein, and I am a vice president and employee benefits policy counsel with the National Retail Federation. I am pleased to appear here today on behalf of the NRF, which is the worldwide voice of retail in all channels and all forms of distribution.

Retail supports one out of every four jobs in the economy today and contributes $2.5 trillion to the gross national product. We support effective implementation of the Affordable Care Act, even though we don't support the underlying law. We are concerned, as people who have to live with the law, by the delays in issuing regulations and agency reliance on temporary guidance rather than formal regulations, but we do recognize that the agencies are balancing a lot of different concerns, and probably we wouldn't have been happy had they issued interim final regulations in the first place.

Still, we cannot afford to have the ACA stumble out of the starting gate, because it is our employees and individuals out there who will bear the brunt of the problems, particularly as regards health insurance exchanges, which is very important to employers and employees alike.

The fate of exchanges will be a significant indicator for the ultimate success or failure of the Affordable Care Act. Unanswered questions abound on exchanges despite a final exchange rule. The lack of additional guidance on questions we and others have asked has not only slowed exchange planning in many of the States, but also employer planning for benefits in years 2014 and beyond. NRF and other members of the Coalition on Choice and Competition have worked hard to encourage both the States and implementing agencies to move forward, but the clock is ticking, and fall 2013 is very short away. We particularly fear that as the regulations are released late in the ballgame, a cascade of regulations will telescope onto employers and really frustrate them as they are trying to manage new responsibilities.

To employers, genuine reform would lower the cost of coverage and make it easier to provide coverage. The ACA is nothing if not complicated, something that advocates and opponents both agree. We do credit the regulatory agencies for working hard and fairly cooperatively to implement the ACA, which has not been the easiest task in the world.

The administration has been appropriately solicitous of the retail industry, partly because of our place in the economy, also because of the difficulty of covering the retail and restaurant workforce. Much of the regulatory guidance released to date will help accommodate our workforce concerns, but we really would prefer not to have to revisit these issues on a year-by-year-by-year basis.

Much of the administration's guidance lacks the notice-and-comment finality employers must rely upon to plan for the future. The consistent attention and cooperation of the administration, though it has been both welcome and helpful, doesn't make up for that finality.

Timing is becoming critical for benefits that are to be available in January 2014. My members tell us that they commonly need 6 to 9 months to prepare for each year for coverage in an ordinary benefit year. 2014 will be anything but normal. It will be a lot of new issues and responsibilities to take on. Without final regulations in the first quarter of 2013, I fear that we will have a lot of attrition in the level of employer-sponsored plans.

Again, I appreciate the opportunity to appear before you today. Fair and final regulations will help individuals, employers, health plans, and exchanges prepare for the difficult transition ahead in January 2014. The best chance health insurance exchanges have to succeed is to launch smoothly and as glitch-free as possible. NRF stands ready to work with the administration and Congress to help make the ACA more workable so long as it remains the law of the land.

Thank you, and I look forward to your questions.

Mr. JOHNSON. Thank you, sir.

[The prepared statement of Mr. Trautwein follows:]

TESTIMONY IS EMBARGOED UNTIL 2:30 PM WEDNESDAY SEPTEMBER 12, 2012

National Retail Federation Testimony

Hearing on

"Implementation of Health Insurance Exchanges and Related Provisions"

Committee on Ways and Means

Subcommittee on Health

United States House of Representatives

September 12, 2012

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Mr. Chairman, Ranking Member Stark and honored members of the Committee, I thank you for the opportunity to appear before you today and to share our views regarding implementation of the Affordable Care Act (ACA). My name is Neil Trautwein and I am a vice president and Employee Benefits Policy Counsel with the National Retail Federation (NRF).

As the world's largest retail trade association and the voice of retail worldwide, NRF represents retailers of all types and sizes, including chain restaurants and industry partners, from the United States and more than 45 countries abroad. Retailers operate more than 3.6 million U.S. establishments that support one in four U.S. jobs – 42 million working Americans. Contributing $2.5 trillion to annual GDP, retail is a daily barometer for the nation's economy. NRF's ***Retail Means Jobs*** campaign emphasizes the economic importance of retail and encourages policymakers to support a **Jobs, Innovation and Consumer Value Agenda** aimed at boosting economic growth and job creation. www.nrf.com

NRF supports effective implementation of the Affordable Care Act, despite our continued opposition to the law itself. We are greatly concerned by delays in issuing regulations, agency reliance on temporary guidance rather than formal regulations, and the fast-approaching deadlines for key issues affecting coverage in every market. Our nation cannot afford for the ACA to stumble out of the starting gate, especially as to health insurance exchanges, a key ACA element important to both employers and individuals. We fear that as time diminishes between now and January 2014, a cascade of last minute regulations will create confusion and thus could encourage more employers to back out of coverage.

We credit the regulatory agencies[1] for working hard and fairly cooperatively to implement the ACA, a difficult task given the law's unorthodox provenance and structure. The Administration has rightly been solicitous of the greater retail industry, both because of our industry's important role in the economy as well as the nature of retail employment. Many retail and restaurant employees do not fit neatly into full and part-time categories. Much of the regulatory guidance released to date will help somewhat to accommodate our workforce concerns.

The concerns I bring to you today are prompted by the Administration's primary reliance on bulletins, guidance, and frequently-asked-question documents rather than more typical notice-and-comment regulatory procedures. Such guidance has been helpful and the opportunity to comment and suggest changes has been welcome. But, much of this process has taken place outside of the strictures of the Administrative Procedure Act[2] and lacks the notice and comment finality employers must rely upon to plan for the future. The consistent attention and cooperation of the Administration – though welcome and helpful – does not make up for the lack of good and fair regulations.

[1] Departments of Health and Human Services, Labor and Treasury.
[2] APA, the Administrative Procedure Act (5 U.S.C. Subchapter II)

Timing is becoming critical for benefits that are to be available in January 2014. Our members tell us that they commonly need six to nine months to prepare for an ordinary benefit year. The key year (2014) will be far from ordinary and will instead entail massive change for many employer-sponsored plans. Without final regulations in the first quarter of 2013, the number of employer-sponsored plans may well suffer significant attrition.

NRF, Allied Coalitions and the Affordable Care Act

NRF has actively encouraged the fair and effective implementation of the ACA, despite our continued opposition to the law itself. We see no inconsistency between the two positions; we owe it to our members to help make the law as workable as possible so long as it remains the law of this land. Commentators as diverse as former President Bill Clinton[3] have said that the ACA is unsustainable as written. We stand ready to assist any effort toward genuine reform.

We are engaged in a number of allied coalition efforts on the new health insurance exchanges and related issues. For example, NRF chairs the Essential Health Benefits Coalition[4] (EHBC) and participates in the leadership of the Coalition for Choice and Competition[5] (CCC) and Employers for Flexibility in Health Care (EFHC). Coalitions addressing aspects of ACA implementation have grown so numerous as to require a degree of coordination between them. NRF established and chairs the Employers' Health Care Clearinghouse, which meets on a monthly basis to do just that.

These coalitions are deeply substantive and deal with specific ACA implementation concerns. They also have served a useful role in developing and coordinating views and comments among allied employer interests.

NRF and ACA Implementation

NRF has been closely engaged in the regulatory process ever since the ACA was signed into law. We have submitted written comments on key concerns and have assisted in submitting joint comments for the coalitions listed above. We have not been litigants against the ACA and also did not submit amicus comments in the ACA case before the Supreme Court.

In marked contrast to past years, more and more of our time is now devoted to regulatory matters. Given the complexity of the law and the uncertain transition, we believe that is an appropriate investment on our members' behalf. We have created a number of targeted resources[6] – based on current guidance – to help our members better understand their responsibilities under the new law. Special webinar

[3] January 2012, before NRF's Annual Convention in New York.
[4] www.ehbcoalition.org
[5] www.choiceandcompetitioncoalition.org
[6] www.retailmeansjobs.com/healthcare. No password is required.

presentations compliment our monthly conference call with members of NRF's Health and Employee Benefits Committee. We are trying to help prevent what threatens to become a regulatory train wreck in early January 2014.

Health Insurance Exchanges

The fate of health insurance exchanges will be a significant indicator for the success or failure of the ACA itself. Unanswered questions and the lack of APA notice and comment procedures have slowed not only the development of exchange plans in many states but also employer planning for 2014 and beyond. NRF and other members of the Coalition on Choice and Competition[7] have worked hard to encourage both the states and the implementing agencies to move forward. I have participated in two separate CCC briefings in the Hall of States building to do just that.

Health insurance exchanges have perhaps the most bipartisan antecedents. From former Congressman Harris Fawell's[8] association health plans to Senator Dick Durbin's[9] SHOP plans, group purchasing has been a common bipartisan reform element. We firmly hope that this bipartisan support for group purchasing will translate to congressional support in its oversight capacity to encourage the Administration to move faster on health insurance exchanges according to APA procedures.

Definitive regulatory guidance is lagging on health insurance exchanges. For example, very little information has emerged on the federally facilitated exchanges that will serve as a full or partial substitute in states that cannot or will not establish their own exchange.

States also lack myriad other key details required to establish health insurance exchanges. For example, the question of whether an eligible employer purchasing coverage through a small business (SHOP) exchange will select one plan for his or her eligible employees or provide them with a defined contribution that can be used to select among plans and levels of personal responsibility is not fully defined. How information from employers and employees and federal databases will be coordinated has yet to be determined. Other integrated issues such as the composition of essential health benefits benchmarks also have yet to be determined. Yet, all of these factors will be important to determining compliance cost or penalty exposure for employers.

Confusion among applicable employers, employees and individuals will not help the launch of health insurance exchanges in 2014. Indeed, initial enrollment in health insurance exchanges is scheduled to take place in the fall of 2013, almost exactly one year from now. These deadlines could cause great confusion if regulatory guidance is released without enough time for compliance. But, with helpful oversight urging from Congress, perhaps these deadlines will serve as an impetus to help encourage the

[7] CCC, www.choiceandcompetitioncoalition.org
[8] Rep. Harris Fawell (R-IL-13), 1985-1998
[9] Sen. Richard Durbin (D-IL)

regulatory agencies to move towards more appropriate notice and comment procedures.

Essential Health Benefits

The basic level of coverage in health insurance exchanges and the surrounding small group marketplace has yet to be determined. Under ACA, the Secretary of Health and Human Services (HHS) will determine what comprises the essential health benefits (EHB) package. ACA prescribes ten required categories of coverage[10]; yet coverage is to resemble a "typical employer plan." Tension between the cost and extent of coverage is a crucial ACA issue.

In December 2011, HHS issued guidance in the form of a bulletin which instructed the states to select a benchmark EHB plan from several options.[11] States are to select their benchmark plan and submit them to the Secretary for approval next month. States that elect not to choose a benchmark will face a federal default option.[12] The Secretary may enhance the state benchmark plans to add additional ACA-required categories of coverage. The result will be published for comment and presumably finalized in early 2013.

As noted previously, employers will be hard pressed to make intelligent choices regarding their options in 2014 without key details like the EHB as early as possible in 2013. We would have much preferred to have this detail finalized in 2012.

NRF and a diverse group of allies established the Essential Health Benefits Coalition[13] in 2011. The EHBC is resolutely focused on the affordability of the EHB package. Whether or not an employer or individual will purchase coverage in the health insurance exchange or surrounding market will in large part be determined by the price of that coverage relative to employer or family budgets.

Employers, Employees and Exchanges

NRF and employer allies have also worked closely with the implementing agencies on questions of accommodating workforce realities to ACA requirements. We participate on the steering committee of the Employers for Flexibility in Health Care Coalition, a group that has been particularly active on these issues.

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[10] Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitation and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care.

[11] The largest (by enrollment) small group plan offered in the state; any of the three largest state employee health benefit plan options; any of the three largest national federal employee health benefit plan options; or, the largest insured commercial Health Maintenance Organization offered in the state.

[12] The largest (by enrollment) small group plan offered in the state.

[13] EHBC, www.ehbcoalition.org; NRF chairs.

For example, the ACA defines a full-time employee as working 30 hours per week on average and does not require coverage for part-time employees. No waiting period for coverage can exceed 90 days. Yet, hours can often vary and part-time employees can be promoted to full-time status or potentially graduate to that status over time.

The Department of Treasury and its Internal Revenue Service (IRS) have worked out a potentially reasonable accommodation trading a "look-back" means of averaging hours over time in exchange for an equal period of prospective coverage regardless of status. Still – and despite assurances in the last notice that employers could rely on this guidance through 2014 – employers want to see this principle as a rule, rather than a notice for future years.

Conclusion

Again, NRF greatly appreciates the opportunity to appear before you today. In sum, we urge this Committee and Congress to encourage the implementing agencies and the Administration to follow the normal notice and comment procedures under the APA between now and the end of the year. Fair and final regulations will help individuals, employers, health plans and exchanges prepare for the difficult transition ahead in January 2014. The best chance health insurance exchanges have to succeed is to launch smoothly and as glitch-free as possible. NRF stands ready to help the Administration and Congress make the ACA more workable, so long as it remains the law of this land.

Mr. JOHNSON. Mr. Blumstein, you are now recognized. Well, wait a minute. Durham, let me get you first.

STATEMENT OF DANIEL T. DURHAM, EXECUTIVE VICE PRESIDENT, POLICY AND REGULATORY AFFAIRS, AMERICA'S HEALTH INSURANCE PLANS, WASHINGTON, D.C.

Mr. DURHAM. Thank you, Mr. Chairman.

Good afternoon. I am Dan Durham, executive vice president for policy and regulatory affairs at America's Health Insurance Plans. I appreciate this opportunity to testify on health insurance exchanges.

AHIP members are strongly committed to competing in the new marketplace and offering high-quality, affordable coverage to consumers who shop in exchanges. Since the day the Affordable Care Act was enacted, our members have been working around the clock to implement the law, while continuing to meet the needs of their 200 million customers. Health plans are complying with the thousands of pages of regulations, data requests, and other requirements that Federal agencies have issued. In short, health plans are focused like a laser on implementation, while continuing to offer high-quality, affordable coverage within the parameters of the law.

My written testimony focuses on key implementation issues and recommends five things: minimizing disruptions as we transition to exchanges, ensuring workable exchange operations and State flexibility, minimizing coordination to prevent redundant regulations in data collection, maximizing choice and competition, and addressing specific ACA provisions to make healthcare coverage more affordable.

I will begin by emphasizing the urgent need for regulatory clarity with respect to exchanges. Health plans, States, and others need clear regulatory guidance on the following: First, the comprehensive insurance market reforms, including guaranteed issue, adjusted community rating, and geographic rating areas. Health plans need clear guidance on how these new market rules will be applied both inside and outside the exchange to appropriately develop and price their products.

Second, essential health benefits. While we appreciate the flexibility provided in the bulletin released last December, health plans need final guidance on essential health benefit requirements to develop products that qualify for individual and small-group coverage. The process for developing new products is data intensive and time consuming and typically takes between 12 and 18 months.

Third, cost-sharing reductions. While the bulletin released last February was very helpful, health plans still need clear guidance on how to develop additional products on the silver tier that will meet the cost-sharing reduction requirements.

Fourth, actuarial value. While the bulletin was released last February, and we know a great deal of work has been proceeding, we look forward to the release of the actual calculator that will provide a simplified means for health plans to compute and report actuarial value for the plans they intend to offer.

Fifth, risk-mitigation programs. While the final rule was released earlier this year, and significant work is ongoing, the specific parameters for reinsurance and the methodology for risk adjustment have yet to be released. Health plans will need to know the details.

And, sixth, the certification standards for qualified health plans, including quality reporting requirements on the activities that im-

prove health outcomes and patient safety. Health plans need to know all the requirements necessary to be certified as a qualified health plan in order to develop their products appropriately.

Clear regulatory guidance in each of these areas is needed in the very near future. Unless such guidance is forthcoming, it will be difficult for health plans to complete product development, fulfill network adequacy requirements, obtain necessary State approvals, and ensure that their operations, materials, training, and customer service teams are fully prepared for the initial enrollment period that begins on October 1, 2013.

Our testimony also outlines specific recommendations for ensuring that exchanges work efficiently and effectively by minimizing duplication of regulations, data collections, and exchange functions and adopting common standards for the flow of data between exchanges and health plans.

And, finally, while the ACA expands coverage to millions of Americans and provides subsidies, several provisions of the law will have the unintended consequence of making coverage less affordable. Our written testimony examines three such provisions: first, the health insurance premium tax; second, the minimum coverage requirements; and, third, the age-rating bands. We strongly urge Congress to revisit these issues to avoid higher costs and potential coverage disruptions for the American people.

Thank you again for this opportunity to testify. I look forward to your questions.

Mr. JOHNSON. Thank you, sir.

[The prepared statement of Mr. Durham follows:]

***TESTIMONY IS EMBARGOED UNTIL 2:30 PM
WEDNESDAY SEPTEMBER 12, 2012***

**Implementation of the Affordable Care Act's
Health Insurance Exchanges and Related Issues**

by

**Daniel T. Durham
Executive Vice President, Policy and Regulatory Affairs
America's Health Insurance Plans**

**for the
House Ways and Means Committee
Subcommittee on Health**

September 12, 2012

I. Introduction

Chairman Herger, Ranking Member Stark, and members of the committee, I am Dan Durham, Executive Vice President for Policy and Regulatory Affairs at America's Health Insurance Plans (AHIP), which is the national trade association representing health insurance plans. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality and innovation.

We appreciate this opportunity to testify on the development of health insurance exchanges and other issues surrounding the implementation of the Affordable Care Act (ACA). Our members are strongly committed to competing in the new marketplace and offering high quality, affordable coverage options to consumers who shop in the exchanges. Health plans also have been active partners in supporting states in their efforts to develop state-based exchanges, while also assisting states that will partner with or utilize the federal exchange.

Following the enactment of the ACA, health plans have been working diligently to comply with the thousands of pages of regulations, directives, information requests, guidance, and other regulatory documents that HHS and other federal agencies have issued to implement various statutory provisions, including rate review, rate disclosure, medical loss ratios (MLR), federal external review, internal claims and appeals, grandfathered health plans, lifetime and annual benefit limits, coverage of preventive services, coverage of adult children to age 26, the consumer web portal, pre-existing condition exclusions for children, and access to emergency services. Working closely with our member plans, we have submitted detailed comments and recommendations to the Department of Health and Human Services (HHS) and other agencies in response to the regulatory guidance that has been issued.

Health plans also have responded to data calls to populate the federal health insurance plan finder at healthcare.gov, provide additional information to complete the Summary of Benefits and Coverage (SBC) documents, and submit product details to identify potential essential health benefits benchmark plans, among others. These requirements only will increase as insurers comply with new bulletins, guidance and data collection reporting requirements and prepare for the transformed individual and small group insurance markets, both inside and outside the health insurance exchanges.

As our members prepare for implementation of the exchanges in January 2014 and the initial statutory open enrollment period in October of next year, there is a tremendous amount of work that needs to be done in the intervening months. As we discuss below, it is critically important for HHS to issue clear regulatory guidance on a number of key issues as soon as possible to ensure that health plans, states, and other stakeholders can meet these deadlines. The following sections highlight key implementation issues and our recommendations for accomplishing the five goals we have been discussing with the Department, the National Association of Insurance Commissioners (NAIC), and state officials:

- Minimizing disruptions for consumers, businesses, states, health plans, and other stakeholders as we transition to the new health insurance exchanges;
- Ensuring the workability of the operational architecture of exchanges and allowing state flexibility;
- Maximizing coordination to prevent redundant state and federal regulations and data collections and focusing on ways to reduce the administrative cost burdens;
- Maximizing choice and competition; and
- Addressing specific ACA provisions to make health coverage more affordable for consumers and purchasers.

II. Urgent Need for Regulatory Clarity on Key Issues

We begin by emphasizing that there is an urgent need for more regulatory clarity with respect to exchanges and insurance market reforms. Health plans, states, and other stakeholders need clear regulatory guidance on a number of key ACA provisions including:

- Comprehensive insurance market reforms (guaranteed issue, adjusted community rating, pre-existing condition exclusions, geographic rating areas) – awaiting proposed rule. Health plans must have clear guidance on how these new market rules will be applied both inside and outside the exchange to appropriately develop and price products.
- Essential health benefits (outlining the benefit package provided to consumers) – bulletin released in December 2011; FAQs and other guidance released; awaiting proposed rule. Health plans must have clear guidance on EHB requirements to develop products that qualify

for individual and small group coverage both inside and outside the exchange.

- Cost-sharing reductions (details on how cost-sharing subsidies for consumers will be implemented) – bulletin released in February 2012; awaiting proposed rule. Health plans must have clear guidance on how to develop additional products on the silver tier that will meet the CSR requirements.

- Availability of the actuarial value calculator (simplified means for health plans to compute and report actuarial value) – awaiting beta version of calculator. Health plans must have clear guidance on how to accurately calculate the actuarial value of the plans they intend to offer in the individual and small group markets both inside and outside the exchange.

- Specific parameters for the risk mitigation programs, including reinsurance, risk adjustment, and risk corridors (risk-adjustment model and methodology and annual notice of benefit and payment parameters). Health plans must know the specific risk adjustment methodology and parameters for reinsurance and risk corridors to appropriately price their products.

- Additional details on the certification standards for qualified health plans (health plan quality reporting requirements on activities that improve health outcomes and patient safety) – awaiting proposed rule. Health plans must know all the requirements necessary to be certified as a QHP to develop products appropriately.

Clear regulatory guidance in each of these areas is needed in the very near future. Unless such guidance is forthcoming, it will be difficult for health plans to complete product development, fulfill network adequacy requirements, obtain necessary state approvals and reviews, and ensure that their operations, materials, training and customer service teams are fully prepared for the initial open enrollment period that begins on October 1, 2013.

III. Development of Health Insurance Exchanges

The ACA requires the creation of health insurance exchanges that are intended to function as a new marketplace where individuals and small businesses can purchase health coverage. Because exchanges are such a critical component of the health reform law, the way they are structured and how smoothly they operate – particularly during the first year – will be a major factor in determining whether the law is effective in meeting the health care needs of individuals and small businesses. In an effort to ensure that the exchanges work efficiently and effectively, we have offered several key recommendations to HHS.

Reducing the Administrative Cost Burden of Data Collection Processes

At the same time health insurers are required to meet caps on their administrative expenses, the amount of data being collected by regulators – a process that involves significant costs and manual efforts in some cases – has dramatically increased. For example, health plans have provided information to populate the federal health insurance plan finder (at healthcare.gov) on all of their plans in the individual and small group markets. This process involves plans submitting 169 unique data points for each of their individual market plans.

Health plans also have been required to provide additional data to align with the new Summary of Benefits and Coverage (SBC) regulation, a new and costly administrative requirement on health plans. Notwithstanding all of the data already provided, health plans have been asked to submit data again as part of the effort to identify potential benchmark plans. To manage all of the separate data collections coming from HHS, each requesting that data be submitted in slightly different ways, health plans have had to create new departments and devote considerable resources to these activities. Moreover, additional administrative burdens will result from state-based exchanges developing their own unique data collection processes. This effort will further expand next year as insurers resubmit their plans that will go into effect in 2014.

Given the financial costs and personnel commitment required to meet these requests at the operational level, we have recommended that the Department review the costs of any new data requirements to minimize duplication of effort and maximize coordination with states. We know that state regulators also are concerned about administrative costs. We appreciate that they and the Department are discussing methods to better coordinate and identify ways to reduce administrative burdens on insurance companies through the System for Electronic Rate and Form Filings (SERFF), which is managed by the NAIC. Going forward, it is critical that data collected from health insurers are collected only to fulfill a statutory purpose and, in such cases, are collected once and electronically shared with other entities that also need the data.

Allowing All Health Plans That Meet QHP Certification Standards to Compete in Exchanges

To participate in an exchange, a health plan must be certified as meeting specific requirements as part of a comprehensive "qualified health plan" (QHP) application process. This process includes a comprehensive review of a health plan's ability to provide coverage to consumers in the exchanges and meet the full scope of ACA regulatory requirements. For example, as part of

the certification process, health plans must be licensed and in good standing with the state, have an adequate network of hospitals and doctors in their networks including essential community providers, retain accreditation with standards-setting organizations that measure quality, and be in compliance with the other provisions of the ACA (e.g., essential health benefits) and state law.

We support the decision by HHS to certify a health plan as a QHP that meets all certification standards within the context of the federally-facilitated exchange for 2014. We recommend that this approach be extended to future years to ensure a robust marketplace and a wide array of health plan choices for individuals, families, and small businesses. Recognizing that the ACA certification requirements provide an extensive review of health plans, we believe consumer choice and competition would be severely limited by additional criteria that limit the number and types of coverage options that are available to consumers in the exchanges.

