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ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

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May 13, 2013

Mr. Gary Cohen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Cohen:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Wednesday, April 24, 2013, to testify at the hearing entitled "The Center for Consumer Information and Insurance Oversight and the Implementation of the Patient Protection and Affordable Care Act."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Tuesday, May 28, 2013. Your responses should be e-mailed to the Legislative Clerk in Word format at brittany.havens@mail.house.gov and mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

Attachment—Additional Questions for the Record

The Honorable Fred Upton

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

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

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

4. Have any CCIIO employees been furloughed in 2013?

The Honorable Marsha Blackburn

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

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

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

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

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

The Honorable Diana DeGette

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

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

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

The Honorable Ben Ray Luján

1. The Affordable Care Act called for the creation of Consumer Operated and Oriented Plans or CO-OPs, which will be offered on the health insurance exchanges as nonprofit insurance providers to compete with other carriers in the individual and group markets. This February, the co-op that will operate on my home state's exchange, New Mexico Health Connections received its certificate of authorization from the state insurance Superintendent, making it the first new health insurance company licensed by the state in 8 years. The progress of New Mexico Health Connections has been remarkable-they have announced that they will be

ready to offer policies beginning on October 1 when the state exchange first opens for business-and they couldn't have done it without the help of CCIIO.

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

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

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

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

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

4. One of the goals of the ACA was to ensure that none of our constituents fell through the cracks of our complex healthcare system. Congress enacted a number of protections into the bill to ensure patients have access to the care they need. As the exchanges open for business later this year, I want to be sure that we continue to keep those promises to patients, particularly those who suffer from rare diseases. Many of these patients require specialized care. What are you doing to ensure that qualified health plans operating in the exchanges will have robust networks of providers so that my constituents are not left with few or no options for treatment for their rare diseases?

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

<u>The Honorable G.K. Butterfield</u>

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

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

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

4. I understand the navigators will provide help to customers through the eligibility and enrollment process. For a low income, African American from Roanoke Rapids, North

Carolina with hereditary medical issues, will the navigators be able to provide suggestions about the best plans to fit their health care and financial needs?

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

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

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

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

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

The Honorable Paul Tonko

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

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

3. Along with promulgating a final rule, there are significant concerns that the administration is not doing enough to enforce the interim final regulations that are already in place. Just this

week, an employee from CCIIO was quoted in an article in CQ Weekly, speaking in front of representatives of the health insurance industry that mental health parity was, "an area where we plan on setting the dials pretty low." I find this attitude to be very troubling. Can you please explain what was meant by this statement and speak generally to the Administration's posture towards MHPAEA enforcement?

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

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

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

<u>The Honorable Gene Green</u>

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

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