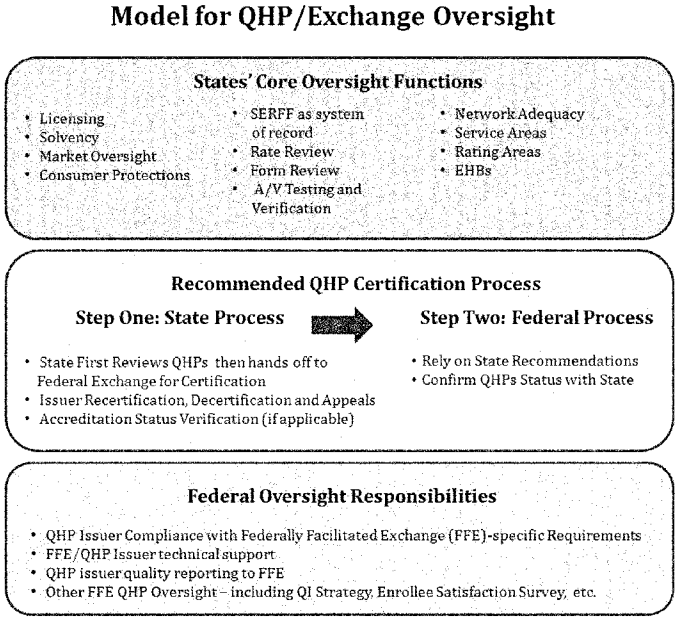
Implementing Common Data Standards to Reduce Administrative Costs and Streamline Enrollment

To ensure a streamlined open enrollment period next year, one of the most crucial partnerships between the federal government and the states involves the implementation of common information technology standards for how exchanges will communicate with the federal government and with health plans. The adoption of common standards across all exchanges will reduce administrative burdens and manual "workarounds," reduce exchange implementation costs, and ensure that the enrollment process is as consumer friendly and efficient as possible – meaning that health care coverage starts on time in January 2014 and no one falls through the cracks.

We believe these standards should be adopted across all exchanges, given that AHIP's members will be working to support multiple state exchanges. For example, it would be operationally infeasible for a state to send enrollment data to a plan one way and the federal exchange to send it another way, given that all the data has to match up for the tax filing season for individuals receiving premium assistance tax credits. Another area where standards are needed is for the application used by health plans to submit their rates and benefits to the exchange. It is inefficient for health plans to use one format to submit data to state regulators and another format to submit data to the exchange. We know that all of these issues are being considered now and have urged that uniform standards be established and be available as soon as possible, since it takes time to adequately build the systems and processes necessary to support the consumer/purchaser selection processes.

Avoiding Duplicative Regulation by Leveraging Existing State Resources

We appreciate the agency's comments that its objective is to minimize duplication of efforts in the administration of an exchange. To avoid the duplication of exchange functions and keep costs affordable, we believe there is an opportunity to take advantage of existing state resources and expertise in areas such as rate review and QHP certification. Where state systems are already in place, they should be utilized instead of creating parallel federal systems. This means that to the maximum extent possible, federally-facilitated exchanges should leverage the state's existing review process and authority by depending on state departments of insurance as illustrated below:



The success of exchanges will be highly dependent on the creation of a QHP certification process that does not create duplicative regulatory reviews, is consistent with existing state requirements, and is nimble and flexible to ensure that all QHPs receive all necessary approvals in a timely manner. AHIP has provided comments to HHS outlining recommendations for

removing uncertainty from the QHP certification process and ensuring that all necessary approvals are granted in a timely, coordinated, and streamlined fashion.

Specifically, we have recommended that exchanges adjust the QHP certification process to make state review and approval the first step in the process. Following state approval, the exchange could then conduct its review of any QHP-specific requirements. This more streamlined approach would eliminate the unnecessary duplication of review between the Department and the states.

Utilizing Health Plan Expertise in the Performance of Certain Exchange Functions

Another way to improve the efficiency of exchanges – and also avoid added costs and complexity – is to utilize the experience and expertise of health plans. Health plans have been performing many of the same functions of exchanges for many years. We recommend that existing health plan resources are leveraged to both reduce the cost of exchange implementation and increase the speed of implementation. While the specific functions that would be appropriate for plans to perform may vary from state to state, the following are examples of the types of exchange functions that could be handled very effectively by health plans.

Exchange Functions That Can Be Provided by Health Plans

OUTREACH:
- Hosting applications for insurance coverage via web and paper; and
- Responding to certain calls and inquiries.

PLAN SELECTION AND ENROLLMENT:
- Maintaining accurate enrollment status information;
- Hosting provider directories;
- Calculating cost-sharing and enrollee out-of-pocket expenses; and
- Supporting enrollment in a qualified health plan.

POST-ENROLLMENT:
- Managing disenrollments and termination of coverage;
- Managing premium payments and related issues;
- Receiving and reconciling premiums from small employer groups;
- Tracking and resolving complaints, appeals, and grievances by individuals and employers;
- Engaging in fraud detection;
- Handling additional analytical reporting, supporting risk adjustment analysis, and supporting cost analysis; and
- Handling certain website functions, correspondence and notifications, call centers, and inquiries.

Ensuring Consumers and Small Businesses Coverage Options Outside of an Exchange

Exchanges should not be built or expected to serve as the only option for obtaining coverage in the individual and small group markets, but function as another competitive channel to encourage individuals and businesses to purchase coverage in states and across the nation. Those who have coverage today, and who are satisfied with that coverage, should be able to keep that coverage. In the future, consumers seeking coverage should have options available both through the exchange and through new and existing products outside of the exchange.

By way of example, in Massachusetts most individuals and small businesses finding access to and enrolling in coverage are doing so outside of the exchange. According to the latest statistics from the Massachusetts Health Connector, 3-5 percent of the total insured population in Massachusetts is enrolled through the exchange. Out of the 4,586,765[1] individuals with health coverage in the group and non-group markets, 157,579 are enrolled through Commonwealth Care (subsidized coverage) and 43,731 individuals are enrolled through Commonwealth Choice (non-subsidized coverage).

Exchanges should be established in the market to serve as an additional opportunity for individuals and businesses to access coverage. Consumers should continue to have access to the coverage options they have today.

IV. Affordability of Coverage

In addition to focusing intensely on the mechanics of implementing the exchanges and other major health reforms in 2014, our members also believe it is critically important for policymakers and stakeholders to prioritize the issue of affordability. Health plans long have supported the goal of expanding health coverage to all Americans, but this goal can be achieved only if coverage is affordable. As implementation proceeds and health plans develop coverage options for consumers, it is essential to look at provisions that were included in the ACA that will have an unintended consequence of increasing costs. While the law expands coverage to millions of Americans and provides important subsidies, specific provisions of the law will have unintended consequences for consumers and employers. We examine three such provisions: the health insurance premium tax, the minimum coverage requirements, and the age rating bands.

[1] Commonwealth of Massachusetts. "Key Indicators: Quarterly Enrollment Update: June 2011 Edition." February 2012. http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/12/2011-june-key-indicators.pdf

Unless these issues are revisited, the cumulative effect of these and other provisions will result in higher costs and potential coverage disruptions. At the same time, to improve health outcomes and patient safety and slow the growth of health care spending, we need a system-wide commitment to build upon the innovative delivery system and payment reforms that health plans have pioneered. Government in its role as a payer implementing payment and delivery system reforms should build on successful programs in the private sector. For example, when uniform or dominant models exist in the private sector such as the patient-centered medical home, Medicare could adopt the existing model rather than pursue a different approach. The Centers for Medicare and Medicaid Services collaborated with ongoing private sector medical home efforts when they launched their Multi-Payer Advanced Primary Care Practice demonstration project. Similar collaborations are needed with other programs and initiatives between the public and private sectors. To make such public-private collaboration a reality will require additional building blocks, such as a common approach to performance measurement and administrative simplification.

Health Insurance Premium Tax

Beginning in 2014, the ACA will impose a new health insurance premium tax that will exceed $100 billion over the next ten years. The tax begins at $8 billion in 2014, rises to $14.3 billion in 2018, and increases annually based on premium growth thereafter. While the tax is assessed on health plans, experts agree that it will impact consumers and employers that purchase coverage directly from a health insurance plan in the individual and group markets as well as beneficiaries in public programs. The Congressional Budget Office (CBO) has stated that this tax will be "largely passed through to consumers in the form of higher premiums."[2]

An actuarial study[3] by the Oliver Wyman firm, commissioned by AHIP, examined the impact the premium tax will have on employers and families purchasing coverage in different segments of the commercial market. This analysis found that average premiums will increase by as much as 2.8 to 3.7 percent due to the new tax – increasing the cost of family coverage in the small group market by about $6,800 over a 10-year period. The Joint Committee on Taxation also found the

[2] CBO letter to Sen. Even Bayh. "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act." 30 November 2009.
[3] Carlson, Chris. "Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans." Oliver Wyman. 31 October 2011.

new tax to have an impact on premiums and estimated that repealing the ACA's health insurance premium tax would reduce health insurance premiums by 2.0 to 2.5 percent in 2016.[4]

The Oliver Wyman study found that the premium tax is likely to increase costs – through higher premiums or higher cost-sharing – for beneficiaries enrolled in Medicare Advantage plans and Medicare Part D prescription drug plans. Medicare Advantage plans will pay between $16-$20 per member per month in 2014 and up to $32-$42 per member per month in 2023 as a result of this tax. For Medicare Part D plans, the tax will increase premiums by an estimated $9 in 2014 and $20 in 2023 for a total increase of $161 over 10 years. In addition, the tax will put even greater pressure on state Medicaid budgets by increasing the average cost of Medicaid coverage by an estimated $1,530 per enrollee between 2014-2023.

To avoid these outcomes, we strongly support bipartisan legislation, H.R. 1370, that would repeal the ACA's health insurance premium tax. We applaud Congressman Charles Boustany for introducing this bill, and we thank the 193 House members who have cosponsored this important legislation.

Minimum Coverage Requirements

Beginning in 2014, the ACA will require health plans to provide coverage for an essential health benefits (EHB) package covering a broad range of mandated benefits, some of which are not typically included in individual and small group policies today. The ACA further requires that coverage sold through the exchanges must be at one of four actuarial value levels: 60% (bronze); 70% (silver); 80% (gold); and 90% (platinum). As a result of these provisions, millions of people may be forced to purchase health insurance that is more comprehensive – and more expensive – than they currently have.

We believe that the EHB package must be affordable for families and small businesses and that affordability should be the cornerstone of consideration in defining the EHB package. The non-partisan Institute of Medicine – in its recommendations to HHS – underscored the need to ensure affordability in defining the EHB standard and cautioned that "if cost is not taken into account, the EHB package becomes increasingly expensive and, individuals and small businesses will find it increasingly unaffordable. If this occurs, the principal reason for the ACA – enabling people to purchase health insurance, and covering more of the population, will not be met."[5]

[4] See JCT Letter to Senator Jon Kyl. 12 May 2011.
[5] IOM Report—*Essential Health Benefits: Balancing Coverage and Cost.* 7 October 2011.

The imposition of broader benefit packages than what consumers and small businesses are purchasing today will force consumers to "buy up" coverage that they may not want or need. In recent months, many state departments of insurance and state exchange boards have requested formal actuarial and economic forecasts of the impact of the new insurance reforms on their state. These independent studies have found that several provisions, including the EHB and actuarial value requirements, will result in higher premiums. The following chart indicates the estimated impact of the EHB requirements from these independent state studies.

Individual Market: Independent State Studies Show "Buy-Up" Due to Federal EHB Requirement	
State	**Increase in Non-Subsidized Premiums**
Alaska[6]	3.2%
Colorado[7]	8%
Indiana[8]	20%-30%
Ohio[9]	20%-30%
Oregon[10]	8%
Maine[11]	33%
Maryland[12]	8%-10%
Minnesota[13]	8%-11%
Nevada[14]	3%
Wisconsin[15]	6%-7%

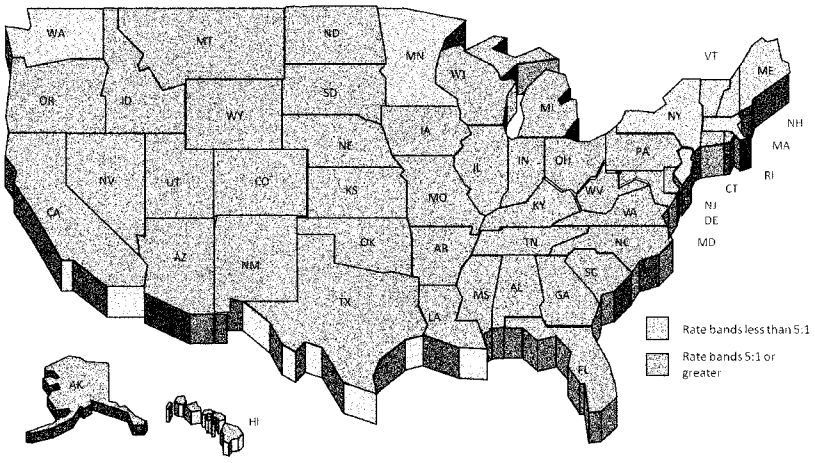
[6] Lewis & Ellis Inc. Design Options for a Health Insurance Exchange – Actuarial Analysis; June 2012. Prepared for the Alaska Department of Health and Social Services Division of Health Care Services.
[7] Jonathan Gruber. Colorado Health Benefit Exchange Background Research. January 2012. Prepared for the Colorado Health Benefit Exchange.
[8] Milliman. Individual and Small Group Premium Changes Under the ACA; May 2011. Prepared for the Indiana Health Care Exchange Policy Committee.
[9] Milliman. Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange; 31August 2011. Prepared for the Ohio Department of Insurance.
[10] Wakely Consulting Group. Actuarial Analysis: Impact of the Affordable Care Act (ACA) on Small Group and Individual Market Premiums in Oregon; 31 July 2012. Prepared for the State of Oregon.
[11] Jonathan Gruber and Gorman Actuarial. The Impact of the ACA on Maine's Health Insurance Markets; 31 May 2011. Prepared for the Maine Bureau of Insurance.
[12] Oliver Wyman. Potential Impact of the Affordable Care Act on the Current Individual and Small Group Markets; 16 June 2011. Prepared for the Maryland Health Care Commission.
[13] Jonathan Gruber and Bela Gorman. Coverage and Financial Impacts of Insurance Market Reforms in Minnesota; 17 November 2011.
[14] Gorman Actuarial. Nevada Health Insurance Market Study; March 2012. Prepared for the State of Nevada.
[15] Jonathan Gruber and Jennifer Smagula. The Impact of the ACA on Wisconsin's Health Insurance Market; 18 July 2011. Prepared for the Wisconsin Department of Health Services.

Recognizing that these ACA provisions will have a major impact on the cost of coverage, we believe that the important goals of the EHB package can be met if HHS and the states place a high priority on offering affordable coverage options to consumers. In addition, consideration should be given to lowering the minimum actuarial value for coverage sold in the exchanges to ensure the availability of affordable coverage options and to allow smoother transitions to the new benefits packages.

Age Rating Bands

Beginning in 2014, the ACA will allow heath insurance rates to vary, based on an enrollee's age by a ratio of no more than 3 to 1 (3:1). This is a dramatic change from the "age bands" of 5 to 1 (5:1) or more that are currently effective in 42 states.

Allowable Age Rating Bands by State



In these states, current state policies on age rating recognize that utilization of health care services is correlated with age and that health insurance only works if younger and healthier consumers are part of the risk pool. An age band of 5:1 strikes a careful balance between these goals by providing protection to older consumers without making it unaffordable for younger consumers to purchase insurance.

We are deeply concerned that the ACA's restrictive age band will cause premiums to increase dramatically for younger people, increasing the likelihood that younger, healthier people will wait to purchase coverage until after they get sick or injured. To protect young people from dramatic cost increases, we believe the ACA's age rating requirement should be replaced with a 5:1 age band. This change in policy will prevent rate shock for younger individuals and families, encourage enrollment by consumers aged 18-34, and maintain cost stability for people of all ages.

Greater Focus on Delivery System and Payment Reform

Health plans have a track record of partnering with hospitals and physicians to reform the payment and delivery system to advance the National Quality Strategy's three aims of achieving better care for individuals, better health for populations, and lower cost growth. Health plans also have pioneered innovative programs and services to coordinate care for patients with multiple chronic conditions, help patients manage chronic disease, and promote prevention and wellness.

These initiatives have proven to be highly successful in improving health outcomes, promoting patient safety, and lowering health care costs. In particular, health plans have prioritized reducing preventable hospital admissions, readmissions, and emergency room visits. To ensure patients are getting appropriate follow-up care, health plans offer a variety of services, such as:

- Expanding patient access to urgent care centers, after-hours care, and nurse help lines to give patients safe alternatives to emergency rooms for non-emergency care;
- Arranging for phone calls and, in some cases, in-home visits by nurses and other professionals to make sure that follow-up appointments are kept, medications are being taken safely, care plans are being followed, medical equipment is delivered, and home health care is being received;
- Offering intensive case management to help patients at high risk of hospitalization access the medical, behavioral health, and social services they need;
- Arranging for home visits by multidisciplinary teams of clinicians, who provide comprehensive care, teach patients and their caregivers how to take medications correctly, and link families with needed community resources; and

- Revamping physician payment incentives to promote care coordination and improved health outcomes.

The initial research demonstrates the success of these programs. A study[16] published in the January 2012 edition of *Health Affairs* found that beneficiaries with diabetes in a Medicare Advantage special needs plan (SNP) had "seven percent more primary care physician office visits; nine percent lower hospital admission rates; 19 percent fewer hospital days; and 28 percent fewer hospital readmissions compared to patients in FFS Medicare." These findings are reinforced by a series of studies, conducted by AHIP's Center for Policy and Research, comparing patterns of care for enrollees in the Medicare Advantage program and the Medicare FFS program. One recent study[17] found that after adjustments for readmission risk and disability entitlement status, the MA readmission rate was about 13 percent to 20 percent lower than that in Medicare's traditional FFS program. An earlier study[18] based on an analysis of hospital discharge datasets in five states estimated that risk-adjusted 30-day readmissions per patient with an admission ranged from 12-27 percent lower in MA than in Medicare FFS among patients with at least one admission.

Looking forward, both public programs and the private sector need to continue building upon this progress in order to create a health care system that is affordable for consumers and employers and sustainable in the long run. Meeting this challenge will require a system-wide commitment from all stakeholders to advancing delivery system reforms that improve patient care and payment reforms that reward physicians who deliver high quality and efficient care.

A new analysis,[19] by researchers at the University of Southern California and AHIP, outlines the optimal role of the government to help accelerate delivery system reform. The authors suggest: (1) opportunities for joint public and private sector participation in payment reforms already underway; and (2) the opportunity for government to disseminate information on which payment models work, and for whom, creating a forum for broader awareness about the effectiveness of these payment and delivery system reforms.

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[16] Cohen, Robb, Jeff Lemieux, Jeff Schoenborn, and Teresa Mulligan. "Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients." *Health Affairs.* January 2012. Vol. 31, no. 1, p. 110-119.

[17] Lemieux, Jeff, MA; Cary Sennett, MD; Ray Wang, MS; Teresa Mulligan, MHSA; and Jon Bumbaugh, MA. "Hospital Readmission Rates in Medicare Advantage Plans." *American Journal of Managed Care.* February 2012. Vol. 18, no. 2, p. 96-104.

[18] AHIP Center for Policy and Research. "Using AHRQ's 'Revisit' Data to Estimate 30-Day Readmission Rates in Medicare Advantage and the Traditional Fee-for-Service Program." October 2010.

[19] Sood, Neeraj and Aparna Higgins. "Posing A Framework To Guide Government's Role In Payment And Delivery System Reform." *Health Affairs.* September 2012. Vol. 31, no. 9.

V. Conclusion

Thank you again for considering our perspectives on these important issues. Our members remain strongly committed to working with Congress, the Administration, and other stakeholders to expand access to high quality, affordable coverage options.

Mr. JOHNSON. Professor Blumstein, now you can talk.

STATEMENT OF JAMES F. BLUMSTEIN, UNIVERSITY PROFESSOR OF CONSTITUTIONAL LAW AND HEALTH LAW AND POLICY, VANDERBILT LAW SCHOOL, NASHVILLE, TENNESSEE

Mr. BLUMSTEIN. Thank you, Mr. Chairman, Mr. Stark. My name is James Blumstein. I am a professor at Vanderbilt Law

School and Vanderbilt Medical School. I am pleased to be invited to appear before the committee. I speak as an individual, however, not as a representative of Vanderbilt or any other institution.

Briefly, I have been asked to address a very focused and very specific question: What is the scope of subsidy that is available on these new exchanges that are going to be created under the Affordable Care Act? Clearly there are subsidies available under the statute for State-run exchanges. The question I want to focus on is whether those same subsidies exist or can exist under the law for federally run exchanges.

Secondly, the IRS has issued a rule that extends coverage of the subsidy to federally run exchanges. Is this rule sustainable?

The subsidies have two roles. They support those who have incomes at 100 to 400 percent of the Federal poverty level, but they also serve to trigger an employer tax, a penalty, if an employer is obligated to provide—a large employer is obligated to provide coverage that is affordable and meets the Federal standards. And the question is whether or not the IRS, through the rule, can impose the subsidy requirement which, in turn, triggers this tax or penalty upon employers. My brief conclusion is the following: The Affordable Care Act, or the ACA, does not provide for a subsidy on the Federal exchanges, and the IRS exceeds its authority in promulgating this rule.

So let me focus first on the provisions of the Affordable Care Act. The Affordable Care Act provides two types of exchanges, a State-run exchange under Section 1311 and a federally run exchange under Section 1321. Under Federal constitutional principles, the Federal Government can induce States to establish exchanges, but they cannot force them or commandeer them to do that. So inducement is okay, but coercion is not.

The ACA provides different treatment for these two exchanges. There is a subsidy expressly provided for State-run exchanges, and to make clear there is no ambiguity, under Section 1311, that is the section that provides for State-run exchanges, there is an important canon of construction in written documents, contract statutes called, excuse my Latin here, but expressio unius est exclusio alterius, which means the expression of one thing is the exclusion of another of the same kind.

So there are two—very straightforwardly, there are two types of exchanges under the ACA, State run and federally run. The subsidy provided for in the ACA provides only a subsidy for the State-run exchange. So under the exclusio unius principle, granting subsidy on one exchange and omitting that subsidy on the Federal exchange means that there is no grant of comparable subsidy on the Federal exchange, and so if the issue were only under the statute, it would be pretty straightforward, and it would be relatively easy to interpret.

What about the IRS rule? The IRS expands the scope of coverage so that subsidies exist on both the State-run and the federally run exchange. There is no question that the IRS has rulemaking power to establish the rules of the road on how these exchanges will be implemented. The question is whether they have, narrowly speaking, power to extend the subsidy to these Federal exchanges and thereby impose a tax on large employers.

Federal agencies have gap-filling authority when an issue is either expressly delegated to it, or when, because of ambiguity, the issue is implicitly delegated that power to fill a gap. But the agency gap-filling power, because of ambiguity, must relate to the specific issue the agency addresses in its rulemaking not globally, but specifically. Here that question is the scope of the subsidy.

In determining whether ambiguity exists, the courts have said that you look at traditional tools of statutory construction, for example, the expressio unius rule, and under the expressio unius rule, there is no ambiguity on the question of the scope of subsidy. Only State-run exchanges are qualified for that subsidy. The ACA provides for subsidy on only one of the exchanges, the State-run exchanges. It makes reference to the statutory Section 1311 to make sure that there is no ambiguity, so it mentions State-run exchanges, and it mentions Section 1311. Absent ambiguity, the IRS's power to expand the subsidy vanishes, there is no gap to fill, and thus no power for the IRS to act as it did.

Thank you, Mr. Chairman.

Mr. JOHNSON. Thank you, sir.

[The prepared statement of Mr. Blumstein follows:]

House Committee on Ways and Means, Health Subcommittee

Testimony of James F. Blumstein

University Professor of Constitutional Law and Health Law & Policy

Vanderbilt Law School

Wednesday, September 12, 2012

I have been invited by the Subcommittee staff to provide testimony regarding the following question: whether income-qualified persons who purchase medical insurance on exchanges operated by the federal government under Section 1321 of the Patient Protection and Affordable Care Act (Affordable Care Act or ACA), may receive the same subsidies to which those persons would be entitled if they purchased medical insurance on an exchange operated by the state or on the state's behalf by a non-profit organization under Section 1311 of the ACA, even as the Internal Revenue Service has so provided in rules it has promulgated under the ACA.

This is an issue that I have helped flag about a year ago.[1] But while I have had a not insubstantial role in giving birth to the issue, the matter has truly been raised to analytical maturity by Jonathan Adler of Case Western law school and Michael Cannon of the Cato Institute. Their working paper, "Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits under the PPACA,"[2] reflects a thoughtful and comprehensive analysis of the issue. In my testimony, I cannot hope to cover the issues in the comprehensive and nuanced way that Adler and Cannon do, and I commend those who seek further insights on the matter to consult the Adler and Cannon working paper. My goal is more modest – to provide a thumbnail of the issue and an accessible Baedeker to the concerns that serious analysts must have about the way that the IRS, in broad rulemaking on the exchanges provided for under the ACA, has likely exceeded its authority under the ACA.

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[1] http://www.investors.com/NewsAndAnalysis/Article/584085/201109071840/ObamaCare-Subsidy-Error-Found.htm; http://www.investors.com/NewsAndAnalysis/Article/585053/201109161746/ObamaCare-Goof-On-Firm-Fines-.htm

[2] Case Research Paper Series in Legal Studies, Working Paper 2012-29 (July 2012).

I very much appreciate the invitation of the Subcommittee to appear before it and the opportunity I have been given to share some thoughts on this important matter – a critical matter as a number of states have reported that they do not plan to establish exchanges, with the result that federally-run exchanges will likely be more prevalent than once thought. In the comments I make in this testimony and in my in-person appearance before the Subcommittee, I speak as an individual, not as a representative of Vanderbilt University or any other institution.

The issue affects opportunity for subsidy by residents of states that choose not to establish an exchange under Section 1311 of the ACA, and it affects (large) employers, which face liability if even one employee receives federal subsidy for the purchase of medical insurance on an exchange. The issue also affects significant institutional interests. For example, its resolution implicates state autonomy – states' roles as gatekeepers of federal subsidies and their ability to strike the appropriate balance between (i) providing access to federal subsidies for their residents who have incomes that qualify for federal subsidies and for (ii) providing a safe harbor (and competitive advantage) for their employers who face taxes/penalties if their employees secure federal subsidies. The issue also bears, importantly, on the relationship between a federal agency (the IRS) and (i) the prerogative of Congress to provide for and define the scope of benefits for citizens and (ii) the prerogative of Congress to levy taxes/penalties and determine the scope and incidence of such levies.

Federal agencies operate on the basis of delegated authority from Congress, and within the scope of such authority their actions receive appropriate deference. But in the process of determining the scope of that authority, the statutory framework governs.

I. The Provisions of the ACA

The ACA's relevant provisions are rather straight forward on the issue. The ACA makes provision for two types of exchanges where persons may purchase medical insurance and where health insurance companies compete with each other. Section 1311 provides for states to establish such an exchange. The language seems mandatory (states "shall" establish such an exchange), but Section 1321 softens the mandatory quality of Section 1311 by providing that the federal government must ("shall") set up a federally run exchange where states do not set up such an exchange. Section 1321 undoubtedly is a recognition that the federal government cannot, under the anti-commandeering principle, compel states to establish an exchange.[3]

[3] Printz v. United States, 521 U.S. 898 (1997); New York v. United States, 505 U.S. 144 (1992). See generally, James F. Blumstein, *Enforcing Limits on the Affordable Care Act's Mandated Medicaid Expansion: The Coercion Principle and the Clear Notice Rule*, CATO SUPREME COURT REVIEW (forthcoming September 2012).

Under the ACA's terms (Section 1401), subsidies are established for persons who are enrolled in a qualified health insurance plan through an exchange that is (a) established by a state and (b) established by a state pursuant to its authority under Section 1311. Both descriptive and limiting terms [(a) and (b)] are expressly enumerated in Section 1401.

No comparable subsidy provision exists in the ACA for persons who are analogously enrolled in a qualified health insurance plan through an exchange that is (a) established by the federal government and (b) established pursuant to Section 1321. Two types of exchanges are contemplated, but, under Section 1401 of the ACA only one provides access to federal subsidies – the one established by states under Section 1311.

Under the familiar canon of statutory construction, *expressio unius est exclusio alterius*, the expression of one thing is the exclusion of another (of the same kind). That is, where a written instrument, such as a contract or a statute, by its express terms includes one or more things of a class, it simultaneously implies the exclusion of the balance of that class. Under this canon of statutory construction, the ACA's granting of subsidies for income-qualified enrollees under state exchanges established under Section 1311 is to be construed not to grant comparable subsidies for income-qualified enrollees under federal exchanges established under Section 1321.

If one examines the ACA by itself, the *expressio unius* canon of construction would very likely end the analysis, absent some very strong reason for a court to reason otherwise. As Adler and Cannon carefully and clearly establish, there are no strong reasons for a court not to accept the plain language of the ACA about the scope of federal subsidies available.

II. The IRS Rule

Despite the clear distinction between federally run exchanges under ACA Section 1321 and state run exchanges under ACA Section 1311, the IRS has issued a rule that provides for federal subsidies for income-qualified persons who are enrolled in either a state run or a federally run exchange. The question is whether the IRS rule is sustainable in light of its substantial expansion of the scope of federal subsidy described in the plain language of the text of the ACA.

The IRS' rule was promulgated in the context of rulemaking, and it is to be applauded procedurally in that regard. Rulemaking is a preferable process to informal regulatory guidances, which have been used in other contexts in the implementation of the ACA. Such informal procedures are not subject to notice and comment and are not typically reviewable as part of executive regulatory review through the Office of Information and Regulatory Affairs at the Office of Management and Budget. The problem with the IRS rule is not procedural but substantive.

Under the ACA, large employers (more than fifty employees) are required to offer their employees health insurance that is affordable and that meets federal minimum coverage/benefits

standards. If large employers do not offer qualifying health insurance coverage for their employees, they face liability in the form of a substantial per-employee tax/penalty. The tax/penalty is triggered if a single employee receives a health insurance premium credit on an exchange established by the state under Section 1311. The ACA makes no mention of triggering the employer tax/penalty if one of the employer's employees receives a health insurance tax credit on a federally run exchange under Section 1321.

By extending the health insurance premium tax credit to income-qualified persons enrolled in federally run exchanges, the IRS rule triggers liability for employers in states that have federally run exchanges and for employers who have at least one employee enrolled and receiving premium tax credits in a federally run exchange. By itself, the ACA only imposes such employer liability when a large employer does not provide qualifying health insurance and when an income-qualified employee receives a health insurance premium tax credit through a state run exchange under Section 1311.

So, the IRS rule on this issue is a double-edged sword. It expands benefits to income-qualified employees in states that choose not to set up exchanges (and therefore have federally run exchanges). At the same time, the rule triggers potentially substantial taxes/penalties to employers whose employees receive the expanded IRS-driven benefits. Can the IRS add benefits and impose costly sanctions in this way – beyond the authorization in the ACA itself?[4]

At the outset, one should recognize that specific statutory terms are often adopted by an administering agency, even if the terms appear odd. *United States v. Locke*[5] is a good example. Congress in that case specified a filing deadline of December 30, even though it was customary for a deadline to track the end of a month, and December has thirty-one days. Despite the risk of confusion, which triggered the litigation, the agency adopted the December 30 deadline, not extending it to December 31. It respected the Congressional will as reflected in the text of the statute, not taking it upon itself to undo and redo the straight forward textual command. Speaking for the Court, Justice Marshall upheld the December 30 date.

In the case of the exchange subsidy rule, the IRS is moving out on its own with little authority derived from the statute itself. Adler and Cannon present evidence that the legislative history supports a claim that the decision to vest gatekeeping power with states was purposeful – an incentive for states to establish exchanges, which the federal government desired but could

[4] It does not appear that the IRS actually claims express statutory authority for this component of its rule. It seems to assert only that the rule is consistent with the ACA, but that is only true if the IRS disrespects the *exclusio unius* canon of construction and treats the plain language as not reflecting a plausible or coherent statutory policy. The legislative text is traditionally the most reliable indicator of legislative meaning and intent. See note 12, *infra*.

[5] 471 U.S. 84 (1985)(per Justice Marshall).

not command (despite the "shall" language in Section 1311). After a phase-in period, states are responsible for paying for (and raising revenue to pay for) the operation of state-run exchanges. The cost of operating federal exchanges must be borne by the federal government.

But whether or not this distinction between exchanges was purposeful, there is surely a plausible argument that the distinction serves valid federalism and state autonomy goals. Under the statutory terms of the ACA, states choose the proper balance between access to subsidies for medical insurance for its residents, on the one hand, and competitive advantage for its businesses, on the other hand (typically an important part of attracting or retaining employers to a state and an important part of job creation in a state).

In addition, there is a concern that the IRS not be permitted to impose taxes or penalties when such sanctions have little or no basis in statutory law. At a minimum, the statute should contemplate an agency role in filling in a gap; but nothing in the ACA seems to contemplate such a role for the IRS on this specific issue. In short, given the ACA's provisions on the exchange subsidy issue, there is no evidence that Congress contemplated that there was a gap to fill here. And such a finding is a threshold requirement in order to authorize agency action like that of the IRS and, correlatively, to invoke norms of deference to agency decisionmaking.

The ACA authorizes the IRS to promulgate regulations to implement the terms of the statute. So, the authority of the IRS to engage in ACA rulemaking is not subject to question, as a general matter.

But agency authority exists only to resolve or fill gaps regarding legislative ambiguity. And then, the agency can act to clarify but only within the scope of the ambiguity.[6] Where statutory language is unambiguous, as it is here with the ACA, "Congress did *not* delegate gap-filling authority to an agency."[7] And the question of ambiguity relates not in the abstract but to a "particular issue"[8] and a particular "context."[9] Traditional tools of statutory construction are to be used in determining whether ambiguity (and thereby gap-filling authority) exists regarding "the precise question at issue."[10] So the *expressio unius* canon of statutory construction is critical here in understanding the limitations on IRS gap-filling authority.

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[6] United States v. Home Concrete & Supply, LLC, 132 S. Ct. 1839, 1848 (2012) (Scalia, J., concurring).

[7] *Id.* at 1843 (plurality opinion of Breyer, J.)(emphasis in original).

[8] *Id.*

[9] FDA v. Brown & Wiliamson Tobacco Corp., 529 U.S. 120, 132-33 (2000).

[10] Home Concrete, 132 S. Ct. at 1844. (internal cite and quote omitted).

It is one thing for the IRS to adopt a rule about the details of how the exchanges will work. That task was given to the agency. It is quite another to assume that the agency has power to define what the ACA has already unambiguously defined under the *expressio unius* doctrine – namely, which exchange(s) qualify for federal subsidies. On that question, there is no ambiguity.[11] Subsidies are provided for on one type of exchange – state run exchanges under Section 1311. Under the traditional canon of *expressio unius*, one should infer no ambiguity regarding the absence of provision for subsidy for those enrolled in federally run exchanges under Section 1321.[12] And in the absence of ambiguity, the justification for the IRS rule vanishes, since agency gap-filling authority is absent when a particular component of a "statute is unambiguous," and therefore "there is no gap for the agency to fill" and "thus 'no room for agency discretion.'"[13] Under *expressio unius* principles, Congress has not delegated to the IRS "the power to fill a gap"[14] on the question of whether a federally run exchange under Section 1321 can serve as a vehicle for a federal subsidy and thereby a tax/penalty on a large employer. For these reasons, the IRS rule in question is likely beyond the agency's delegated power under the rule in question.

An argument has been made that a reconciliation bill passed as part of the ACA enactment process authorizes the IRS' rule in question.

The reconciliation bill imposed an obligation on both federally run and state run exchanges to report information "regarding tax credits provided to individuals."[15] This set of reporting requirements, applicable to both federally run and state run exchanges, purports to show that "Congress demonstrated its understanding that federal exchanges would administer premium tax credits."[16]

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[11] Cf. Cuomo v. The Clearing House Assn., LLC, 557 U.S. 19, 525 (2009)(Federal agency "can give authoritative meaning to the statute within the bounds of that uncertainty. But the presence of some uncertainty does not expand *Chevron* deference to cover virtually any interpretation" of the statute involved).

[12] As the Supreme Court has stated, "[t]here is... no more persuasive evidence of the purpose of a statute than the words by which the legislature undertook to give expression to its wishes." Griffin v. Oceanic Contractors, 458 U.S. 564, 571 (1982).

[13] Home Concrete, 132 S. Ct. at 1843 (plurality opinion of Breyer, J.).

[14] *Id.* (internal quote and cite omitted).

[15] Timothy S. Jost, *Yes, the Federal Exchange Can Offer Premium Tax Credits*, HEALTH REFORM WATCH, Sept.11, 2011, http://www.healthreformwatch.com/2011/09/11/yes-the-federal-exchange-can-offer-premium-tax-credits/.

[16] *Id.*

This reporting requirement does not change any substantive provision of the ACA. At most it demonstrates a misunderstanding of the provisions of the ACA. It does not demonstrate any ambiguity in the text of the statute, and it does not indicate anything about a policy preference for subsidies to apply to both federally run and state run exchanges. The reporting requirement does not affirm the desirability of any change in the ACA. All it shows is that the House drafters of the reconciliation legislation, in the heat of the moment, did not understand the provisions of the Senate-drafted ACA. This type of misunderstanding does not and cannot alter the substantive terms of the underlying provisions of the ACA, nor can it serve to justify a *post hoc* expansion of administrative power to expand federal subsidies and, correlatively, impose monetary penalties or taxes on employers. Nor can it justify the loss of state autonomy in states' roles as gatekeepers of federal subsidies, a loss of state authority that should be achieved under a much clearer legislative mandate.[17] The reporting requirement of the reconciliation legislation is not a substantive provision and effects no substantive change in the ACA. It cannot and does not provide administrative authority to fill a gap that does not exist in the terms and provisions of the ACA.

III. Conclusion

The ACA contemplates two forms of health insurance exchange – one run by states under Section 1311, the other run by the federal government under Section 1321. The ACA provides for tax credits (subsidies) for income-qualified persons enrolled in plans through a state run exchange under Section 1311. The statutory provision specifically enumerates the state as administrator (itself or through a non-profit agency) and also specifically enumerates the statutory section that provides states authority to set up an exchange. There is no comparable provision for subsidy for federally run exchanges. The listing of one exchange for subsidy and the omission of the other exchange means, under the *exclusio unius* canon of statutory construction, that the statutory design excludes enrollees on federally run exchanges from receiving subsidies for the purchase of health insurance.

The addition of subsidies for those income-qualified enrollees on federally run exchanges triggers a tax/penalty for large employers that do not provide qualified health insurance to their employees. Under the ACA, the employer tax/penalty accrues when an income-qualified employee of such a large employer receives a federal subsidy on a state run exchange. The IRS rule extends this financial exposure to employers in states that do not choose to set up an exchange. This extends the power of taxation and monetary sanctions to the IRS in ways not contemplated by the terms of the ACA itself.

[17] Cf. Gregory v. Ashcroft, 501 U.S. 452 (1991).

Under the circumstances, there would seem to be no ambiguity and therefore no gap-filling power for the IRS on this specific issue. If this legislative change is to be made, then, it should be done by Congress. And the fact that there has been a significant change in the legislative balance of power in Congress is, if anything, a stronger case against the IRS rule since it reflects administrative supersession of a legislative prerogative and a dubious shift in power to the executive branch from the legislative branch.

Mr. JOHNSON. Ms. Howard, you are recognized.

STATEMENT OF HEATHER HOWARD, DIRECTOR, STATE HEALTH REFORM ASSISTANCE NETWORK, LECTURER IN PUBLIC AFFAIRS, WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS, PRINCETON UNIVERSITY, PRINCETON, NEW JERSEY

Ms. HOWARD. Thank you, Chairman Johnson, Ranking Member Stark, Members of the Committee. My name is Heather Howard, I direct the State Health Reform Assistance Network, or State Network. It is a program of the Robert Wood Johnson Foundation that is helping States implement the coverage provisions of the Affordable Care Act. The program is housed at Princeton University's Woodrow Wilson School, where I am a lecturer in public affairs teaching about health policy, and before coming to Princeton, I was New Jersey's commissioner of health and senior services.

My testimony today calls on my experience working with States on exchange implementation and my previous service as a State health official. My comments are my own and not on behalf of Princeton University or the Robert Wood Johnson Foundation.

From my experience I can tell you that while hurdles remain to be overcome, many States are actively implementing and are on schedule to stand up health insurance exchanges that will provide a competitive marketplace for individuals and small businesses to shop for affordable coverage just over a year from now.

Today I want to talk about a couple of the themes that we are seeing in State implementation of health reform. First, we are seeing that States that want to move ahead with reform are effectively implementing exchanges. Second, those States that have not yet made significant progress have a path forward through the partnership or federally facilitated exchange. Third, we are seeing that the Federal-State relationship has been marked by flexibility and collaboration. And, finally, we are seeing that States are using that flexibility to innovate and tailor their solutions to meet their State's needs.

Let me start first with what we are seeing in the States that are successfully getting ready to implement the Affordable Care Act. We know that 49 States and D.C. have received Federal planning grants, 35 States received establishment grants to facilitate additional planning and implementation, 13 States plus D.C. have already submitted letters to HHS affirming their intent to establish a State-based exchange, and 15 States already have exchange structures in place.

Now, that is 13 States and the District of Columbia that have already signaled their intent to establish a State-based exchange. We know that other States, though, are working diligently, but may need to use the partnership model to bridge the gap to when they can actually stand up a State-based exchange. This partnership model allows States to retain plan management and consumer assistance functions. Those are two areas where States have traditional expertise and regulatory authority. And we know that still other States have done little beyond basic research in preparing for an exchange, but many of them are studying the issues and preserving their options. And we know that the ACA clearly envisioned that not all States would stand up a State-based exchange,

so the federally facilitated exchange will provide consumers access to affordable health insurance products in those States.

Now, we have heard today that the reason for State inactivity is a lack of guidance from HHS, but if a lack of guidance were a real barrier to progress, one would expect that the leading States would be confronting the most barriers and complaining the most loudly about the need for additional rules and regulations. In reality, the opposite is true. Those States, those leading States, are seizing the flexibility afforded them to pursue innovative approaches, and I believe, indeed, that the primary factor contributing to this variation in State activity is the political climate in the States.

Now, we are also seeing that Federal officials are taking a flexible and collaborative approach to ACA implementation. In my experience they have provided enough guidance, responsiveness, and flexibility to enable the States to be successful. Indeed, we are seeing time and again that they have come down on the side of State flexibility, and something that as a former State official I know and appreciate. The best example of this is the guidance establishing the exchange blueprint which CCIIO has offered to the States. It is a step-by-step outline of what States will need to accomplish in order to comply with the ACA. HHS has set up a series of collaborative meetings, what they call establishment reviews, to go over State progress and address State concerns.

Another example that is in my testimony that I can refer you to of this State flexibility is the essential health benefit process, where CCIIO has indicated that States can choose their own benchmark based on plans in their own States.

Now, are more formal rules on EHB and other difficult topics still needed? Absolutely. But do implementation efforts need to come to a halt in the absence of formal rules on every open issue? State Network States and other States across the country are proving that is not the case.

Now, finally, we are seeing that States are using the ACA resources to address long-standing problems and persistent needs. While ACA implementation has presented an enormous challenge to States, we know they are dealing with, of course, budget constraints, staffing constraints, but at the same time, I have talked to many State officials who are seizing the historic opportunity to expand health insurance coverage and are tailoring their implementation efforts to meet their State's unique needs, and I offer many examples of this in my written testimony.

So in conclusion, the range of tasks that lie before States and the Federal Government are both daunting and exciting in scope. Nevertheless, States that haven't made substantial progress have a path forward under the partnership or federally facilitated exchange models, and States that want to implement reform have and will continue to make great strides in developing and implementing exchanges.

Thank you.

Mr. JOHNSON. Thank you, ma'am.

[The prepared statement of Ms. Howard follows:]

TESTIMONY IS EMBARGOED UNTIL 2:30 PM WEDNESDAY SEPTEMBER 12, 2012

House Ways and Means Subcommittee on Health
Implementation of Health Insurance Exchanges and Related Provisions
Testimony of Heather Howard
September 12, 2012

Chairman Herger, Ranking Member Stark, Members of the Subcommittee, thank you for the opportunity to address you today on the implementation of health insurance exchanges. My name is Heather Howard and I am the director of the State Health Reform Assistance Network (State Network), a program of the Robert Wood Johnson Foundation that is helping states implement the coverage expansion provisions of the Affordable Care Act (ACA). The program is housed at Princeton University's Woodrow Wilson School of Public and International Affairs, where I am also a lecturer in public affairs teaching about – among other things – health policy and ACA implementation. Before coming to Princeton I was New Jersey's Commissioner of Health and Senior Services. My testimony today calls on my experience working with states on exchange implementation and my previous service as a state health official. My comments are my own and not on behalf of Princeton University or the Robert Wood Johnson Foundation.

Over the past 18 months the State Network has been working with a diverse group of states helping them implement all aspects of ACA's coverage expansion policies, from health insurance exchanges to insurance market reforms to the Medicaid expansion. Through our technical assistance to states, we have seen them work diligently to capitalize on the opportunities created by the ACA to reform their health systems in ways that meet each state's unique needs and interests. We are working with states as they navigate the many challenges that are part and parcel of any change on this scale that relies on a strong state/federal partnership for success. Indeed, the ACA presents an important test of the critical federal-state relationship: it contains a basic framework for reform with broad national standards and significant federal resources to support implementation, but preserves state-control over the details of design and implementation. Consequently, realizing the ACA's promise of expanding access to affordable health insurance coverage will largely depend on the success of state implementation efforts.

While hurdles remain to be overcome, many states are actively working and are on schedule to stand up exchanges that will provide a competitive marketplace for individuals and small businesses to shop for affordable coverage just over a year from now.

Consistent with the goal of this hearing, my testimony today will focus on what is happening on the ground in the states and the lessons we have gleaned from working with them. I will discuss the significant variation in state progress that is the natural result of the different political, demographic, and health care landscapes across the country (e.g. disparities in uninsured rates, insurance market concentration, provider structure, etc.). I will then focus on the progress of states that are actively working toward developing state-based exchanges. These and other states are working closely with federal officials on exchange development in a collaborative way that creates multiple paths for getting to 2014, taking advantage of the substantial flexibility the ACA affords. Finally I will discuss some of the substantive issues and challenges states are facing and how – despite those challenges – states are making considerable strides implementing ACA's health insurance exchanges.

The State of the States – Understanding the Variation in Exchange Implementation

I know from personal experience that a number of states are putting the building blocks in place to have exchanges ready for 2014. Other states are working diligently but may need to rely on the federal government to assume responsibility – at least temporarily – for key exchange functions. Still others have done little beyond basic research in preparing for an exchange in 2014. The primary factor contributing to this variation is the political climate in the states. Despite this variation, there is a clear path forward for all states resulting from the flexibility offered by HHS with three different exchange models: the state-based exchange (SBE); a partnership model; and a federally-facilitated exchange (FFE).

The ACA clearly envisioned that not all states would necessarily want or be able to create a state-based exchange. The federal government is creating an FFE option that is designed to provide consumers access to affordable insurance products in those states that choose not to set up their own exchanges. Most states that are likely to choose the FFE option will do so because of political reasons and underlying concerns about the ACA and its approach. Other considerations leading to an FFE decision might include existing state staff expertise and capacity, or market factors such as the size of the uninsured population eligible for exchange coverage (especially in smaller states). Regardless, these FFE states have similar opportunities as their partnership and SBE counterparts to work with the federal government on implementation. The FFE will need to talk to existing state Medicaid eligibility and enrollment systems, and states will continue their historic role of approving insurance products available for sale in the state. HHS has also offered federal funds through establishment grants to support necessary state work with the federal government on the establishment of an FFE.

The partnership model allows states to retain plan management and consumer assistance functions, two areas where states generally have strong existing programs and capacity. In 2014 many of the partnership states will be those that have been working diligently on exchange development but encountered some obstacles that have slowed the pace of exchange authorization and infrastructure development. The partnership model is being considered by many states as a bridge to an SBE by providing flexibility and allowing states to maintain control of functions traditionally within state regulatory purview.

Some may argue that the mere existence of FFE and the partnership model is evidence that states are either not capable of building exchanges or that they have received insufficient guidance from federal officials to be able to do so. Our experience with a number of states leading the way on exchange development belies that contention. Those states that are committed to reform are making significant strides in developing exchange infrastructure and implementing insurance market reforms. While states always want more guidance, they do not want it at the expense of flexibility. States that are moving forward are working diligently, in close collaboration with federal officials, to effectively operationalize the substantial guidance that has been released to date. It is these states, their approaches, collaboration with federal officials, engagement with stakeholders, and ongoing challenges that will be the focus of the remainder of this testimony.

States are Effectively Implementing Exchanges

Beginning in 2010 nearly all states began to look at their options for developing an exchange. Taking advantage of $1million federal planning grants, 49 states and the District of Columbia commissioned

reports, held public meetings, assessed existing programs, and studied existing markets in an effort to begin to gain an understanding of the impact of an exchange in their state. A number of states did little more beyond this initial step, but 35 states went on to receive exchange establishment grants to facilitate additional planning and implementation.[1] In all, more than $16 billion in federal funding has supported state exchange implementation efforts (see Figure 1 below).[2]

States that are farthest along in implementing exchanges have taken a range of approaches and utilized varying levels of internal and external resources. These states have chosen different paths, taking advantage of the flexibility afforded them in the ACA: some have established non-profit or quasi-governmental agencies to oversee their exchanges, while others have established their exchanges within an executive agency. They have not done it alone (the next section discusses more about collaboration with federal officials), but they have dedicated themselves to building internal and external coalitions necessary to make the exchange a reality, and through legislation or executive orders have established exchange infrastructure, governance, and guiding program principles. This has allowed leading states to hire staff, make policy decisions, develop business and operational plans and processes, and contract with vendors (especially around information technology (IT) systems development), all the while continuing the stakeholder engagement that is key to making sure exchanges best meet the needs of consumers while recognizing the vital role of carriers, providers, and others in this new system of obtaining coverage.

Successful states have also relied on strong interagency implementation processes to achieve quick progress on complicated issues that impact multiple agencies[3]. Techniques for effective interagency collaboration range from regular meetings and clear delineation of roles and responsibilities to high tech document and project management software. As part of the exchange development process required by the establishment grants, states are developing formal memorandums of understanding between agencies to ensure that key exchange functions do not fall through the cracks. Appendix A at the end of this testimony provides a list of how states participating in our State Network program have attacked this issue.

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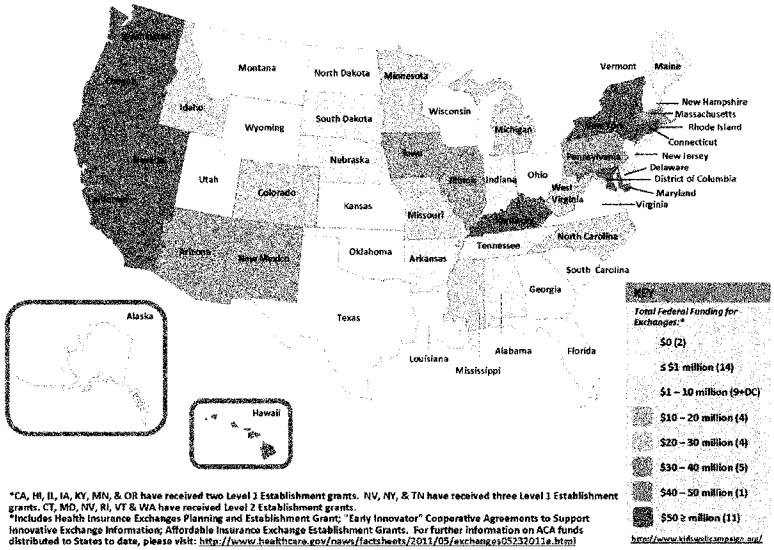
[1] ***Creating a New Competitive Marketplace: Affordable Insurance Exchanges,*** Healthare.gov – U.S. Department of Health and Human services, available at http://www.healthcare.gov/news/factsheets/2011/05/exchanges05232011a.html.

[2] ***ACA Federal Funds Tracker,*** Kaiser Family Foundation Health Reform Source, Available at http://healthreform.kff.org/federal-funds-tracker.aspx.

[3] ***Managing State-Level ACA Implementation Through Interagency Collaboration***, Shelly Ten Napel, MSW, MPP, Kyla Hoskins, MPH, Enrique MartinezVidal, M.P.A. and Heather Howard, J.D., July 2012, available at http://www.statenetwork.org/resource/managing-state-level-aca-implementation-through-interagency-collaboration/

Figure 1



Source: Kidswellcampaign.org

Examples of how states are making progress on different aspects of exchange implementation are too numerous to list here. There are, however, some obvious and some less well known state activities that are illustrative of the type and scope of projects states are undertaking that are critical in setting up their exchanges. In each example, states are working to take advantage of opportunities in the ACA to customize implementation to meet their state's needs.

- **IT Systems:** Much of the funding from establishment grants is being used by states to support the development of exchange IT systems designed to create a Travelocity-like web enrollment experience for consumers. States are hiring software vendors and systems integrators to connect existing state systems and new exchange systems. HHS is actively working with a group of states that received early innovator grants to share IT lessons and system elements, and that sharing has carried over into peer-to-peer collaboration as well. For example, Minnesota and Maryland have been coordinating to leverage the work being done for each state by their IT vendor. If one state is prepared to move forward on developing an element of exchange infrastructure, the other can take advantage of the IT solutions that were developed, enabling them to learn from one another and prevent duplication of resources.

- **Stakeholder Engagement:** States are engaging their citizens, small businesses, insurance carriers, brokers and agents, and consumer groups throughout the exchange implementation process by conducting substantial stakeholder meetings and outreach campaigns. Indeed, stakeholder support is critical for successful implementation, and academics have argued that this support remains strong across the country[4]. In order to promote an open process and foster public engagement (and consistent with establishment grant requirements), all advisory group meetings, committee and sub-committee meetings, and meeting materials can be easily found on each state's health reform website. In many cases these efforts are breaking down long standing barriers between state agencies and stakeholder groups. Examples of state advisory committees and related stakeholder engagement efforts include:
    - Colorado convenes multiple public meetings each week between its advisory groups, exchange board and sub-committees of the exchange board. The meetings regularly attract 20-70 members of the general public.[5]
    - Maryland has five exchange advisory committees covering general exchange implementation, continuity of care, financing, navigators, and plan management. Each committee reviews specific policy issues gathering stakeholder insights to help the exchange board and staff make final implementation decisions.[6]
    - The executive order creating the New York Exchange created regional advisory committees, each with a broad array of stakeholders charged with advising and making recommendations on the establishment and operation of the exchange, with a special focus on recommendations regarding relevant regional factors.[7]
    - Oregon's Exchange enabling legislation directed the exchange's governing body to recruit a diverse, 21-member, Individual and Employer Consumer Advisory Committee to provide feedback to staff and the board on various issues. This Committee represents the state's geographic, cultural, individual, consumer advocate, and business interests. Regular meetings have also been established with consumer groups representing both mainstream advocacy groups and community organizations representing communities of color and immigrant populations.[8]

- **Quality Improvement and Cost Control Systems:** Rhode Island is one of several states that have used ACA to improve their health data infrastructure – which will be critical for helping them understand and manage health care cost and quality across their entire public and private health system. Specifically, Rhode Island is developing an All-Payer Claims Database (APCD) which will be used by state officials, researchers, plans, providers and others to monitor the performance of Rhode Island's health care delivery system, map the causes of health care cost

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[4] Joel Ario and Lawrence R. Jacobs, "In The Wake Of The Supreme Court Decision, Many Stakeholders Still Support The Affordable Care Act," *Health Affairs*, 31, no.8 (2012):1855-1865.
[5] ***Events Archive***, Colorado Health Benefit Exchange, available at http://www.getcoveredco.org/News-Events/Events-Archive.
[6] ***Maryland Health Benefit Exchange Committees***, Maryland Department of Health and Mental Hygiene, available at http://dhmh.maryland.gov/exchange/SitePages/Committees.aspx.
[7] ***Governor Cuomo Issues Executive Order Establishing Statewide Health Exchange***, Office of New York Governor Andrew M. Cuomo, April 12, 2012, available at http://www.governor.ny.gov/press/04122012-EO-42.
[8] ***Consumer Advisory Committee***, Oregon Health Insurance Exchange, available at https://orhix.org/cac.html.

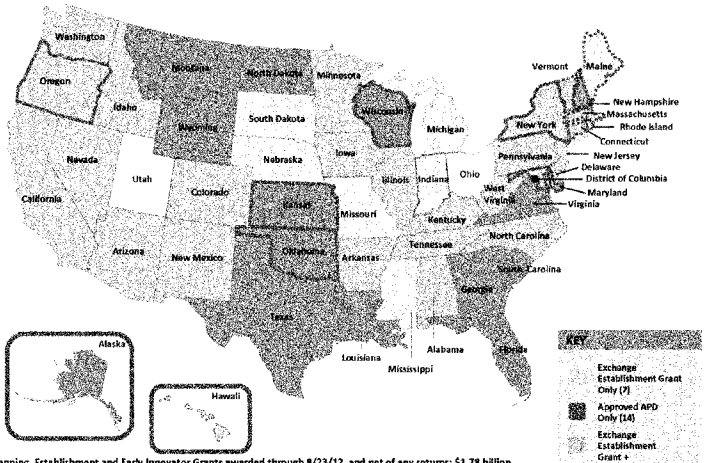
trends, and to assess the impact of delivery system reforms, such as Patient-Centered Medical Home and the Beacon Community Program.

- **Improving Existing Eligibility Systems:** Exchange implementation has opened new doors for states to improve existing systems as well. More than 40 states have received HHS approval of advanced planning documents (APDs), which allow states to upgrade their Medicaid eligibility systems with the help of 90/10 federal match (see Figure 2 below).[9] In addition to providing the impetus to upgrade decades old legacy Medicaid systems for the 21st century, the funding also requires building capacity for interoperability with exchanges to ensure seamless, streamlined, single point of entry eligibility for all who access the exchange, regardless of the program for which they are eventually determined eligible.

- **Thinking beyond Coverage to Health System Transformation:** There are many other aspects of the ACA that states are excited about pursuing, not the least of which are designed to test delivery system reforms that can reduce costs while increasing quality. Accountable Care Organizations, new health insurance co-ops that will be available on the exchanges, and the State Innovation Model multi-payer reform planning and testing grants are just a few of the delivery system improvements that states are excited about and actively pursuing. Oregon recently reformed its Medicaid delivery system through the creation of Coordinated Care Organizations, which may eventually pave the way for a whole new way of delivering care in the state across payers. The availability of State Innovation Waivers (ACA Section 1332) beginning in 2017 also provide a vehicle for states to build on these delivery system reforms and apply identified high quality and low cost solutions to ACA coverage expansion populations more broadly.

[9] ***Exchanges and Upgrading Medicaid Eligibility Systems***, Kidswell, National Snapshots, available at http://www.kidswellcampaign.org/National-Snapshots.

Figure 2



Source: Kidswellcampaign.org

This progress in implementing exchanges has all happened at a time when states are facing substantial fiscal challenges. Only now in fiscal year 2013 are total state revenues reaching pre-recession 2008 levels, and in 23 states revenues still have not returned to those levels.[10] States face hiring freezes, early retirements and furloughs, and program budgets have decreased substantially, all during a time when demand for state-funded services is at an all-time high. The fact that states have been able to weather the fiscal storm, do more with less in managing existing programs, and take on new duties in setting up exchanges is a remarkable feat. As previously mentioned, they have not done it alone. Constant collaboration with in-state stakeholders and with federal officials has been a key to state success in tight budgetary times.

Flexibility and Collaboration between Federal and State Officials

In my experience, the relationship between federal officials and the states has been characterized by flexibility, responsiveness, and collaboration. That, of course, was the vision conceived in the ACA, and it is proving to work that way. This is appropriate given that the task of ACA implementation requires complex and innovative thinking. I have watched federal officials seek out conversations with states in which they are truly interested in the ideas coming from the state level. Rather than setting an exacting set

[10] ***Fiscal Survey of the States Spring 2012***, National Association of State Budget Officers, available at http://www.nasbo.org/publications-data/fiscal-survey-states/fiscal-survey-states-spring-2012.

of standards with which states must comply, federal officials are asking states for their best ideas and working with states to help them achieve their goals within the context of the law.

The options for the federal government's role could be seen along a continuum. On one end, federal officials could provide meticulous, exacting standards, providing states very clear direction. At the other end of the continuum, states could be invited into a collaborative process that encourages them to innovate. Certainly, this is a balancing act. Some standards and guidance must be provided, though my observation is that federal officials (inclusive of HHS, Labor, and Treasury) have come down on the side of flexibility and innovation. I think this is appropriate given the enormity of the task at hand, as well as the variations across the states.

Federal officials have used various tools and techniques to work with states, share information, and educate states about various policy options and flexibilities. For example, I have had the fortune to attend a number of meetings CCIIO has held for the states. The states we work with have found these meetings to be extremely valuable. At the most recent national meeting last May, I participated in a panel with two of our states, facilitating a conversation amongst a number of states about their unique successes and challenges. I have found that this type of in-person, peer-to-peer interaction is one of the most efficient ways for states to learn from each other, discuss best practices, and share functional elements that improve exchange development across states. It is also an opportunity to discuss obstacles and forecast problems early in the process. In addition to the large national meetings, CCIIO has hosted regional convenings and nearly weekly conference calls with states, which provide additional opportunities for collaboration between federal officials and states on exchange implementation.

Group-based assistance is extremely important for explaining guidance and level-setting around establishment grant and general exchange requirements, but the complexity of implementation also requires one-on-one support. We have found in our program that the rubber meets the road in moving from a high-level understanding of what an exchange must do to the more granular tasks, such as operationalizing the business rules and IT systems requirements that will actually make an exchange work. States receive assistance from vendors, consultants, and programs like ours, but each state also has a designated state officer at CCIIO who works with them to provide technical guidance on federal requirements and to help provide them with maximum flexibility to implement. In addition, the federal government has set up a collaborative process of "establishment reviews." Rather than the usual approach of rigid rules and a highly formalized process of application and approval, establishment reviews are more like an ongoing conversation in which states can demonstrate their early accomplishments and receive feedback on implementation models and ideas. This approach of individualized attention takes substantial time and effort on the part of both state and federal officials, but it ensures exchange implementation can happen in a way that remains state-specific while conforming with federal guidance and the statute.

Much of the collaboration between state and federal officials has been around the substantial amount of guidance that has been released to date. A mix of final rules, proposed rules, bulletins, and other guidance has given states and stakeholders the tools they need to continue making progress in establishing exchanges.[11] The mere fact that more than a dozen states are well down the path of setting up their

[11] ***Regulations and Guidance***, Center for Consumer Information & Insurance Oversight, available at http://cciio.cms.gov/resources/regulations/index.html.

exchanges suggests there is sufficient guidance for states to meet the 2014 effective date. Final rules on exchange establishment and qualified health plans (QHPs), in conjunction with the exchange blueprint, have given states a clear path forward for building their exchanges and getting them approved by HHS. Even where final rules have not been promulgated, federal officials have provided substantial guidance that has allowed states to move forward.

Let me provide a concrete example. One of the most difficult and contentious issues in health reform implementation has been the selection of an essential health benefit (EHB) benchmark, the package of benefits that each exchange plan must officer. Federal officials sought input from the states and stakeholders and took advantage of the advice of an expert panel convened by the Institute of Medicine. On December 16, 2011, HHS issued a bulletin indicating their proposed approach, which allowed states significant flexibility to choose an EHB based on health plans that already were popular in each state's market. In January 2012, HHS issued additional information on the three largest small group health plans in each state. That was followed by a set of Frequently Asked Questions that specifically addressed many of the questions states and stakeholders had posed in the interim.

Leading states took that guidance and developed a plan for selecting an EHB. They collected information about the benefit packages and coverage rules of the leading plans in their market. They compared those benefit sets with the ten required benefit categories outlined in the ACA. They assessed the potential impact of each benefit set on premium cost. Leading states took that information to their stakeholders and asked them to help decide how their state should balance the desire for a comprehensive benefit set with the desire to keep premiums low. In addition, states weighed other values like limiting disruption to the existing markets or promoting a high level of carrier participation in the exchange. For states that are unable to make a proactive choice due to political challenges or other concerns, a reasonable fallback (the largest plan in the small group market) has been identified.

In the absence of more formal rules, states are beginning to select their EHB plans. For example, the Oregon Exchange Board issued a preliminary recommendation to select the third largest small group plan as its EHB benchmark.[12] In Colorado, the governor's office – in collaboration with the Health Benefit Exchange and the Division of Insurance at the Department of Regulatory Affairs – released a draft EHB benchmark plan recommendation for public comment following substantial analysis and a stakeholder input process.[13] This final round of public comments will inform the state's final decision to be made by the end of the month. While highly specific guidance could have made the choice easy for states, the deliberate and open process of selecting an EHB in several leading states has helped to ensure broad acceptance from the stakeholder community and a clear understanding of why and how the EHB was chosen.

Are more formal rules on EHB and other difficult topics still needed? Absolutely. Do implementation efforts need to come to a halt in the absence of formal rules on every open issue? State Network states and

[12] ***Board Packet***, Oregon Health Insurance Exchange Corporation Board of Directors, joint meeting with Oregon Health Policy Board, August 14, 2012, available at https://orbix.org/meetings.html.
[13] ***Draft Recommendation for Stakeholder Input***, Office of the Governor, Colorado Health Benefit Exchange and Department of Regulatory Affairs – Division of Insurance, August 31, 2012, available at http://www.getcoveredco.org/COHBE/media/COHBE/public%20meetings/EHB-selection-8-31-12-recommendation.pdf.

other states across the country that want to implement reform are proving that is not the case. We know that states and those helping states will continue to work with federal officials to ensure forthcoming guidance and rules support and reflect the emerging reality in innovative and leading states.

Conclusion

There have been and will continue to be many challenges for state and federal officials working diligently to launch exchanges by this time next year. Politics will continue to be a factor even after the election, as many states still need authority from the Governor or legislature to move forward with exchanges. State budget and staffing pressures will continue to be a pressure point, even with the availability of substantial federal funds for exchange development. Likewise, as states assess the long-term fiscal impacts of the Medicaid expansion and financial sustainability models for ongoing operations of the exchanges, the budgetary implications will drive many decisions. However, despite these challenges, we believe states that want to implement reform have and will continue to make great strides in developing and implementing exchanges. States will continue to learn from each other and draw on the expertise and support of federal officials to move quickly once political barriers are ameliorated. Moving forward, states will continue to take innovative yet pragmatic approaches that take advantage of flexibility in the ACA and give them the best opportunity to develop exchange solutions that meet their unique needs.

Appendix A
Coordinating and Governing Structures in State Network States Following the Passage of the ACA

State Network State	Executive Order	Description
Alabama	Yes	Governor Robert Bentley created the Health Insurance Exchange Study Commission by Executive Order on June 2, 2011 which included the Commissioners of Medicaid and Insurance and the Director of Finance. The Study Commission is an advisory group to the Governor that made recommendations to the governor and legislature in late 2011. Governor Bentley also appointed an Executive Director in June 2011 to coordinate Alabama's efforts to establish and implement a state-based exchange in accordance with the provisions of the ACA.
Colorado	Yes	Former Governor Bill Ritter issued an Executive Order to designate a Director of Health Reform Implementation and an Interagency Health Reform Implementing Board to develop a strategic plan for implementation of the ACA. When Governor John Hickenlooper was elected in 2011, he established an internal health care team and worked with the legislature to establish a non-profit Health Benefits Exchange with its own governing board. A legislative oversight committee was also established to oversee Executive Director selection, certain financial decisions, and the initial work plan of the board.
Maryland	Yes	Governor Martin O'Malley signed an Executive Order on March 24, 2010 creating the MD Health Care Reform Coordinating Council, consisting of the Executive Director of the Office of Health Care Reform; and the Secretaries of Health and Mental Hygiene; Budget and Management; Human Resources; and Labor, Licensing and Regulation. The legislature then established a quasi-governmental Health Benefits Exchange with its own governing board.
Michigan	No	Michigan has established a Health Reform Steering Committee that includes the Department of Community Health, the Department of Technology, Management and Budget, the Department of Licensing and Regulatory Affairs, the Office of Financial and Insurance Regulation, the Department of Human Services and others that meet regularly to discuss and coordinate on health care related issues, including health reform. This mechanism helps keep agencies informed and involved in multiple aspects of the reforms taking place in Michigan.
Minnesota	Yes	Governor Mark Dayton signed an Executive Order on October 31, 2011 creating the Minnesota Health Care Reform Task Force (charged with broadly studying health reform) and directing the Minnesota Department of Commerce to design and develop a Minnesota Health Insurance Exchange.
New Mexico	No	Governor Susana Martinez established an Office of Health Reform that is located in the Human Services Department and is charged with coordinating health reform efforts across agencies.
New York	Yes	New York's reform efforts are coordinated by an inter-agency team directed by the Governor's office, including staff from the Department of Health, the Department of Financial Services (Insurance Division), and staff charged with initial planning for the exchange. Governor Andrew Cuomo also established an exchange for New York within the state's health department through Executive Order.

Oregon	No	Prior to passage of the ACA and as a part of the state's own health reform efforts, Oregon integrated several health-related agencies and functions into one agency: the Oregon Health Authority. The legislature then established a quasi-governmental Health Benefits Exchange with its own governing board.
Rhode Island	Yes	Governor Lincoln Chafee signed an Executive Order creating the Rhode Island Healthcare Reform Commission on January 11, 2011. The Executive Committee of the Commission includes the Lt. Governor, Secretary of the Executive Office of Health and Human Services, Health Insurance Commissioner, Director of Administration, and the Governor's Policy Director. The full commission, comprised of over 200 stakeholders, is charged with the coordination and management of all healthcare reform efforts, and maximizing stakeholder engagement. Governor Chafee also established the Rhode Island Health Benefits Exchange through Executive Order.
Virginia	No	Virginia utilizes the Virginia Health Reform Initiative (VHRI), which was established by Governor McDonnell. VHRI has an Advisory Council of 24 members and is chaired by the Secretary of Health and Human Resources. The group met from August 2010 to September, 2011 and generated recommendations related to exchange development, Medicaid reform, insurance reform, purchasing, technology, capacity and delivery/payment reform. The group remains active.

Source: Managing State-Level ACA Implementation Through Interagency Collaboration, State Health Reform Assistance Network, July 2012. Available at: http://www.statenetwork.org/resource/managing-state-level-aca-implementation-through-interagency-collaboration/

Mr. JOHNSON. Commissioner Consedine, you know, you said you had never gotten a response out of the Secretary.

Mr. CONSEDINE. That is correct, Mr. Chairman.

Mr. JOHNSON. And our concern is that HHS has been slow to provide States with the necessary information on a number of key issues. In reviewing your letter, your requests seem very reasonable, like asking for a detailed timeline on when the hundred fu-

ture or forthcoming exchange-related regulations cited by HHS will be released, and if HHS will be issuing final regulations to their numerous interim final rules, when HHS will release its rule governing federally facilitated exchanges, and when will they release a mandated benefit package rule, and you have never received an answer; is that true?

Mr. CONSEDINE. Not today, Mr. Chairman, no.

Mr. JOHNSON. And you asked all those questions?

Mr. CONSEDINE. We did, indeed.

Mr. JOHNSON. Well, let me get this straight. States are supposed to make decisions on benefit packages in the exchange by the end of the month; is that true?

Mr. CONSEDINE. That is generally true at this point.

Mr. JOHNSON. Yet HHS hasn't released so much as a proposed regulation outlining the details of this process.

Mr. CONSEDINE. We have guidance at this point.

Mr. JOHNSON. What kind of guidance? Detailed?

Mr. CONSEDINE. It is detailed in some ways, lacking in others.

Mr. JOHNSON. And States are supposed to let HHS know by November 16th—that is not that far off—whether or not they intend to create their own exchange despite the fact that there are nearly 100 forthcoming exchange-related regulations, and HHS has yet to propose regulations on what a federally facilitated exchange might look like; is that correct?

Mr. CONSEDINE. That is correct.

Mr. JOHNSON. It is baffling that the Obama administration can expect State governments to make informed decisions, ones that could require tens of millions of dollars in additional cost in the face of such regulatory uncertainty. Perhaps I shouldn't be surprised, however. By withholding information critical from stakeholders, stakeholders are paralyzed, and the Obama administration holds all the power. By keeping information from States, employers and health plans, the Federal Government's takeover of our health care system will be complete. As a defender of states' rights, that frightens me.

I thank you for your testimony, all of you, and, Mr. Stark, I recognize you for 5 minutes.

Mr. STARK. Thank you, Mr. Chairman.

Thank the witnesses for enlightening us today.

I am concerned, Mr. Consedine, that you are having trouble getting in touch. You wrote to Secretary Sebelius in August, the end of August, with a bunch of questions regarding exchanges, and have you had any meetings with them?

Mr. CONSEDINE. Not since we sent the letter, Representative.

Mr. STARK. Have you asked for any meetings?

Mr. CONSEDINE. We have fairly regular discussions with the—with HHS, but not in response to our questions, no. We have not asked for a meeting at this point.

Mr. STARK. I see. Well, if you contact Mr. Dioguardi, the Health and Human Services External Affairs, he will set up a meeting. If you didn't have to catch a 4 o'clock train, I would set up the meeting for you this afternoon, and I am sure that they could help you far better than any of us could, and, you know, they would welcome the chance. So I hope that you will take advantage of that and

sometimes not wait for a letter. I mean, wait for a call back we learn in this business is to wait a long time. Make the second call, will you, and see if they can't help you. I think they would cooperate with you and get you all the information you need. It may not make it any easier, don't misunderstand me, but I think that they could probably answer a lot of questions for you.

I am concerned. All of you, I can recall some time ago, had to implement supplemental insurance rules, right? Your State has? Mr. Trautwein? Mr. Durham? Ms. Howard? I mean, and there was some grumping and complaining by the insurance companies and others, but now it seems to work pretty well. Seniors like it. They can all look at the same policies, different in each State, but they get a selection of, what, 10 or 11 policies varying from very limited benefits to generous benefits, and the prices are all there, and it is wonderful for the consumers. And I shouldn't think that the insurance companies, then, it would seem to me, and their brokers or salespeople are selling the same benefits at different prices, and they have to pitch the fact that they can provide good service. And that is—you know, it is hard to spell out what is good service, but people can check with references, or if it is a company, people dealing with group policies can find out from their other companies how well Aetna does against Blue Cross.

And I think that it serves us so well and serves your constituents or States so well to have some kind of a determined outline so that people—so that we make it easier—not easy, but easier—to compare. Most of us are not experts in insurance, as you all are, and you are dealing with people who get the broad idea, but if they can see a list, and that is really what I think we are talking about, I think you do a real service to your constituents.

I would say that it is too bad we don't have anybody from California. But we are going to be ready on time, the Governor, our great Republican Governor, is ready to roll up his sleeves. He signed the implementing legislation in September, and I would hope that other States' Governors would move ahead.

Sometimes we just have to dig in and say, this is a pain in the butt, like a new tax regulation or a new whatever. You have got to go ahead and do it, and I don't mean to say that we just put those things in law to make trouble for you, but we try and put them in law, so that we have to write laws here for every State in the Union. We can't write one law for California and one—and so thank you for putting up with us, and please call on our staff. I know the Republican staff is willing to help and see if we can't cooperate and get this done for all of our constituents, because in the end to bring in millions of additional people is going to save us all money. It is going to save the taxpayers money. It is going to lower in time the cost of medical care.

The worst thing we could have is somebody without medical insurance or a way to pay for medical care ending up in the emergency room. That costs all of us; you, it raises our insurance premiums, it raises our taxes. And that is one thing I think we can all agree, we have to see that everybody gets covered one way or another. You may not like my universal health care plan, but let us work toward it.

Thank you very much, Mr. Chairman. Thank the witnesses again.

Mr. JOHNSON. Did the Governor of California change parties?

Mr. STARK. No, he hasn't. Now, we have talked to him about that.

Mr. JOHNSON. Well, you called him a Republican Governor.

Mr. STARK. But then his wife would become a Republican, and then we would have real trouble.

Mr. JOHNSON. Well, you called him a Republican.

Mr. STARK. Well, he is.

Mr. JOHNSON. Really?

Mr. STARK. Arnold?

Mr. JOHNSON. Arnold? Arnold's not Governor anymore, I don't think.

Mr. STARK. Well, no, but he signed it. It was Governor Schwarzenegger, I am sorry, not Governor Brown.

Mr. JOHNSON. Okay. Mr. Nunes, you are recognized.

Mr. NUNES. Thank you, Mr. Chairman.

I just want to state for the record that in my district from California, with Medicaid and Medicare going broke and the State of California in dire need of financial and budget reform, they actually can't even pay the bills now. Governor Brown, who is a Democrat, is going to the people to raise taxes, and they are not even sure if those taxes will pay for the current requirements under Medicaid, what is known as MediCal in California.

Ms. Howard, in your testimony that Federal officials have been responsive, I think you used the words "flexible" and "collaborative," I am troubled to understand how it is collaborative or responsive when bulletins and guidelines are being substituted for the normal procedures which involve drafting clear rules allowing for public comment and then setting formal policy.

Ms. HOWARD. Well, actually it is more collaborative the way they have been doing it because it allows them to meet with stakeholders. And I think we heard from some of the stakeholders here that they had been involved in that process, and that they are able to inform the formal policymaking role; that in the first year of ACA implementation, they issued a number of interim final rules, and there was an outcry from the regulated community that, you know, we want to be more collaborative.

And so now they have taken the less formal approach, and they have been meeting with stakeholders, and I have certainly seen that. I saw the commissioner at the National Association of Insurance Commissioners meeting in August, and there were a number of Federal officials there holding office hours, meeting with State officials.

So I think this process and EHB, the central health benefits, is another example of where the Federal Government has been flexible. They received input from an expert panel at IOM, they met with stakeholders, they developed initial guidance. Then they met with stakeholders again, they issued frequently asked questions, and in the end they came down on giving States flexibility and said to States, you can choose a plan that operates in your State; we are not going to come up with a one-size-fits-all Federal approach.

So I think we really are seeing the Federal Government be as flexible as they can. And as a former State official, I know you want clarity from the Federal Government, but that is not always the best thing, because what we are seeing is States are seizing that flexibility to come up with solutions that work for themselves.

Mr. NUNES. Well, that sounds nice, but in reality here we passed legislation. I didn't vote for it; many of us up here didn't vote for it. But at the end of the day, there has to be clarity for folks like the insurance commissioner to implement law in his or her own State.

So, Commissioner, how are you finding the flexibility?

Mr. CONSEDINE. Representative, we hear the words "flexibility," "collaboration" a lot. You know, what we often get, however, is we will be collaborative and flexible within a fixed sort of parameter of a mindset within HHS, but outside of that you quickly run into resistance.

You know, we have a very good working relationship with HHS, a number of those folks are former insurance regulators, and I have nothing but admiration for the job they are trying to do, but what we often get—well, you know, what we are really after at this point is the guidance and the clarity that you talk about. And they are not, you know, in-the-weeds questions at this point. We are asking very general, broad questions like how much is this going to cost us? What level of autonomy are we really going to have? How is this going to work? And it is, we will get back to you soon.

Mr. NUNES. Well, it sounds like the flexibility you are going to need is you are going to have to have friends on the Ways and Means Committee to get you appointments with the folks over at HHS who you can't get a response from.

I just want to be kind of general here just to get a general flavor for all of you on the panel, just on a scale of 1 to 10, just to kind of give the general public your view of whether or not how successful this is going to be by 2014 in terms of its implementation. So 1 being it is going to be great, not going to be any problems, to 10 being it is going to be a complete train wreck, and we have got a lot of problems before 2014. Why don't we start with you, Mr. Commissioner.

Mr. CONSEDINE. Thank you for putting me on the spot.

Mr. NUNES. We can start on the other end if you like.

Mr. CONSEDINE. I would give it an 8. I mean, we have very grave concerns at this point that people, if they don't have good information, they are going to make bad choices, and when you are making bad choices when it comes to health insurance, that has very significant repercussions.

Mr. NUNES. Mr. Trautwein?

Mr. TRAUTWEIN. I worry that we are in that 7 to 8 range myself. I represent employers who are going to have to deal with the compliance issues and understand how to navigate through their responsibilities. I spent a lot of time trying to educate my members about how the law will come into effect and what their responsibilities will be. There is a lot of confusion out there.

Mr. NUNES. Thank you.

Mr. Durham. I am out of time here. The chairman's being very gracious.

Mr. DURHAM. It depends. The sooner we get clear regulatory guidance, the closer we can get to 10 on the scale.

Mr. NUNES. You mean to 1 or 10?

Mr. DURHAM. It depends on——

Mr. NUNES. It depends on the guidance.

Mr. DURHAM. The sooner the better.

Mr. NUNES. Mr. Blumstein?

Mr. BLUMSTEIN. Yeah. I don't know that I can give you a number. Of course, I am from Tennessee where we implemented our TennCare program in about 60 days, so our folks are pretty good in navigating that process.

I would have to say that it would be nice to get more clarity and have a rule of law. When you talk about negotiation, it is really not a rule of law, and that is the problem that I have with that process.

Mr. NUNES. Great words.

Ms. Howard.

Ms. HOWARD. And like the professor here, I am a lawyer, not a math person, so I will just say that I think the building blocks are in place. The Federal Government has experience with Part D, with HIPAA, with the early implementation of the under 26 and the preexisting exclusion for kids, a lot of experience under its belt, and I am hopeful it will be close to that end of the spectrum.

Mr. NUNES. So 3 heading to 1?

Ms. HOWARD. You know, I am hopeful it will get there. Millions of people are hoping for it.

Mr. NUNES. Thank you.

Thank you, Mr. Chairman.

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

Mr. Kind, you are recognized.

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

I want to thank the panelists for your testimony here today.

Ms. Howard, let me start with you. Perhaps I missed the memo that went out somewhere that said this was going to be easy, that this was going to be seamless, that this was going to be perfect right out of the block. I think we all know, those of us who have been dealing with healthcare reform, how complicated and how difficult this is going to be to try to increase the access of healthcare coverage in our country, improve the quality of care, and bend that cost curve.

This is probably the paramount issue that we are facing with as a Nation today. We are not going to get our fiscal house in order unless a lot of these reforms succeed, and being able to bring healthcare costs while expanding coverage and improving quality. I mean, it is as simple as that. And yet I hear a lot of people complaining that things aren't happening immediately and perfectly right out of the block.

Mr. Consedine, I appreciate your testimony, but I think you are here and you are a little more sophisticated than you are leading us to believe in the political world. You don't send a letter to a Department like HHS and expect an immediate response within 2 weeks and then rush down to Washington complaining about lack of responsiveness. I will guarantee you, you pick up the phone, you call and you set up a meeting down there, they will be more than happy to sit down with you and go through this chapter and verse.

And you are not going to need any leverage on this committee or any other Member of Congress to help grease the skids to get an appointment with HHS.

Ms. Howard, I am hearing from you that with the collaboration that you are working with the States, willing to go forward on the exchange, that there has been some open communication, and yet we heard testimony today there is a lack of communication, there is a lack of direction, there is need for clear guidance. Is this what you have been experiencing in working with the 10 States that are trying to implement the exchanges right now?

Ms. HOWARD. I will start by saying I think you are right; if it were easy, we would have done it already, and it would have been done generations ago. And we have some good early news today with the census numbers. I am seeing a drop in the uninsured rates. There is a lot of work to be done.

What we are seeing in our States is that the States that want to move are able to move. And, in fact, they are seeing this flexibility as an opportunity. So I will take, for example—I am sorry that Congressman Blumenauer is not here right now, but Oregon is seizing the flexibility under the EHB rules. They have recommended the third most popular small-group plan in their State to be their central health benefits benchmark. So if there had been something from on high from the Federal Government saying, this is what the benefits package will look like, Oregon wouldn't be able to do the analysis and see what works for Oregon.

So certainly time and again we are seeing States are seizing this opportunity and are really able to do it in a way that works for them, and that is that Federalism that I think we want to see, that collaboration between the Federal Government and the States.

Mr. KIND. Well, we just heard previously from Mr. Trautwein, and I appreciate his testimony, that by the first quarter of next year, we are going to need some clear direction, we are going to need clear rules at that point. Do you agree with that assessment?

Ms. HOWARD. I agree. I agree, absolutely. I think the Federal Government has been prioritizing what they have done. They have done a number of final rules this year, they did the exchange final rules. They actually did the final rules on risk adjustment, which was really important, very complicated, and that is something they tackled early knowing that it was so complicated. So I think you are seeing a sequencing, and I think we will see more as soon as they are able.

Mr. KIND. I thank you, and with all due respect to the chairman of this committee, this hearing may be a little premature in that regard, but as far as I am concerned, I am of the attitude the more oversight, the more hearings, the more feedback we can get, the better off I think everyone is going to be. So I don't have a complaint having a hearing like this today, but let us also be realistic in regards to the timetable involved.

I guess what is frustrating for me is, you know, the whole creation of the exchanges in the Affordable Care Act was based on legislation that I and others had introduced for years around here, called the SHOP Act, and every time I introduced that bill, I had an equal number of Republicans and Democrats supporting it, because, I mean, what is conceptually not to like? It is giving con-

sumers choice to be able to go to a health insurance exchange and be able to choose their own plan amongst competing private health insurance plans through the power of the competition in the marketplace that is going to help drive prices down and hopefully improve the quality of care, and then we couple it with tax credits to make it affordable for those who can't do it on their own, for low-income families. That is really the whole concept behind the exchanges.

By the way, I mean, if States want to join together and form a larger exchange across borders, they are allowed to do that, too, under the Affordable Care Act. There is no restriction for States to be able to partner and create even larger exchanges. If all 50 States want to eventually create 1 national exchange, there is nothing stopping them or prohibiting them from doing it.

But I sense from your testimony, Ms. Howard, that your opinion is that there is a difference in attitude and therefore approach from those States willing to make their best effort and go forward in the implementation of the exchange and those that for whatever political reason are choosing not to. Is that a reasonable assumption?

Ms. HOWARD. I think that is correct. I think that variation in State approaches is due in large part to the political climate in the States, and the States that do want to move and are trying to seek or trying to implement are finding ways to do so.

Mr. KIND. Well, I think this is a response to the 54 million uninsured and the fact that the small-group market has failed miserably for so many individuals, small businesses and family farmers, and if anyone has a better idea of how we can extend healthcare coverage on an affordable basis to more Americans, we are all ears. I mean, this is not all set in stone, and we are willing to make adjustments as we go along, too.

Thank you for your testimony. I yield back.

Mr. JOHNSON. Drink more milk.

Mr. Reichert, you are recognized.

Mr. REICHART. Thank you, Mr. Chairman.

I want to quickly follow up, Mr. Blumstein, with some questioning as far as how you communicate with the government. I was a sheriff for a long time and had the opportunity to work closely with some of the Federal law enforcement agencies and know that sometimes communication by phone is an expedient way of getting things done, but sometimes you need things in writing.

And I was just listening to your earlier testimony and your description of the two exchanges that exist, the Federal and the State, but we have information here, too, that lists some other—maybe these are subexchanges under the two main exchanges—American Health Benefit Exchange, the sub—the Small Business Health Options Program, the regional, or other interstate exchanges, the subsidiary exchanges, exchanges operated by HHS Secretary. And then there is a partnership exchange listed, and under that title it says, via rulemaking HHS has created and modified federally controlled partnerships—in quotes, "exchanges"—which are not defined or contemplated anywhere in the law.

So when we go to the question of how we communicate with the government, what would you rather see, something in writing, you send a letter, you get something back in writing so you would know

that the government has answered the question in a way that you can respond to; or does a phone call, personal meeting—what is your opinion on that?

Mr. BLUMSTEIN. Well, I think that the relationships between citizens and their government should, when possible, be based upon rules. And we live in a rule-of-law society, and I think it is important to specify those rules; otherwise one lives in a world of governmental discretion. And governmental discretion can be exercised in ways that are appropriate, and it can be exercised in ways that are questionable, and it can be exercised in ways that are questionable and inappropriate. And so I tend to err on the side of having clearly delineated structures and rules and guidelines and to develop a process with some degree of transparency so that the accountability concern that citizens have is really adhered to.

I have been in many negotiations, and, you know, what is negotiated can work for one situation and not for another. That sounds flexible. But it also runs the risk of bias, cronyism, using leverage in an inappropriate way. So I think that the way, the better way, to communicate is through formality. Now, that doesn't mean that there is not a role. I think that Mr. Stark's proposal to get together is not a bad proposal. I think that is a reasonable proposal. But at some point at the end of the day, the proposal has to be written down, and it has to be neutrally administered so that the particular government official is going to be—is going to say what the deal is, what the structure is, and you don't always have to go to the government, please, Daddy or Mommy, can I do something at a certain time? There have to be claims of right, and that is what the rule of law is about.

Mr. REICHART. If you have a piece of paper to look at, we all know what the rules are. So it bothers me that this last partnership exchange is not mentioned anywhere in the law or in any rules, but it is still a part of the plan that maybe some of you may or may not know about as yet.

I want to focus on the cost real quick in referencing our State of Washington in particular with the commissioner and Mr. Trautwein. The healthcare law requires exchanges to be self-sustaining by 2015, as you well know, and this means that the Federal Government cannot support ongoing exchange operations and administrative costs. Washington State's own exchange consultants have estimated that in 2015 the cost of operating the exchange will range from 40- to $60 million per year. So this runs between 11 and $22 per member per month, runs about 500 to $1,000-plus for a family of four per year. And this is on top of the premium for health insurance and just to pay for the administrative costs of operating the exchange. That is the cost. So many of the functions of the healthcare exchange are already provided in the private sector; for example, verifying eligibility, billing, those examples.

Why is it costing taxpayers in the State of Washington from 500 to over $1,000 per family per year to receive subsidies through this structure?

Mr. CONSEDINE. Congressman, I really don't have much in the way of insight as to Washington State's costs. In our experience looking at various exchange options in Pennsylvania, cost is really dependent on the design of the exchange you go with. Some States

are looking—were looking and are looking at designs where the State's involvement is minimal, and, therefore, costs are less. Some are looking at a very engaged State exchange with additional levels of bureaucracy, employees, and of course that adds to the tab.

Certainly from our perspective, coming from a State that does have its fiscal challenges, being cognizant of the cost is a significant part of the analysis process we are going through, because at the end of the day, those costs will be borne by the taxpayer directly or indirectly. And again, this is coming at a time when healthcare costs, even with the passage of the Affordable Care Act, continue to go up. So to add to that further by adding additional costs caused by potentially moving forward with the State exchange is, again, part of the dynamic that we are all looking at in weighing our options at this point.

Mr. REICHART. I see my time has expired, Mr. Chairman. Thank you.

Mr. JOHNSON. Thank you.

Mr. Pascrell, you are recognized.

Mr. PASCRELL. Mr. Chairman, the exchange grants program has awarded over $1.6 billion to States and territories in pursuit of this effort to implement the legislation. My home State of New Jersey—and I am glad we have a Jersey girl on the panel—my State of New Jersey has already received 8.6 million in grants for research, planning, information technology development to get the exchange off the ground; yet there is some political involvement there, which continues to get in the way. And it seems that certain Governors and certain legislatures would rather reject input into something critically important for their own constituents just to make a point.

Now, I am convinced after listening to the distinguished panel, each and every one of you did a really fantastic job, that, number one, we are here discussing the bill and the act right now and the particular exchanges that are going to come about in 2014 because the past system or the system that we have now didn't work. There is a lack of competition, and you have said it in different ways. There are some States where you had only three or four companies writing policies, and that is controlled by the individual insurance director or commissioner of that particular State.

So it wasn't easy just to talk about; there is no easy answer to why don't we just have people out to cross the State lines and go into Nova Scotia, which is not a State, and buy insurance? It wasn't that easy.

How much competition do we have in most States? Very little. Is this what capitalism advocates? No. Don't we essentially desire to increase competition? Yes. Is the objective of the exchange system to increase options in competition; is that what its purpose is? And do we have really an enlargement of a Federal system, whatever that is? The answer to the first question is yes, yes and yes. And the answer to the last question is no.

How this is an enlargement of the Federal system—and remember, in the beginning it was called socialism; now we have gotten off that term, and we are using other terms now. How, when we want to increase competition, when people are going into the private market into these exchanges regardless of how they are estab-

lished in each State, does that reduce private entrepreneurship? That is a good question, I think. I have never heard a good answer to it.

Now, Mr. Blumstein said that—rightfully so—that there are only subsidies for those State-run exchanges. I think that is what you said, Mr. Blumstein, correct? If you read the legislation, I think it is pretty clear. So you omit subsidies, subsidies are omitted for Federal exchanges; in other words, for Federal Government exchanges. I would like to know Ms. Howard, Director Howard, what do you think about that?

Ms. HOWARD. So we have—what is also clear is we have very clear guidance from the IRS on this issue. And the IRS actually testified yesterday before another subcommittee of this committee on this issue, and we have career attorneys at the Department of Treasury that have been looking at this and have come down, in all due respect to my colleague here, on the other side. And certainly what I am seeing across the country——

Mr. PASCRELL. What is "the other side"?

Ms. HOWARD. The other side is that the exchanges—that regardless of the type of exchange, consumers should have access to subsidies.

Mr. PASCRELL. That isn't what he said.

Ms. HOWARD. Right.

Mr. PASCRELL. Oh, okay.

Let me ask you this question: In your testimony you identified several different forms, State exchanges. The forms they have taken are very different. It seems that a rigid approach would not be the most effective. I think we all agree with that.

Can you discuss some of those different approaches that States are taking and address some of the unique State-level insurance market issues that might be beneficial to one State and not another?

Ms. HOWARD. Thank you. That is a great question, and I will tie it back to your earlier point, which is that we do see variation across the country. In some States they have one insurer may have 85 percent of the market, so you have incredible competition—you have incredible concentration.

Mr. PASCRELL. You wouldn't call that competition, would you? Would anybody on the panel call that competition. When one firm—when one company is writing 75 percent of the policies in that State, is that competition?

Mr. DURHAM. I would just like to add here that you can go to healthcare.gov in any State, in any ZIP code, and you can see all the plans that are available now in the individual and small-group market. The plans have made an awful lot of effort to load those systems with what they have to offer in those States. So there is a lot of choice.

Mr. PASCRELL. Well, things have changed in the last few years. It is interesting that when we debated the bill, it precipitated many changes in many plans and many offerings. So already I think before we get to the exchanges we have healthcare reform to some degree. But I interrupted you.

Mr. JOHNSON. One more.

Ms. HOWARD. Congressman, you are right. There are different exchanges options available to the States. There is the State-based exchange in which the State runs all the functions of the exchange. At the other end of spectrum is the federally facilitated exchange with the Federal fallback. But there is this new model called the partnership model, which would allow the State to take on some of the functions of the exchange, and that model is attractive to some States that might not yet be ready to run their own exchange, might want to do only parts of it, and it really allows a State to maximize the areas in which they have expertise.

A State like New Jersey that has a robust regulatory scheme, the Department of Banking and Insurance has a lot of expertise there, they might want to maintain plan management, or they might choose to maintain control over their insurance market rather than having the Federal Government come in and do it. So that is that partnership model, which is really a flexibility for the States.

Mr. PASCRELL. Mr. Chairman, in conclusion, if I may, if—we heard complaints about certain States having a problem getting to the goal line. One-third of the population of this country right now is living—are living in States that have a darn good exchange plan moving, one-third of the population already.

Mr. JOHNSON. Okay.

Mr. PASCRELL. Thank you.

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

Mr. Gerlach, you are recognized.

Mr. GERLACH. Thanks, Mr. Chairman.

Commissioner Consedine, you have had a couple of questions from some of our Members of the Committee today about your August 23rd letter to Secretary Sebelius and whether realistically you have given her enough time to respond to your questions. But I understand also you might have had prior meeting with HHS on a number of issues that you still continue to question. Is that accurate? And if so, what was the outcome of that meeting or meetings?

Mr. CONSEDINE. I appreciate the question, Representative, and the opportunity to clarify.

The questions that we have in the letter are questions that we have been asking for months now as part of our meetings with CCIIO and HHS that we do have. And they are very accommodating in meeting with us and sitting down with us, but what we haven't gotten to date are answers, and guidance and the clarity that we need on these questions. So really the letter is the formalization of the process that we have been going through for months now.

And, you know, we are nearing the end of sort of the timeline we have been given. We have until November 16th really to make a decision as to when—what the States are willing to do. So we need these answers.

Mr. GERLACH. Okay. Also understand there is a July 23rd letter to Kathleen Sebelius from the Republican Governors Policy Committee asking a whole slew of questions very similar to the questions you have raised in your August 23rd letter. And since Governor Corbett of Pennsylvania is a member of the Governors association, do you know whether or not he has received any responses to that letter or to the questions raised in that letter?

Mr. CONSEDINE. To my knowledge, there was a response to the letter, but not answers to the questions that were raised.

Mr. GERLACH. Ms. Howard, you indicate, I think, on two occasions that really the lack of progress in moving forward with State exchanges is really connected to the political climate in a State and not maybe other things. Are you suggesting that the questions posed by Commissioner Consedine or the Republican Governors Policy Committee, those questions really aren't valid or fundamental as to whether a State ought to move forward in establishing a commission—excuse me, an exchange?

Ms. HOWARD. No, not at all. I think there are important questions to be raised, and this is a deliberative process. And I think they are in constant dialogue, as we have heard actually, with CCIIO, and I think it is constructive to be asking these questions.

I just make the larger point that while some States may be in a holding pattern now because of external forces, external factors, the—you know, some States, the States that really do want to move, are able to move absent the guidance that they are asking for.

Mr. GERLACH. As somebody that has been in the State legislature in Pennsylvania, before I would be asked to put up a vote on whether or not to move forward with something that commits taxpayer dollars at the State level, I would want to have answers to the questions of how much it is going to cost the taxpayers of Pennsylvania to have this exchange. Based on your work with the foundation, do you know how much it is going to cost taxpayers in Pennsylvania to have an exchange in the Commonwealth?

Ms. HOWARD. No, I don't think we know that yet, because it is an evolving—we don't even know what policy decisions and what type of exchange Pennsylvania would choose to have.

Mr. GERLACH. Here is a question from one of those posed to the Secretary: What financial costs will the State face if it elects to default on a federally facilitated exchange? Do you have an answer to that question?

Ms. HOWARD. No. That is the issue that is pending, the final federally facilitated exchange rules.

Mr. GERLACH. Another question: If HHS operates an FFE in the State, will the multiple State insurance plans be required to adhere to all applicable Pennsylvania insurance laws? Do you know the answer to that?

Ms. HOWARD. I do not.

Mr. GERLACH. So how can you expect any State to really put forward a public position on whether to move forward with an exchange if it doesn't know the impact on costs to the taxpayers of that State or to the insurance laws of that State? Isn't it prudent for the State decisionmakers to have those answers before they make that decision?

Ms. HOWARD. Well, I think they are all proceeding prudently in the sense that they are all investigating their options and making policy decisions. And I do think it is admirable that they put so much effort in. And I know there are a lot of people working hard in Harrisburg, and in Trenton and in all these State capitals.

I do go back, and while every "I" may not be dotted, there has been substantial guidance. In fact, we heard, I think, one Member

testify about thousands of pages of guidance. So I think there is substantial guidance out there.

Mr. GERLACH. But if the right questions aren't being answered, you still don't have the information as a decisionmaker in a State to move forward. So just as you acknowledged that the August 23rd letter from Commissioner Consedine and the July 23rd letter from the Republican Governors Policy Committee were appropriate to raise with the Secretary of HHS, wouldn't it be prudent for her to respond as soon as possible?

Ms. HOWARD. I think so. I do know, having been a government official, that sometimes getting letters out is not always easy. And I do agree that often the phone may be the best way, and I think that hopefully will be one outcome of today.

Mr. GERLACH. But answers need to be in writing because there could be litigation down the road, could there not? And so having formal answers in writing from both sides would be a very important part of building the record in making sure the proper decisions are made; would you agree?

Ms. HOWARD. Not always, because, again, sometimes on the spectrum of Federal options, the Federal Government could be very prescriptive, and they could handcuff the States. And we are seeing the States that want to implement are seizing that flexibility and moving ahead.

Mr. GERLACH. If I were in the State, I think I would want something in writing before I could rely on it from some Federal agency. Thank you, I yield back.

Mr. JOHNSON. Good point.

Commissioner, I understand you have got to catch a train, so I just want to thank you for being here and for answering our questions so intimately. Thank you again, and you are excused, if you desire. Thank you.

Mr. CONSEDINE. Thank you, Mr. Chairman.

Mr. JOHNSON. Mr. McDermott. Doctor, you are recognized.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Mr. Chairman, I disagree with the main point of this hearing. If the point is that the administration won't be ready for implementation of the Affordable Care Act, then I am here to tell you that is wrong.

I come from the State of Washington, which is leading the way in moving forward with the Affordable Care Act. My office is in regular contact with all the principal players in Washington State, and they say that all systems are go. The legislature has enacted the authorizing legislation necessary to implement the act. In March of this year, the Governor signed into law the second and final piece of exchange legislation.

Washington State is one of the first States to receive a Level 2 establishment grant funding to build its exchange. Washington is also one of the first States to select a benchmark healthcare plan. It is a Blue Shield plan that is currently the most popular small-group plan in the State of Washington.

The exchange now has an 11-member board of directors, including various operating committees. The exchange also has in place an advisory committee and working groups that focus on consumer protection and plan management, among other things. The ex-

change has a CAO and staff in place. They have hired the contractors to build the necessary user infrastructure. They are on track to get conditional certification from the administration in January and to start using testing in the spring.

The exchange CEO tells me they are projecting to have 300,000 Washingtonians in the exchange, in the pool, by 2015 in a State with 1 million people without insurance, which spends $1 billion annually on uncompensated care. Getting those people into plans is what I am most focused on, not on picking fights over perceived faults with the new system. I think if you are looking for excuses for not implementing, you can find them. If you want to implement, you can do it, because the State of Washington is perfect proof that that is going on.

And what I hear from the State about the administration is really nothing but praise. They have said that HHS is working with them at every step of the way and giving them all the guidance and support they need. So if my colleagues on the other side of the aisle are here to argue that stakeholders don't have the tools they need to get health reform off the ground, I am here to tell you I am not buying it.

Mr. Kind is correct, this is a premature hearing, because you could have had States out here that are actually up and running. You brought one person who says, I couldn't get them to write down exactly how I should do it. Well, you can always find that kind of stuff, but there are other places where it is in place, working, and Washington State is ready to go.

And I think that I just want to say one last thing before I stop here, and that is the chairman said in his opening statement that the administration is implementing the Affordable Care Act, quote, "behind closed doors with little or no public input." Now, I would like to submit for the record, and I ask unanimous consent for that, for a record—a list of 34 just exchange-related conferences, meetings, listening sessions and consultations HHS has held since December 2010. Thirty-four meetings is hardly without public input.

[The information follows: The Honorable Jim McDermott]

Exchange Public Meetings and Stakeholder Engagement

Dec. 16-17, 2010	Exchange Planning Grantee Meeting (Arlington, VA). Intended Participants: State Grantees and other State Staff
Mar. 30-Apr. 2011	Information Technology (IT) Innovator Grantee Meeting (Alexandria, VA). Intended Participants: State Grantees and other State Staff
May 5-6, 2011	Exchange Planning Grantee Meeting (Denver, CO). Intended Participants: State Grantees and other State Staff
Aug. 22, 2011	Tribal Consultation on the Exchange and Medicaid Proposed Rules (Seattle, WA). Intended participants: Federally Recognized Tribes
Aug. 23, 2011	Listening Session on the Exchange and Medicaid Proposed Rules (Portland, OR). Intended participants: stakeholders including State officials, providers, consumers, businesses, industry, and any other interested parties
Aug. 24, 2011	Listening Session on the Exchange and Medicaid Proposed Rules (Denver, CO). Intended participants: stakeholders including State officials, providers, consumers, businesses, industry, and any other interested parties
Sept 7, 2011	Tribal Consultation on the Exchange and Medicaid Proposed Rules (Denver, CO). Intended participants: Federally Recognized Tribes
Sept. 13, 2011	Listening Session on the Exchange and Medicaid Proposed Rules (Atlanta, GA). Intended participants: stakeholders including State officials, providers, consumers, businesses, industry, and any other interested parties
Sept. 15-16, 2011	Tribal Consultation on the Exchange and Medicaid Proposed Rules (Washington, DC). Intended participants: Federally Recognized Tribes
Sept. 21, 2011	Listening Session on the Exchange and Medicaid Proposed Rules (New York, NY). Intended participants: stakeholders including State officials, providers, consumers, businesses, industry, and any other interested parties
Sept. 19-20, 2011	State Exchange Grantee Meeting (Arlington, VA). Intended Participants: State Grantees and other State Staff

Sept. 26, 2011	Listening Session on the Exchange and Medicaid Proposed Rules (Chicago, IL). Intended participants: stakeholders including State officials providers, consumers, businesses, industry, and any other interested parties
Nov. 4, 2011	Listening Session on Essential Health Benefits (Chicago, IL). Intended participants: stakeholders including providers, consumers, businesses, industry, and any other interested parties
Nov. 8, 2011	Listening Session on Essential Health Benefits (Boston, MA). Intended participants: stakeholders including providers, consumers, businesses, industry, and any other interested parties
Nov. 8, 2011	Listening Session on Essential Health Benefits (Philadelphia, PA). Intended participants: stakeholders including providers, consumers, businesses, industry, and any other interested parties
Nov. 9, 2011	Listening Session on Essential Health Benefits (Dallas, TX). Intended participants: stakeholders including providers, consumers, businesses, industry, and any other interested parties
Nov. 14, 2011	Listening Session on Essential Health Benefits (New York, NY). Intended participants: stakeholders including providers, consumers, businesses, industry, and any other interested parties
Nov. 15, 2011	Listening Session on Essential Health Benefits (Kansas City, MO). Intended participants: stakeholders including providers, consumers, businesses, industry, and any other interested parties
Nov. 16, 2011	Listening Session on Essential Health Benefits (Atlanta, GA). Intended participants: stakeholders including providers, consumers, businesses, industry, and any other interested parties
Nov 17, 2011	Listening Session on Essential Health Benefits (Seattle, WA). Intended participants: stakeholders including providers, consumers, businesses, industry, and any other interested parties
Nov. 18, 2011	Listening Session on Essential Health Benefits (Denver, CO). Intended participants: stakeholders including providers, consumers, businesses, industry, and any other interested parties
Nov. 19, 2011	Listening Session on Essential Health Benefits (San Francisco, CA). Intended participants: stakeholders including providers, consumers, businesses, industry, and any other interested parties

Dec 7-8, 2011	Establishing and Sustaining a State-Based Exchange (SBE) in Lower Population States (Bethesda, MD). Intended Participants: State Grantees and other State Staff
Feb. 8-9, 2012	Plan Management Workgroup Meeting (Mclean, VA). Intended Participants: State Grantees and other State Staff
May 7-8, 2012	Risk Adjustment Spring Meeting (Arlington, VA). Intended Participants: State Grantees, Actuaries, Other Interested Stakeholders
May 21-23, 2012	Health Insurance Exchange System-wide Exchange Conference (Washington, DC). Intended Participants: State Grantees and other State Staff
July 26, 2012	Tribal Consultation on the General Guidance on Federally-facilitated Exchanges (Washington, DC). Intended participants: Federally Recognized Tribes
Aug. 8, 2012	Tribal Consultation on the General Guidance on Federally-facilitated Exchanges (Anchorage, AK) Intended participants: Federally Recognized Tribes
Aug. 9, 2012	Tribal Consultation on the General Guidance on Federally-facilitated Exchanges (Denver, CO). Intended participants: Federally Recognized Tribes
Aug. 9-12, 2012	National Association of Insurance Commissioners (NAIC) Annual Summer Conference (office hours and multiple meetings with State Department of Insurance (DOI) Commissioners and staff; plan management forum) (Atlanta, GA)
Aug. 14, 2012	District of Columbia Affordable Care Act Implementation Forum with Department of Health and Human Services (HHS) officials. Intended Participants: States and stakeholders
Aug. 15, 2012	Atlanta Affordable Care Act Implementation Forum with HHS officials. Intended Participants: States and stakeholders
Aug. 21, 2012	Chicago Affordable Care Act Implementation Forum with HHS officials. Intended Participants: States and stakeholders
Aug. 22, 2012	Denver Affordable Care Act Implementation Forum with HHS officials. Intended Participants: States and stakeholders

Mr. MCDERMOTT. This is a process that is working in some States because the political leadership wants it to work, and is not working in certain places because the political leadership thinks that this is how they will use it to defeat President Obama in the election. And there is a very clear break point. It is possible to implement, it is being done.

And will there be problems? I am certain we are going have problems in the 2013 session that we are going to be in here trying to tinker with this and tinker with that and make things, because you

can never design a human system without making mistakes. You cannot anticipate all the problems that you face.

But we are on our way in Washington State, and it can be done, and anybody who says it can't simply is unwilling to look at the facts on the ground in some States. You heard about Oregon from Ms. Howard, and I can give you Washington. These are the States with the lowest healthcare costs in the country. Medicare costs in the State of Oregon and Washington are the lowest. And we also are implementing our exchanges because we are getting ready to make this thing work.

I yield back the balance of my time.

Mr. JOHNSON. Thank you. The gentleman's time has expired.

We don't like the program in Texas either, and there is no taxes in Texas.

Dr. Price, you are recognized.

Mr. PRICE. Thank you, Mr. Chairman. And I want to thank the witnesses as well. I am sorry Mr. Consedine had to leave.

I was pleased to hear, though, from Mr. Kind that nothing is set in stone. Whew, thank goodness that nothing is set in stone. I thought this was a law that was moving forward.

And Mr. Kind also said, look, if anybody has got a better idea, just bring it to us, we are happy to listen to it. Well, the fact of the matter is that during this whole process, there were many of us who felt like we had a better idea, and we appealed to the administration week after week after week to just sit down with us, just talk with us about these ideas, because we believe that you can solve all these challenges without putting Washington in charge. And the administration ignored us at every single turn week after week after week. So there is great skepticism on our side when we hear someone say, oh, if you have a better idea, we are happy to listen to it.

The question I wanted to ask Mr. Consedine was who is subject to the penalties if you don't comply with the law? Ms. Howard, who is subject to the penalties if the law is not complied with; is it the Federal Government that is subject to the penalties?

Ms. HOWARD. I think it is—which——

Mr. PRICE. Is it the Federal Government?

Ms. HOWARD. I don't believe so.

Mr. PRICE. Heck no. It is these folks, the folks in the States, the folks trying to comply with this law. And all that we are hearing is that the rules haven't been promulgated in enough time to be able to put things in place, and they are working as hard as they can.

Mr. Durham, you have a paragraph in your testimony: Clear regulatory guidance in each of these areas is needed in the very near future. Unless the guidance is forthcoming, it will be difficult for health plans to complete product development, et cetera.

How long does it take usually to—when the Federal Government or when it—there are major changes to rules and regulations that come out, how long does it take the plans to come up with the programs and products to be able to market to the public?

Mr. DURHAM. I believe it typically takes 12 to 18 months to fully develop a product, get it through the State review and get it to market.

Mr. PRICE. Twelve to eighteen months, Mr. Chairman.

And, Mr. Durham, am I correct in saying that the time that the enrollment period begins that you are required to have something available is October 1st, 2013; is that right?

Mr. DURHAM. That is correct in the statute.

Mr. PRICE. We are bumping up against that right now.

Mr. DURHAM. Yes.

Mr. PRICE. So, Mr. Chairman, it is clear that HHS has been delinquent in their responsibilities and what they have been able to do. And these folks are trying just as hard as they can to comply with the law.

Mr. Durham, I also want to touch on the whole issue of choices for patients, because as a physician, having cared for patients, what they want are choices. They want to be able to know who is going to take care of them. They want to be able to know that they are going to be able to pick a plan that has the doctors that they want in that plan to care for themselves and for their family.

Do you know if your members are planning on offering State- and Federal-facilitated exchanges in all the States where they have networks?

Mr. DURHAM. I don't know that because it really depends upon getting clear regulatory guidance here before plans can really decide which markets they want to compete in, and so I think that is a critical step in the process here. We have some guidance as has been discussed today, but there is still guidance missing, and to be able to develop products, get them through the various State review processes, and if they have to be a qualified health plan, there are additional requirements, that will take time. And I think it depends in terms of plans being able to compete in those markets when they get the final guidance to be able put together the product and comply. So it is very important, but they want to serve their customers, absolutely.

Mr. PRICE. But it is possible that the guidelines will come out and make it such that it will be impossible for them to provide products or—to individuals out there in certain markets; is that accurate?

Mr. DURHAM. I guess that is possible. We would hope that would not be the case, because the plans really do want to compete in these marketplaces.

Mr. PRICE. Mr. Durham, I also want to talk about some of the plans—one requirement for the plan sold for small-group markets in the exchange is they have got to meet annual deductible limits; is that correct? Isn't that right?

Mr. DURHAM. Yes. In the statute the deductible limits are $2,000 for a single individual and $4,000 for a couple.

Mr. PRICE. Now, my sense, my understanding about that is that that will make it extremely difficult or problematic for small business employees to enroll in, for example, a high-deductible health savings account or catastrophic plan.

Mr. DURHAM. That could be the case. We haven't received the clear guidance there yet. We expressed in terms of a bulletin on this issue that in—reach the actuarial value requirements, they ought to allow and count the employer's share to health savings account and the high-deductible health plan. But clearly I think the

deductible limits in the small-group market will be a problem since they are lower than what is offered in today's market, and that will reduce choice for small businesses.

Mr. PRICE. Reducing choices, that is right.

Thank you, Mr. Chairman.

Mr. JOHNSON. Thank you.

Mrs. Black, you are recognized.

Mrs. BLACK. Thank you, Mr. Chairman, and I want to thank you for allowing me to sit on this committee although I am not a member, and I appreciate the opportunity to be able to ask questions as well.

Very informative panel, and thank you so much for being here today on this very, very important topic as we move forward.

Mr. Blumstein, I have a question for you. I thought you brought up a very interesting question that I have been reading about now on more and more in publications, and that is the issue, the matter that was raised by Alder and Cannon, and in particular does the ACA clearly provide for subsidies if the Federal Government runs a program.

I can hear what was said by Ms. Howard or others who are experts disagreeing with your analysis and their analysis. Who will eventually make this decision; will this be another court struggle here?

Mr. BLUMSTEIN. Well, nice to see you, Representative Black. I guess we should say we are in neighboring congressional districts in Tennessee, and thank you for your service.

I would have to say that, you know, the statements that the IRS—some official at IRS has said that the agency has authority is, you know—that is not a surprise. They issued the regulation. But they are supposed to speak in a regulatory process in a formal way. They are supposed to explain their reasons. The reasons are lacking; they are virtually nonexistent, in my opinion. And for someone to say, oh, well, an IRS person said X without saying what the argument is is not very satisfying, I must say.

In terms of how arguments occur, usually lawyers reason with each other. And I have certainly have changed my mind on issues, but I only change my mind in response to arguments, not in response to these, you know, five different people said something to disagree with you. I am sure there are millions of people disagree with me on many things. Until you know what the arguments are, it is hard to confront them.

I think the IRS has overreached here. They have not explained their rationale. The rationales that are out there are unsatisfying, they are not satisfactory. The IRS has to establish that there is ambiguity, implicit authority to rule not just in gross, but on this specific question. They have not established that because the courts have said that these normal ways of construing statutes, the exclusio unius rule is part of the interpretive process. And so once you say that that is part of the interpretive process of determining whether there is ambiguity, then, to me, the IRS really has a problem.

And so it is conceded; everyone concedes that there are two exchanges. The statute provides subsidies in one exchange; it does not provide subsidies in the other exchange. And when that hap-

pens, basically there can be no subsidies in the other exchange. So then you have to look for exceptions to those kinds of rules, and I have not seen exceptions that really hold—in my opinion are persuasive.

So then the question you asked is who—how will this be determined, and I see two different scenarios. If there is a change in the administration in this election, my guess is that Governor Romney as President will very likely have a new set of interpretations in the Internal Revenue Service, and that this very well—this rule may be modified or changed in some way, because I think the argument in favor of it is very thin, it is very results oriented.

If President Obama is reelected, then I think the rule will stand, and then there will be a legal challenge here. I think we will be in court. And at first I thought that it would be hard to imagine who would bring this case, because it adds benefits to certain people, and that is the good part. But it also adds a tax to some people and companies, these large companies, and they are paying $2,000 or $3,000 per employee in taxes if their provisions don't meet the affordability criteria and the benefits and coverage criteria of the Federal Government.

And so I think States may have the ability to bring this action. They will claim that they would have a competitive advantage if they choose not to set up an exchange. So I think you are going to find some kind of injury in the recruiting of companies. And certainly the companies themselves will have standing ability to challenge it. So I think you are going to see a coalition, and coalitions are actually in the process of being formed, I am told, where States and arguably private employers of 50 or more employees would bring this action and challenge the IRS ruling.

Mrs. BLACK. I think you certainly laid this all out very well. I am not an attorney, I am a nurse, so reading your statement, it flowed very well so that I did understand it. But what it did make me think of is just one more complexity, one more complexity in what is already a very complicated program, one that we don't have a lot of definition. Frankly, I am just hearing it from my employers and hearing it from folks back in my State, where they are employers or they are government officials or whatever, that there is so much uncertainty and confusion, and it is very, very hard to make a decision when there is not clarity.

And just to end here, we come from a State where we tried to have a single-payer system, where we tried to have universal care, and it was very difficult and didn't work in our State of Tennessee. I know we're involved with our good Governor in trying to fix a program which ultimately just really unraveled, and we no longer have the program.

Mr. BLUMSTEIN. Yes, Governor Breseden is a hero for trying, and I must say he is—in Tennessee, as you know, the Tennessee Democrats, and he is a Tennessee Democrat, and I have worked and am proud to work for him and support him.

Mrs. BLACK. Well, I served under the good Governor, and I know what difficulty we had there with the program, and, now that it is gone, on looking at what may be a mirror of what we tried and didn't work. So thank you so much for your testimony and coming here today.

Mr. JOHNSON. Thank you.

The lady's time has expired.

I want to thank the witnesses for their thoughtful testimony and insights into the status of health insurance exchanges. The Obama administration's repeated avoidance of a transparent regulatory process and ongoing delays may be politically expedient, but it has not been without substantial cost. How do we account for the cost of unemployed Americans losing job opportunities because businesses are not hiring workers while the full compensation costs are unknown? Can you put a price on the family forced to forgo healthcare coverage because they have been priced out of the market by costly regulations?

The more Americans learn about the law, the less they like it. Despite years of assertions to the contrary, information is the most significant threat to Obamacare. Holding back necessary regulation to avoid public scrutiny is irresponsible. Americans deserve better from their government.

As a reminder, any Member wishing to submit a question for the record will have 14 days to do so. If any questions are submitted, I ask the witnesses to respond in a timely manner.

Mr. JOHNSON. With that, the committee stands adjourned. I thank you all for being here today.

[Whereupon, at 4:48 p.m., the subcommittee was adjourned.]

Public Submissions For The Record
American Society of Association Executives

asae
The Center for Association Leadership

September 11, 2012

Committee on Ways and Means
Health Subcommittee
1101 Longworth House Office Building
Washington, DC 20515

The American Society of Association Executives ("ASAE") is a section 501(c)(6) individual membership organization representing more than 22,000 association executives and industry partners from nearly 12,000 tax-exempt organizations. Its members manage leading trade associations, individual membership societies, and voluntary organizations in every state as well as in 50 countries around the globe.

For many associations, providing insurance is one of their highest budget costs annually. According to ASAE's Compensation & Benefits survey, over three fourths of associations provide some health coverage for employees; this percentage is even higher for associations with eleven to thirty staff. The average premium increase, however, is 10% annually. ASAE has historically been active on this issue because effective and accessible networks of small employers can work to reduce the cost of this increase.

ASAE has long been a strong supporter of allowing employers to form health insurance pools because of the cost-saving elements passed on to small employers. This sort of instrument creates a large consumer base and the scale that gives bargaining power to small employers. Small employers are often a class that faces the most difficulty when accessing affordable and quality insurance. Similar to small businesses, many associations could benefit from a well run insurance exchange that provides affordable options for employees, as well as budget relief for the employers.

As the deadline approaches for Exchanges to be put in place in every state as part of the ACA, it is imperative that these Exchanges run well. ASAE supports reasonable adjustments to deadlines, if needed, in order to ensure that statewide exchanges are built effectively before they are put into place. States should look to existing models, such as association health plans, in order to build effective Exchanges. In addition, the ACA created a role for "navigators" or organizations that represent large populations that are able to guide eligible employers through the Exchange. The navigator role is critical to the success of the Exchange and, as associations are rightly included as eligible navigators, we urge the federal government and states to use them appropriately in the creation of Exchanges.

ASAE hopes careful consideration is made to ensure that the Exchanges are fully operational in time for the deadline just over a year away. Should you have any questions, please contact me or Jim Clarke, sr. vice president of public policy, at (202) 626-2865 or jclarke@asaenet.org.

Sincerely,

John H. Graham IV, CAE
President & CEO

Association of American Physicians and Surgeons

September 26, 2012

waysandmeans.submissions@mail.house.gov

To: Chairman Wally Herger, House Ways and Means Subcommittee on Health

RE: Implementation of health insurance exchanges and related provisions, as considered in the hearing of September 12, 2012

The Association of American Physicians and Surgeons (AAPS) is a nationwide organization of physicians in all specialties founded in 1943 to preserve and promote the practice of private medicine. We support the sanctity of the patient-physician relationship, traditional medical ethics, and free market principles.

AAPS opposes the formation of state or federal exchanges. While these are touted as a market mechanism, they will in fact have the effect of stifling competition, reducing patients' choices, increasing the cost of insurance, and exacerbating the destruction of true insurance in favor of "health plans" that are basically mechanisms of prepayment for consumption.

Rather than simplifying administration and reducing the costs, exchanges will create yet another bureaucracy. The costs of running the exchanges will become very burdensome to states as federal funding is phased out. There are already huge expenses involved in attempting to prepare to comply with rules that are ambiguous or not even written at the time of the deadlines.

In a free marketplace, decisions are made by people making choices about how to spend their money. Decisions are based on individual values. Individuals have every incentive to get the best value for their money. The exchanges, in contrast, will impose complex administrative rules handed from the top down.

It is not even clear how exchanges can work at all since they require information that at present is not reportable, such as household income. They will establish a whole new level of intrusion of the federal government into individuals' lives by having the IRS a party to individual decisions about insurance and medical care. The detailed level of reporting is also totally destructive of patient privacy.

The exchanges will undermine, if not totally destroy, the employer-based system of health insurance, as employers have incentives to move workers into exchanges so that they can collect tax subsidies. Employers will also have to choose between greatly inflated insurance premiums or taxes based on the number of employees who do not receive benefits from the workplace. The other choice of course is to cut down on employment, especially full-time employment. Thus the exchanges are job killers.

The exchanges are largely an untested idea, an experiment being foisted on the American people without their consent. The first working model in Massachusetts has led to greatly increased insurance costs, and much higher portions of costs being shifted onto government.

AAPS favors the repeal of the Affordable Care Act in its entirety. Pending that, we are in favor of defunding the exchanges and recalling all unspent federal funds already supplied for exchanges.

Respectfully submitted,

Jane M. Orient, M.D.
Executive Director
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Barney Nemiroff MD

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September 14, 2012

Chairman Wally Herger
Ways and Means Subcommittee on Health
Via email

Dear Chairman Herger,

I am writing to express my strong opposition to health insurance exchanges, and to PPACA, in general. Implementation of these exchanges amounts to implementation of government-run health care by promoting Federal involvement in too many aspects of the healthcare system: choice of health plans, the state insurance market, and even medical decision-making are among these. Although our health care delivery is certainly not perfect, a government takeover is not the answer, and it is not the American way.

Chairman Herger, please consider doing away with these exchanges and repeal of the entire PPACA. This plan was hastily conceived and imposed the people of this country against the will of approximately half our citizens, largely for political reasons. Let us take a step back and rethink the direction in which we want our healthcare to go. Thank you for your attention.

Regards,

Barney Nemiroff, MD

Citizens Council for Health Freedom

CITIZENS' COUNCIL FOR Health Freedom
SECURING HEALTH FREEDOM FOR ALL

FMI: *StopHealthInsuranceExchange.org*

15 REASONS: Oppose Obama's Health Insurance Exchanges

1. **Exchanges are Federal Takeover Centers, not marketplaces.** The federal government controls the health plans and the benefits---and oversees patient care. Exchanges will also become *single-seller bureaucracies* where only government-approved health plans are sold and no real "market" exists. It is expected that all people in the future will be required to buy insurance from the Exchange. (see #5)

2. **States will lose.** State-run exchanges will hide the federal takeover; enable federal access to state-held data on citizens, patients and providers; and shift the *annual* $10 million - $100 million cost of operating the exchange to State taxpayers.

3. **State-run Exchanges are not required.** That would be commandeering of the state by the federal government. Obama's health care law acknowledges this fact by having a fallback plan for creation of a Federal Exchange---but no money to do it. They've asked for ~$750 million, but Congress has thus far refused.

4. **All Exchanges are Federal Exchanges.** State-run Exchanges must follow the federal law and all federal rules. They are required to report annually to the U.S. Secretary of Health and Human Services (HHS) and are under control of HHS.

5. **State-run Exchanges are part of a National Exchange.** State exchanges are 50 state-named website portals of a national system. They are extensions of the federal government into each state through the "Federal Data Services Hub," which will receive and share private data. Data entered online to buy insurance is sent for verification through the Federal Data Services Hub ("Hub") to at least five federal agencies, and compared with myriad state databases and data systems made accessible to the Hub by state government.

6. **The Exchange is a national registration and enforcement tool.** The National Exchange (with 50 website portals) will register the insurance status of every citizen and allow the IRS to enforce the penalty-tax for refusing to buy health insurance. *The purpose is universal coverage — national health care.* Registration takes place through purchase of insurance or online registration of an exemption.

7. **The Exchange will create an unprecedented tracking system.** Whether they pay taxes to the Federal government or not, everyone must *annually register* with the IRS either on their own through the Exchange or through their employer. State governments are already considering how to "pre-populate" the exchange using other databases such as state taxpayers, voting registration, and vital statistics.

8. **The Exchange will enable Obamacare fines.** Employers face significant fines if even one of their employees buys health insurance on a state-based Exchange.

9. **The Exchanges will expand Medicaid and build middle-class dependency**. All persons and families up to 400% of federal poverty levels (FPL) will be enrolled into Medicaid (up to 138% FPL) or be able to receive a taxpayer-funded premium

subsidy to buy health insurance. In 2012, 400% FPL is $44,680 for an individual and $92,200 for a family of four.

10. **"Federally-facilitated exchanges" are a facade meant to deceive.** The FFE will have a state name (i.e. Iowa Exchange) but operations will be conducted by the federal government—leaving the public in the dark about the federal takeover.

11. **Redistribution of Wealth to Health Plans.** Fully 98% of the new spending under the federal health reform law goes directly to health plans approved by the government to offer health insurance on the Exchanges. Approximately $1 trillion will be transferred from taxpayers to health plans through federal premium subsidies offered on the Exchanges and through the expansion of Medicaid through the Exchanges. *(Bloomberg.com http://bit.ly/NRxw7P and http://bit.ly/TCoVt9)*

12. **The "Clawback."** Individuals signing up for insurance on an Exchange must estimate annual income for the coming year. If it's between 100% and 400% of the federal poverty level (FPL), federal premium subsidies are available to help cover the cost. However, if the income is greater or family status has changed, the IRS can ask for all or part of the subsidy to be repaid. Thus, "If you received a subsidy based on a prediction that your income was 350% FPL and it later turns out your income is $1 above 400% FPL—you have to pay 100% of the premium subsidy back," according to *Inside Health Insurance Exchanges* (Aug 2011).

13. **Risk Scoring of Individuals.** Under the Obamacare Exchange "risk adjustment" regulation, states are required to analyze data and calculate individual risk scores on all persons: "*Individual risk score* means a relative measure of predicted health care costs for a particular enrollee that is the result of a risk adjustment model."

14. **Gaming the System.** Health plans with the sickest enrollees receive more health care dollars. According to an expert cited in *LDI Health Economist*, "If an insurer is able to work [the risk adjustment system] in combination with subsidies, which are also complex, then that carrier may be able to enroll a lot of people who kind of 'look' sick and are subsidized and also get bonus risk-adjustment payment on top of that. An insurer may be able to make a killing by working both sides."

15. **Sicker Patients on Paper.** "Risk adjustment" dollars will travel on state-based "risk corridors" from Exchange health plans with low risk enrollees to Exchange health plans with high risk enrollees. Experts quoted in *LDI Health Economist* report, "the entire country is going to get a lot sicker on paper" *and* "an insurer will have an incentive to give people the absolutely most thorough physical of their lives when they join because if there is even a trace of conditions like cancer or diabetes…the insurer may be able to get more risk adjustment money."

Lawmakers can stop the federal takeover. State legislatures and governors must refuse to create or accept any Exchange and return Exchange funds to the federal government. Congress must not fund a Federal Exchange, must defund Exchanges and repeal the law.

Sign up** for weekly health care news you won't hear anywhere else: **bit.ly/cchfenews

David J. Pasek MD

DAVID J. PASEK, M.D.

April 29, 2013

Dear Chairman Wally Herger, Ways and Means Subcommittee on Health,

Please vote to defund the ObamaCare Insurance Exchanges, recall all unspent federal exchange dollars, and repeal the ObamaCare law during the "Implementation of Health Insurance Exchanges and Related Provisions" hearing.

Because of relentless and ill advised government intrusion into the practice of Medicine, I prematurely retired from the practice of Primary Care Medicine at the early age of 53 years after a spotless 26 year career. No medical malpractice suits. No Medical Board problems. No DEA issues. No HIPPA privacy violations. No Medicare or Medicaid fraud accusations. No racial discrimination accusations. No sexual harassment issues. My 26 year career practicing Primary Care in primarily rural, under served areas was unblemished and squeaky clean.

Unfortunately, the relentless intrusion by the Federal government into the practice of Medicine over the past 3 decades made it impossible for me to provide the high quality medical care that I became dedicated to provide as a youth. For example, how could I expose my female patients who trusted me with their personal secret that they had had an abortion years ago to "outing" by a WikiLeaks-type hacker who hacks into the Federally mandated electronic medical records databases and exposes her secret on the internet? Mandatory electronic medical records are possibly the single worst idea the Federal government has imposed on those of us charged with the responsibility to guard our patients' most vulnerable secrets. The argument that these electronic medical records will be secure from hackers is laughable.

Furthermore, the danger to our political system that electronic medical records poses is enormous. Do you really think that Republicans will refrain from hacking into Hillary Clintons' electronic medical records to expose her abortion history if any is found? Or that the Democrats will refrain from hacking into Sen. Hatch's psychiatric records if any is found? Or that either party will refrain from doing a search of all Congressmen and Senators to see which have ever been treated for venereal disease?

Electronic medical records should be prohibited by law, not mandated by law. ObamaCare has it backwards. Anyone old enough to remember J. Edgar Hoover's illegal wiretaps or Richard Nixon's enemy's list should cringe at the very thought of searchable, digitized, electronic medical records available globally over the internet by WikiLeak-type hackers who are one step ahead of the IT security industry.

I absolutely guarantee that if you fail to defund and repeal ObamaCare, you will regret it. The crazy anti-abortionists are breathlessly waiting for the opportunity to hack into the ObamaCare electronic medical record databases and do a search of all Americans who have ever had an abortion, and publish it on Facebook. Is this the America you want?

Sincerely,

David J. Pasek, M.D.

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Medical Research Technology Information Consortium

Medical Research Technology Information Consortium
MRTIC
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Land Line: 979-446-0003

MEMORANDUM FOR RECORD

To:	Chairman Wally Herger, Ways and Means Subcommittee on Health
E-address given:	**<waysandmeans.submissions@mail.house.gov>**
Subject (Hearing):	Implementation of Health Insurance Exchanges and Related Provisions
Testimony due date:	5 PM EDT; Wednesday, September 26, 2012
From:	Dr. Mark M. Brauer PE(TX), CSP and MRTIC Managing Director (address and phone as given in the Header, above)
Reference:	CCHF Health Freedom News, September 2012

MESSAGE

Summary statement

The undersigned, with a life-time career devoted to Health research and implementation, hereby testifies concerning the Subject measure, sans any profit motivation, and prays that the factors presented below will accrue to the total defeat of said measure.

Detailed issues of concern that should enable Congress to defeat the Subject measure

Exchanges are 'Government-Run Health Care' and as such defeat private enterprise, free trade and entrepreneurship. They will insert another impersonal, wasted layer of bureaucracy between a patient and his/her doctor; proven to be wasteful, detrimental to speedy treatment and impractical.

Exchanges will require new and wasteful Federal government controls, laws, rules and regulations that, by themselves, will also increase Medical/Health-Care (M/HC) costs that are already too costly.

Federal control of health care encroaches on what is State's Rights in all of the 50 states.

Exchanges, as discussed, will require a new layer of National tracking, another wasteful layer of cost without ANY positive impact on individual or collective (National) health.

Exchanges will force costly, intrusive data-sharing via another cost driving layer, or data hub.

Exchanges will require National identity for costly IRS enforcement of the individual mandate.

Exchanges will reduce freedom of choice for one's own control over one's own health and health plan.

The undersigned cannot condone any Federal interference in the state insurance market and individual medical decision-making;

Even though a Federal program, Exchanges will, as already accepted, impose $10M - $100M additional annual operating costs upon states that are already straining economically.

Exchanges eliminate the entire, free-market/free-enterprise health-insurance-agent industry in favor of a less efficient Federal system such as the experience with our Postal System.

By defeating the Subject Exchanges, our Government will curtail a myriad of employer lawsuits deriving from employees using such Exchanges.

Metro Pain Associates

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April 29, 2013

Hon. Wally Herger
Chairman
House Ways and Means
Subcommittee on Health

Re: Government funded health insurance exchanges

Dear Mr. Herger:

I wish to state my opposition to the creation of federally funded health insurance exchanges. Creation of these exchanges is designed to allow the federal government to take over health care in the United States. It will be yet one more obstacle standing in the way between the patient and his or her physician. As a result decisions on health care and treatment will be dictated by a third party who controls the purse strings and, thereby, controls the type of treatment that will be allowed.

Health insurance exchanges will add a burdensome and inflexible layer to the already difficult practice of medicine. Imagine the rules and regulations as they stand under CMS and multiply them to an infinite degree.

Sincerely,
Gary L. Reasor, MD, FIPP

National Association for the Self-Employed

National Association
for the Self-Employed

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Washington, DC 20004
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Statement for the Record
Submitted to the Ways and Means Committee
United States House of Representatives
Washington, D.C.

"Implementation of Health Insurance Exchanges and Related Provisions"

Submitted by Kristie Arslan
CEO & President, National Association for the Self-Employed
September 12, 2012

The National Association for the Self-Employed (NASE) respectfully submits this official statement for the record on today's hearing *Implementation of Health Insurance Exchanges and Related Provisions*. For the 22 million self-employed Americans (77% of which are currently self-insured), we believe the development of health insurance exchange markets is an attractive option for the self-employed and, if constructed accurately, will provide affordable health care options for our members.

However, we remain deeply concerned that the lack of clear guidelines and expectations for the development of state-based exchanges by the Department of Health and Human Services to states, insurance companies, employers, and consumers in delivering final guidance, will result in the creation and implementation of **ill-constructed** exchange markets. Millions of Americans are expected to participate in both state and federally operated exchanges in the fall of 2013 and yet, key guidance from the federal government has been minimal.

Essential to the creation and implementation of the exchange system, three areas deeply concern the NASE:

1) The number of States that have declined to establish state exchange markets;
2) Lack of final regulation defining Essential Health Benefits;
3) Finalized regulation related to the creation and implementation of exchanges

We are committed to serving as partners with the Department of Health and Human Services and other key stakeholders to ensure that the exchange-market is thoughtfully created and implemented. At a time when the self-employed are at their highest for being insured while expressing their concerns related to increasing cost of insurance, we need the implementation of exchanges to move forward, smoothly.

Kristie Arslan
CEO & President
National Association for the Self-Employed

Robert L. True

To: Chairman Wally Herger, Ways and Means Subcommittee on Health

From: Robert L. True, MD
Private practice, solo physician
5203 Heritage Ave.
Colleyville, TX 76034
817-399-8783
rbrttrue@yahoo.com

Regarding hearing: hearing on Obamacare's government health insurance exchanges (federal takeover centers) and Obamacare.

Dear Sir:

I say NO to Federally controlled Exchanges because they are simply Government-Run Health Care. Government run systems (socialistic systems) have failed to provide the excellent medical care that we have in the United States today. We have one of the best health care systems in the world and to change this from private enterprise to government control care is absolutely NOT necessary. It should never be regarded as the Law of the Land.

I feel strongly that the Obamacare law is bad for the United States. Part of this law is the federal and state exchanges. I say NO to these Exchanges; I Say No To: Federal government controls (law/rules); No to a National tracking system of insurance status; No to Intrusive data-sharing through the Federal Data Services Hub ; No to a National registration system for IRS enforcement of the individual mandate; No to Federal control over health plan choices; No to Federal interference in the state insurance market and individual medical decision-making; No to Elimination of the existing entire health insurance agent industry which this law would do; No to Federal control of health care in the 50 states; No to Accountable Care Organizations (ACOs); No to the Independent Patient Advisory Boards (IPAB); And No to National health care Obamacare law, encompassing over 2000 pages of federal bureaucratic control over the best private health care system in the world.

Privatization should be encouraged, as well as incentives for proper behavior and lifestyle. Putting healthcare responsibility back into the hands of the physicians and the consumer, taking it away from big Wall Street insurance companies and the unknowledgeable federal bureaucracy should be the prime goal of healthcare reform. We had many hospitals and entities that gave out charity care because it was the right thing to do, and people gained access to health care. What the present Medicare and Medicaid system has done is simply created excessive abuses for the system and the physicians providing the care. Expanding this existing system that is broken is totally illogical and wrong.

In addition, no personal responsibility is factored into the Obamacare law. People should be incentivized for maintaining a proper weight, eliminating obesity, exercising, eating properly, discontinuing smoking, and a number of other behaviors which can reduce healthcare expenditures by over a third. None of these ideas are in Obamacare, yet all of these should be paramount in any health care reform. Each individual should be held accountable to their own health care improvement.

I am asking you to defund the exchanges, recall all unspent federal exchange dollars, and repeal the Obamacare law.

Sincerely,

Robert L True, MD

Stephen Welk MD

Stephen Welk M.D.
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September 14 2012
Tel. 716 496 7440

Chairman Wally Herger

RE: Hearing " Implementation of Health Insurance Exchanges"

Dear Chairman Herger

Implementation of health insurance exchanges will be the beginning of the destruction of the American health services by the fiasco known as Obamacare. These exchanges not only will dictate a national health service but they will add a tremendous burden to each and every employer in the US. Countless rules and regulations will encumber every business that has employees. Employer tax penalties associated with these exchanges will unleash an epic and expensive nightmare of paperwork. I strongly encourage you to abandon these exchanges and not fund them. I have been a private practicing physician for 30 years. Every day it becomes more difficult to practice medicine with constant government intrusion into what should be the most private and personal aspects of a patient's life. The dictates of these exchanges will be just another layer of bureaucracy and intrusion into the delivery of health services in this country.

Sincerely,

Stephen Welk M.D.

The Leukemia and Lymphoma Society

LEUKEMIA & LYMPHOMA SOCIETY
fighting blood cancers
www.LLS.org

House Ways and Means Subcommittee on Health
Implementation of Health Insurance Exchanges and Related Provisions
Testimony for the Record of:
Mark Velleca, MD, PhD, Chief Policy and Advocacy Officer
The Leukemia and Lymphoma Society
September 12, 2012

Chairman Herger, Ranking Member Stark, Members of the Subcommittee, thank you for the opportunity to submit a statement for the record on the implementation of the health insurance exchange. The Leukemia & Lymphoma Society (LLS) appreciates the opportunity to provide our recommendations, particularly on the implementation of the federal Essential Health Benefits (EHB) benchmark plan for use in the individual and small group insurance markets. LLS is the world's largest voluntary health agency dedicated to blood cancer. LLS funds lifesaving blood cancer research around the world and provides free information and support services. The mission of LLS is to cure leukemia, lymphoma, Hodgkin's disease and myeloma and improve the quality of life of patients and their families.

LLS is committed to ensuring access to and compliance with the most appropriate, evidence-based treatments for all blood cancer patients. Treating blood cancers involves accessing a complex set of health care services including diagnostic tests, chemo and radiation therapy, prescription drugs, and cancer treatment planning, among others. These long-term treatment plans often put patients at great financial risk due to the cost sharing burdens associated with care, even if they are insured.

Blood cancer patients and survivors who are currently uninsured and underinsured, are among those who stand to benefit greatly from the establishment of both the state-level and federal Health Exchanges. We commend those states who have progressed significantly in implementation of their state exchanges, as well as those which have demonstrated a commitment to meeting federal deadlines for implementation of health reform. After much anticipation, the U.S. Department of Health and Human Services (HHS) released a bulletin, on December 16, 2011, to provide guidance to states when determining the EHBs for state health exchanges, the small group market inside and outside the exchange, benchmarks for Medicaid and Basic Health Programs.

Instead of providing a detailed list of criteria and services that states must cover in 2014, the bulletin was vague, leaving in depth coverage decisions to states, proposing unnecessary flexibility for insurers, and creating confusion on how state policymakers move forward. This lack of clarity from HHS will place an undue burden upon states, and ultimately upon the patients we represent. We hope that HHS will soon provide more clarity in order to ensure continued progress in those states that are committed to implementing the Affordable Care Act. Furthermore, clarifying guidance from HHS could potentially encourage states that are currently undecided on exchange implementation.

Office of Public Policy
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LEUKEMIA &
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www.LLS.org

One of the most important next steps for states and the federal government is to establish a comprehensive EHB package of health care services, both inside and outside of the exchanges. As you are aware, to determine what services will be included in the EHB, states must choose from ten benchmark plans. Unless states provide affordable access to comprehensive care, the promise of meaningful access to quality, coordinated cancer care will not become reality for patients or survivors. If an EHB package leans too heavily toward maximizing flexibility at the expense of ensuring patient access to comprehensive and quality cancer care, blood cancer patients may find themselves with insurance that is inadequate and unable to meet their health care needs, while being saddled with crippling financial responsibilities.

LLS believes that states and the federal government must take a comprehensive approach when setting the standard for the EHB package. To that end, LLS supports a set of recommendations that ensures access, quality and affordability for blood cancer patients. These recommendations focus on three key principles:

1. A meaningful prescription drug benefit that is comprehensive, affordable and enables access to the most effective, evidence-based drug therapies that are tailored to the patient's needs;
2. Access to specialists, procedures and technologies for needed diagnostic and treatment services; and
3. Coverage for comprehensive cancer planning as well as palliative and end of life care.

Policymakers must take a comprehensive approach when setting the standard for the Health Exchange and the EHB package. Creating a benchmark plan that is broad in scope, while offering affordable coverage, is key. Because blood cancers are generally not preventable, we urge HHS to encourage the implementation of robust plans with sufficient benefits to ensure coverage for diagnosis, care planning and treatment.

LLS strongly encourages HHS and states to adopt the following recommendations as part of their benchmark plans:

1. A prescription drug benefit with full coverage of the six protected classes, including multiple drugs in a range of therapeutic categories, as defined in the Medicare Part D program, and a patient appeals process.

2. Independent Pharmacy and Therapeutic (P&T) Committees that review the drugs included on a Plan's formularies, as well as the utilization management requirements for such drugs, and consideration of newly approved treatments and indications for inclusion in formularies within certain timeframes, such as those required under Part D.

3. A mechanism for incorporating new therapeutic categories or classes in order to protect patients' access to innovative therapies as they become available.

4. Equal treatment of out-of-pocket expenses to patients receiving intravenous, injectable, and/or orally administered anti-cancer therapies.

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5. Drugs and biologics, both physician & self-administered and off-label uses, according to the evidence-based standards utilized in the Medicare program.

6. Affordable access to procedures standard to the treatment of blood cancers, including bone marrow and cord blood transplants and radiation therapy.

7. Allow cancer patients to seek treatment at National Cancer Institute (NCI) Cancer Centers or any other out of network provider.

8. An external appeals process for cancer patients denied coverage of "routine patient care" in cancer clinical trials until the federal requirement for coverage of routine patient care in clinical trials takes effect in 2014.

9. Diagnostic services using all available evidence-based technologies.

10. Individual, comprehensive cancer planning that is communicated by health care professionals both orally & in written form.

11. Palliative & hospice care.

We greatly appreciate your consideration of our recommendations. We would welcome the opportunity to discuss our recommendations further, or answer any questions you may have.

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The National Small Business Association

Statement of Todd McCracken
on behalf of
The National Small Business Association
regarding
Implementation of Health Insurance Exchanges
before the
Health Subcommittee of the House Ways and Means Committee
September 12, 2012

My name is Todd McCracken and I am the president of the National Small Business Association (NSBA).[1] The National Small Business Association (NSBA) was founded in 1937 to advocate for the interests of small businesses in the U.S. It is the oldest small business organization in the U.S. The NSBA represents more than 65,000 small businesses throughout the country in virtually all industries and of widely varying sizes.

NSBA Supports Voluntary Health Insurance Exchanges

Provided that participation in the exchange is voluntary, the NSBA supports state level health insurance exchanges as a reasonable step designed to improve the competitiveness of the health insurance market, to increase the information available to health insurance purchasers (whether individual consumers or small businesses) and to constrain health insurance costs.[2]

We want health insurance exchanges to be a success.

Exchange Implementation is Inadequate for Success

We are concerned that the implementation of health insurance exchanges is, to date, inadequate for success.[3] Present regulatory guidance leaves open over a hundred significant unanswered questions.[4] This will hinder the ability of states to implement the exchanges and the willingness and ability of insurers to participate in the exchanges. Time is running very short.

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[1] 1156 15th St., NW, Suite 1100, Washington, DC 20005. (202) 293-8830.

[2] Health insurance exchanges are, essentially, a structured marketplace where relatively standardized health insurance policies are offered by insurance companies and complete information disclosure is required in a standardized format. Section 1311(b) of the Patient Protection and Affordable Care Act (PPACA) requires that states establish an "American Health Benefit Exchange" that meets approximately 10 criteria. If they do not, then the federal government will establish a federal health insurance exchange in the state.

[3] The primary guidance issued to date is contained in three documents: (1) "Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans," Federal Register, Volume 76, Number 136 (Friday, July 15, 2011) (2) "Patient Protection and Affordable Care Act: Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers," Federal Register, Vol. 76, No. 159 (Wednesday, August 17, 2011) and "General Guidance on Federally-facilitated Exchanges," HHS, May 16, 2012. NSBA has provided detailed comments on all three documents.

[4] See "Open Issues From HHS Guidance and Regulations on Exchanges," August, 2012, Choice and Competition Coalition (CCC). Available at http://4f5af795897ec8db96a9-d1d3a2eb28ffdfd2c4ddf8fc44e87179.r41.cf1.rackcdn.com/List_of_ACA_Implementation_Tracking_8-3-12.pdf NSBA is a member of CCC. http://www.choiceandcompetitioncoalition.org/.

States are required to submit a blueprint to the Department of Health and Human Services (HHS) documenting their plan for establishing an Exchange no later than November 16, 2012 for the 2014 plan year. HHS must approve or conditionally approve state-based Exchanges no later than January 1, 2013. Open enrollment in the exchanges begins on October 1, 2013.

Key Open Issues

The open issue of the most direct importance to small firms is whether HHS intends for employers offering insurance through Small Business Health Options Programs (SHOPs) component of exchanges to be able to determine what insurance is being offered to their employees and on what terms. Small businesses should be provided the option to choose which plan or plans they will offer their employees. Retaining this degree of control over their health insurance costs, and the type of insurance offered, is very important to small firms. If they do not retain effective control over what insurance is offered, fewer small businesses will participate and the SHOPs are much less likely to succeed whether the SHOP is a federally facilitated SHOP or partnership SHOP. HHS should clarify that small business participants in the SHOP will be able to choose what insurance is offered to their employees. This recommendation is consistent with the Final Exchange Rule, which allows exchanges to permit employer choice of one or more Qualified Health Plans (QHPs). This is the single most important concern of small businesses.

There are, however, a host of other issues that must be resolved for states and insurers to build effective exchanges.[5] Important open issues include (1) the criteria for HHS approval of a state exchange, including details for conditional approval, (2) processes for integrating eligibility systems with the federal data services hub, (3) the transaction standards for enrolling individuals into qualified health plans, (4) the mechanism for coordination of premium payments within mandated premium aggregators, (5) how to determine "affordability" for assessing penalties on employers when individuals receive an exchange subsidy, including whether affordability will be measured for employee dependents, (6) essential health benefits requirements and (7) how to determine actuarial value for issuers and states for purposes of determining whether a product complies with the required metallic levels (bronze, silver, gold or platinum). Without answers to these questions, the exchanges will not function properly.

Comments on Other Specific Open Issues

The HHS Federal-Facilitated Exchange Guidance White Paper[6] states that "[t]o ensure a robust QHP market in each State where an FFE operates, and to promote consumer choice among QHPs, at least in the first year HHS intends to certify as a QHP any health plan that meets all certification standards. In future years, HHS will analyze the QHP certification process and may identify improvements or changes to this process." (at page 8) NSBA supports allowing any QHP that meets all certification standards to sell insurance on the exchanges. We have urged HHS not to reverse this policy decision after the first year (as it appears to be considering). In fact, a permanent unrestricted market is likely to induce more insurance companies to offer

[5] Ibid.
[6] "General Guidance on Federally-facilitated Exchanges," HHS, May 16, 2012.

insurance in more markets at lower costs since they will be assured that they will be able to recover their start up costs (notably design, actuarial, legal, training and regulatory approval costs) over a longer period. Thus, the sooner that HHS makes it clear that exchanges are permanently open to all QHPs, the better. It is hard to believe that any other policy will lead to lower health insurance costs. This is an example of a situation where enhanced insurance company profitability and lower consumer costs are achieved by the same policy.

The Guidance White Paper states that "HHS expects that licensed agents and brokers will continue to assist consumers in accessing health insurance, and will work with agents and brokers to promote enrollment through the Exchange." (at page 16) "HHS anticipates that agents, brokers, and other producers will be a primary channel small businesses use to access coverage through an FF-SHOP. In addition to providing assistance with enrollment activities, HHS anticipates that agents and brokers will continue to be a primary point of contact for a variety of administrative, billings, and claims-related issues, and will work with FF-SHOPs to assist their clients in resolving these issues." (at page 17)

Insurance agents and brokers are very important to helping make exchanges a success. They play a crucial role in educating their customers and constructively framing choices for small businesses. A vibrant and healthy role for them in the insurance marketplace should be retained.

The Guidance White Paper states that:

> QHP issuers participating in an FFE will be required to be accredited by an accrediting entity and comply with quality reporting requirements that HHS will specify in future rulemaking. HHS intends to propose a phased approach to accreditation and quality data reporting and display in an FFE to accommodate new QHP issuers and Medicaid plans without Exchange or accreditation experience.
>
> HHS also intends to propose a phased process for recognizing accrediting entities. In phase one, the entities that HHS believes will be equipped to provide the statutorily required accreditation review by 2013 certification – the National Committee for Quality Assurance (NCQA) and URAC – would be recognized as accrediting entities on an interim basis subject to conditions. In phase two, we would adopt an application and review process for the recognition of additional accrediting entities. We intend to propose that an FFE will accept existing health plan accreditation from NCQA and URAC on issuers' commercial or Medicaid lines of business in the same state in which the issuer is seeking to offer Exchange coverage until the fourth year of certification (for example, 2016 certification for the 2017 coverage year). HHS intends to propose that QHP issuers without this existing accreditation must schedule this accreditation in their first year of certification and be accredited on QHP policies and procedures by the second year of certification. By the fourth year of certification, all QHP issuers must be accredited on the QHP product type having fulfilled the requirements to submit performance data to the accrediting entity. (p. 11)

This contemplated delegation of regulatory authority to various non-governmental actors raises the question of governance, and effective control, of the accrediting agencies. It is also not clear how open and transparent their decision-making process would be. We have cautioned against this delegation without a thorough discussion of who will effectively control these accrediting agencies and whether such delegation is advisable in the first place. We would also note that have an accrediting agency approval noted on the exchange web site is one thing (its seal of approval, if you will). Mandatory compliance and effective delegation of critical regulatory authority is another. Finally, it is not clear that the accrediting agencies will add much to the process other than an additional layer of compliance costs and regulation (in addition to state and federal regulation of insurance markets).

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Mr. McCracken submits this statement in his capacity as President of the National Small Business Association

Additional biographical information is available at http://www.nsba.biz/?page_id=12 .

Timothy Stoltzfus Jost

House Committee on Ways and Means

Implementation of Health Insurance Exchanges and Related Provisions

Testimony of Timothy Stoltzfus Jost
Professor, Washington and Lee University School of Law

Submitted for myself and not for any organization

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House Committee on Ways and Means

Implementation of Health Insurance Exchanges and Related Provisions

Testimony of Timothy Stoltzfus Jost

In a little more than a year, millions of uninsured Americans will begin enrolling in health insurance plans through the American Health Benefits Exchanges. These Americans—your constituents—will be able to purchase health insurance because of the availability of premium tax credits. At this point, it appears that many states are choosing not to create their own exchanges in 2014, but rather to have their citizens purchase health insurance through federally facilitated exchanges. It is essential that these uninsured Americans be able to receive premium tax credits through these federal exchanges. My testimony addresses the provisions of the Affordable Care Act that will make it possible for this to happen.

My name is Timothy Stoltzfus Jost and I am a law professor at Washington and Lee University. I am also a consumer representative to the National Association of Insurance Commissioners and an elected member of the Institute of Medicine. I have written extensively about the Affordable Care Act, and blog regularly about Affordable Care Act implementation at www.healthaffairs.org/blog.

My remarks today address assertions by Michael Cannon of the CATO institute that the Department of the Treasury's rule providing for the federal exchange to issue tax credits is not authorized by the Affordable Care Act. This assertion has been widely publicized and seems to be causing confusion among state lawmakers. Mr. Cannon's position, however, is based on a misunderstanding of the law, its structure, and history, as I will explain.

The Affordable Care Act Exchanges and Premium Tax Credits

To understand this issue it is necessary to understand the role of the exchange in the Affordable Care Act. The American Health Benefits Exchange is fundamentally a market in which health insurance is bought and sold. The exchange is also responsible for ensuring that insurers who sell their products through the exchange meet certain minimum standards to ensure that individuals and small employers who purchase in the exchange are getting value for their dollar. Finally, the exchange is the gateway to federal premium tax credits, Medicaid, and other assistance programs for those unable to afford health insurance. The exchange concept has until very recently enjoyed broad bipartisan support as a tool for making private sector health insurance widely available and affordable to Americans. Indeed, Congressman and Vice President nominee Paul Ryan's Roadmap for America includes health insurance exchanges.

Section 1311 of the Affordable Care Act asks the states to establish American Health Benefits Exchanges. The federal government cannot order a state to operate a federal

regulatory program, so section 1321 of the ACA authorizes the Secretary of Health and Human Services to establish a federally facilitated exchange in states that choose not to establish their own exchange.

Mr. Cannon takes the position that federal exchanges cannot offer premium tax credits. He bases this opinion on two subsections of section 36B of the Internal Revenue Code (created by section 1401 of the ACA), which provides for tax credits to help middle-income Americans afford health insurance. In defining the premium tax credit amount and the coverage months for which it is available, sections 36B(b)(2) and 36B(c)(2)(A) refer to persons "enrolled in [a qualified health plan] through an Exchange established by the State under section 1311." Mr. Cannon argues that this language precludes premium tax credits being issued through the exchanges operated in the states by the federal government. If this is true, it is likely that many—perhaps most--Americans will be denied access to an important middle-class tax benefit in 2014, as it now appears that many states will, at least initially, have federally facilitated exchanges.

In a recent article, Mr. Cannon, together with Professor Jonathan Adler of Case Western University, claims that this language is not only unambiguous but also intentional, that Congress intended to punish states that refused to establish exchanges by refusing premium tax credits to their residents.[1] Cannon and Adler further claim that final rules promulgated by the IRS making premium tax credits available through federal as well as state exchanges are unauthorized by law, and thus illegal.

If this claim is true, uninsured constituents of members of this committee stand to lose billions of dollars in federal tax relief that would have assisted them in purchasing health insurance.

The Affordable Care Act Explicitly Authorizes Federal Exchanges to Provide Premium Tax Credits

Fortunately for your constituents, Mr. Cannon's claims are simply not true. If the sections that he cites were the only relevant sections of the Affordable Care Act, and if the legislative history and structure of the ACA could be simply ignored, his statutory construction claim would be plausible. But the availability of tax credits through federally facilitated exchanges is recognized through the language of the ACA itself. Moreover, the legislative history of the ACA also establishes that Congress understood that premium tax credits would be available through both federal and state exchanges. The IRS is explicitly authorized by Congress to interpret the statute and its interpretation of the law will be given deference by the courts. The existence of exchanges in every state was assumed both by the Congressional Budget Office and by both proponents and opponents of the ACA as it was being debated. Finally, the structure and purpose of the ACA requires that state or federal exchanges offer premium tax credits in every state.

I begin with the language of the ACA itself. The term "exchange" is a defined term under the ACA, a point that Mr. Cannon does not mention in his article but that would surely be paid great attention by the courts. Section 1563(b) of the ACA states: "The

term 'Exchange' means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act." Section 1311 literally requires that the states "shall" establish an American Health Benefits Exchange by January 1, 2014. Because the Constitution prohibits the federal government from literally requiring states to establish exchanges, however, section 1321(c), provides that "the [HHS] Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate *such* Exchange within the State." Under the ACA's definition of exchange, the term "Exchange" in section 1321 means a section 1311 exchange. This is reinforced by section 1321 itself, in which the term "such Exchange," refers to the "required exchange" mentioned in section 1321(c)(1)(B)(i), which is to say the 1311 exchange. When section 1321 directs HHS to establish an "Exchange," therefore, it means to establish a section 1311 exchange, which section 36B authorizes to provide premium tax credits. Moreover, section 1311(d)(1) defines an exchange as an exchange established by the state, therefore by definition a section 1321 federally facilitated exchange is an exchange established by a state under section 1311.

Section 36B is not the only section of the ACA that imposes duties on the state and federal exchanges relevant to premium tax credits. Section 1311(d)(4)(G) requires exchanges to provide their enrollees with premium calculators that include a deduction for premium tax credits. Section 1311(d)(4)(I), requires exchanges to forward to the IRS information about enrollees who are eligible for premium subsidies. Section 1311(d)(4)(J), requires an exchange to notify employers if their employees are receiving premium tax credits. Finally, section 1413 requires state and federal exchanges to use streamlined applications and eligibility assessments to help people qualify for "health subsidy programs," which programs specifically include premium tax credits, see section 1413(e)(1). All of these sections apply to federal as well as state exchanges.

Most importantly, a third subsection of section 36B itself clarifies that premium tax credits are available through both state and federal exchanges. The ACA is composed of the Senate version of the Patient Protection and Affordable Care Act, Public Law 111-148, and the Health Care and Education Reconciliation Act, Public Law 111-152. The Senate adopted the bill that became Public Law 111-148 in December of 2009, but the House adopted it only in March of 2010. Shortly thereafter, the House and Senate adopted HCERA, through which the House made certain changes in the Senate bill. As a later-adopted statute, HCERA takes precedence over that of the PPACA, if there is a contradiction. Moreover, since the adoption of HCERA was necessary to secure House adoption of the Senate bill, it is doubly important that the provisions of HCERA be taken seriously. The House bill contained only a federal exchange. Section 1004 of HCERA adds to IRC section 36B, subsection 36B(f)(3) which requires both 1311 and 1321 exchanges to provide certain information regarding premium tax credits to the IRS and to taxpayers. Cannon and Adler admit the existence of this provision but simply say it is meaningless, as 1321 exchanges cannot authorize premium tax credits. This position, however, violates another canon of statutory construction—that every provision of a congressional enactment should be given effect.

It should be noted that several other sections of the ACA use the language on which Mr. Cannon relies--"an Exchange established by the State under section 1311." One of them is section 2001, which prohibits states from reducing Medicaid eligibility until an exchange "Established by the State under section 1311" is operational." If Mr. Cannon's interpretation of the ACA is correct, states that decide not to establish a state exchange will be barred indefinitely from changing their Medicaid eligibility requirements. But this is not what the law means.

The Affordable Care Act's Legislative History also establishes that Federal Exchanges can offer Premium Tax Credits

Mr. Cannon's interpretation of the ACA is also refuted by the legislative history of the ACA. The Senate bill which became the ACA was derived from the S 1679,[2] the Senate Health, Education, Labor and Pensions Committee bill and S 1796[3] which emerged later from the Senate Finance Committee. Each of these bills included state and federal exchanges, which were called Gateways in the HELP bill.

The HELP bill (section 142, adding section 3104 of the Public Health Services Act) created an elaborate structure under which states could either establish exchanges themselves ("establishing states"), request the federal government to establish an exchange in the states ("participating states"), or fail to do either, in which case four years after the enactment of the statue the federal government would create a fallback exchange in the state. Premium tax credits were available in establishing and participating states, but would only be available through the federal fallback exchanges in states that complied with the employer responsibility provisions for state and local employees. In other words, the states were threatened with loss of premium tax credits, not for failing to establish exchanges but for not complying with the employer responsibility provisions for their employees.

The Finance Committee bill did not use this elaborate structure. In fact, the rules it creates are very similar to the final ACA. It creates section 2235 of the Social Security Act, which provides that states "shall" establish an exchange, and sets out the duties of the exchange. Section 2225(b) provides, in language very similar to current ACA section 1321, that HHS shall contract with a nongovernmental entity to operate an exchange in states that fail to "establish and operate" an exchange in states that fail to create one within 24 months. The Finance Committee Report[4] refers to these federally established exchanges as "state exchanges." In a number of places, including the precursor of the current premium tax credit provision, the bill refers to exchanges "established by the state," but nowhere does it provide, as did the HELP bill, that premium tax credits would not be available in the any of the exchanges created by the federal government.

The provisions of the current ACA addressing this issue are taken largely from the Finance Committee bill, which makes sense because the Finance Committee has jurisdiction over tax matters. The punitive provisions of the HELP bill were abandoned.

The Senate debated the ACA extensively during November and December 2009. The version of the Act they were considering included both state and federal Exchanges. Throughout the debate, Senators assumed that tax credits would be available in all 50 states. Thus Senator Bingaman stated on December 4, 2009, that the ACA "includes creation of a new health insurance exchange in each State which will provide Americans a centralized source of meaningful private insurance as well as refundable premium tax credits to ensure that coverage is affordable."[5] Senator Johnson stated on December 17, "the legislation will also form health insurance exchanges in every State," which will "provide tax credits to significantly reduce the cost of purchasing that [insurance] coverage."[6]

If Congress had meant to limit premium subsidies to state-established exchanges, as an incentive to States, one would have expected the Finance Committee report on S. 1796 to have mentioned this, and for at least one Senator to have pointed this out during the debate in November and December 2009.

Most importantly, the Congressional Budget Office (together with the Joint Committee on Taxation) provided Congress on November 30, 2009, with an analysis of the impact of the legislation on premiums that assumed that premium tax credits would be available in all states, making no distinction between federal and state exchanges.[7] Over the next few days this analysis was discussed by Republican Senators Grassley,[8] Enzi,[9] and Coburn.[10] None raised what Cannon and Adler see as an obvious point—that the CBO analysis was flawed because it failed to recognize that premium tax credits would not be available though federally facilitated (sec. 1321) exchanges. In fact, the CBO repeatedly provided cost estimates of the ACA and HCERA in late 2009 and early 2010, but never suggested that premium tax credits might be reduced if states failed to establish exchanges. In their most recent report from two weeks ago updating ACA coverage estimates in the wake of the Supreme Court decision, the CBO and JCT reiterates again that premium tax credits will be available though state, federal, and partnership exchanges.[11] As Yale Professor Abbe Gluck notes in a recent blogpost[12] (and forthcoming article), Senators often don't listen to each other, but they all listen to the CBO, which assumed that premium tax credits would be available to all Americans in all states.

Mr. Cannon claims, however, to have found a smoking gun, a colloquy between Senators Baucus and Ensign during the Finance Committee debate on the bill, in which, they claim, Senator Baucus admits that premium tax credits could not be made available through federal exchanges. In fact, the colloquy had nothing to do with federally facilitated exchanges, but rather with whether the Finance Committee or the Judiciary Committee had jurisdiction over malpractice reform legislation that Ensign wanted to attach to the bill. In fact, there is nothing in the legislative history of the ACA that supports the notion that premium tax credits will not be available through federal exchanges.

Mr. Cannon argues that Congress prohibited the federal exchanges from offering premium tax credits as a way of encouraging the states to adopt exchanges. It is in fact

clear that Congress favored state exchanges, and offered generous grants to the states—which to date have totaled nearly $850 million dollars with more on the way.[13] States that fail to establish exchanges will also lose some control of their insurance markets. But Congress did not try to "coerce" states to create state exchanges by threatening their citizens with loss of billions of dollars of premium tax credits. Indeed, under the Supreme Court's recent Medicaid decision, such coercion might have been suspect.

The Structure of the Affordable Care Act Makes it Clear that Federal Exchanges may offer Premium Tax Credits

Moreover, not only do a number of provisions of the ACA, already described, refer explicitly to federal and state exchanges performing functions relating to premium tax credits, but the entire structure of the ACA's insurance reforms are based on the availability of premium tax credits in all states, The ACA's guaranteed issue and community rating requirements apply to insurers in all states, regardless of whether they have federal or state exchanges. So do the ACA's risk mitigation programs. So does the ACA's individual mandate. The premium tax credits are intended to bring millions of new participants into insurance markets, and if they are not available in many states, the nature of insurance markets will change dramatically, increasing the risk of insurers and decreasing availability to middle-income Americans. If this was the intent of Congress, it surely would have made it far more evident.

The ACA is admittedly not a model of clear drafting. It contains three sections with the same number (1563) and amends an existing provision of the Public Health Services Act inconsistently twice within the scope of a few pages. The Senate bill was not supposed to be the final law. Only Senate the election in Massachusetts in early 2010 made a conference committee bill that would have reconciled the House and Senate versions and cleaned up the current bill impossible. The courts are unlikely to find the "established by the state" language a "scrivener's error." But the courts will interpret the ambiguous language in the context of the ACA's structure and purpose, in light of the ACA's legislative history, and putting great weight on the HCERA amendment, and find that federally facilitated exchanges can in fact issue premium tax credits.

The Department of the Treasury is Authorized to Interpret Section 36B and the Courts will Defer to its Interpretation

Finally, the courts are likely to grant great deference to the IRS premium tax credit regulation. Section 36B explicitly grants authority to the IRS to interpret the section. A recent CRS Legal Analysis of this issue states clearly that under the ruling "Chevron doctrine," derived from the case of Chevron v. NRDC,[14] courts will defer to the interpretation of the IRS of section 36B unless they conclude that "Congress has spoken to the precise question at issue." As should by now be amply clear, Congress has not clearly said that federal exchanges cannot grant premium tax credits. If a court finds the issue ambiguous, however, "the question for the court is whether the agency's answer is based on a permissible construction of the statute." In this situation, "legislative

regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." As noted above, the interpretation of the ACA by the IRS is completely consistent with rather than "manifestly contrary" to the statute, and thus will be granted judicial deference.

Conclusion

In 2014, millions of your constituents will gain access to private health insurance coverage with assistance with premium tax credits. It was the hope of Congress and remains the hope of the federal agencies implementing the ACA that they will receive these premium tax credits through state exchanges. But the ACA also created fallback federal exchanges, which will be available in states represented by other members of this Committee to ensure that all Americans get access to affordable health insurance. The Department of the Treasury has correctly determined based on the language and history of the ACA that premium tax credits will be available through all exchanges, state and federally facilitated. None of your constituents will be denied the tax credits made available through the ACA to ensure them access to affordable health insurance. I thank you for the opportunity to address this important issue.

References

[1] Jonathan Adler and Michael Cannon, Taxation without Representation: The Illegal IRS Rule to Expand Tax Credits Under the PPACA (2012), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2106789
[2] S 1679, http://www.govtrack.us/congress/bills/111/s1679/text
[3] S 1796, http://thomas.loc.gov/cgi-bin/query/z?c111:S.1796:/
[4] Senate Report 111-89
[5] 155 Cong. Rec. S12358.
[6] 155 Cong. Rec. S13375.
[7] CBO, An Analysis of Health Insurance Premiums Under the Affordable Care Act, http://www.cbo.gov/publication/41792
[8] 155 Cong. Rec. S12107, 12/2/09
[9] 155 Cong. Rec. S12378, 12/4/09
[10] 155 Cong. Rec. S13687
[11] http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf at n. 14.
[12] http://balkin.blogspot.com/2012/07/cbo-canon-and-debate-over-tax-credits.html,
[13] http://statehealthfacts.kff.org/comparetable.jsp?ind=954&cat=17
[14] 467 U.S. 837 (1984).

Walter H. Wood MD

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September 14, 2012

To: Chairman Wally Herger
Ways and Means Subcommittee on Health

From: Walter H. Wood, MD
American Association of Physicians and Surgeons
Citizens Council for Health Freedom
American Academy of Dermatology

Subject: OPPOSE and do not fund health insurance exchanges

Dear Chairman Herger:

Please OPPOSE implementation of government run health insurance exchanges. Government has no business dictating health insurance requirements to free citizens.

Sincerely,

Walter H. Wood, M.D.

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