

Rep. Joseph R. Pitts
Opening Statement
Energy and Commerce Subcommittee on Health
Hearing on “Cutting the Red Tape: Saving Jobs from PPACA’s Harmful
Regulations.” (MLR and Grandfather regulations)
(As Prepared for Delivery)

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“If you like your current plan, you will be able to keep it. Let me repeat that: If you like your plan, you’ll be able to keep it.” (President Obama, remarks at White House, 7/21/09)

“If you like your insurance plan, you will keep it. No one will be able to take that away from you. It hasn’t happened yet. It won’t happen in the future.” (President Obama, remarks April 2010)

Despite these repeated claims, it has become abundantly clear that the “if you like it, you can keep it” promise to the American people has been broken.

By the Administration’s own estimates, 49 to 80 percent of small-employer plans, 34 to 64 percent of large-employer plans, and 40 to 67 percent of individual insurance coverage will not be grandfathered by the end of 2013.

A May 2011 Price Waterhouse Coopers survey of employers also echoes the Administration’s warnings.

Of note, 51% of employers surveyed did not expect to maintain grandfathered health status, meaning their employees would forfeit their current coverage and pay higher premiums due to the health care law’s mandates on their new coverage.

Because grandfathered plans are subject to many of PPACA’s requirements, employers today are forced to pay more to keep their current grandfathered plans, shop for more expensive plans, or drop coverage for their employees altogether.

The Discussion Draft before us today simply prevents the Administration from implementing its June 17 interim final rule and it prevents the Administration from imposing any standards or requirements, as a result of PPACA, on grandfathered health plans.

That way, consumers who really do like the coverage they have, really get to keep it.

As for the Medical Loss Ratio (MLR), Section 1001 of PPACA requires health plans to spend 80 percent (for plans in the individual and group market) and 85 percent (for large group plans) of premium revenue on medical care, beginning this year.

Plans that fail to meet these thresholds are required to rebate the difference to their consumers.

Supporters of this section claim the medical loss ratio (MLR) regulation was designed to protect consumers from unscrupulous insurance companies. However, it actually contains perverse incentives for insurance companies to ignore waste and fraud, which drives up premiums and copayments for consumers.

Under the regulation, investments in fraud detection, and even quality improvement and care coordination, fall under “administrative expenses,” which can only make up 20 percent of a plan’s spending.

Plans struggling to make the 80 or 85 percent threshold for medical costs often can’t risk these activities – which could save consumers money and provide them with a higher quality of care – for fear of being penalized and having to pay rebates.

Even worse, if a plan does identify fraud, cutting those fraudulent payments and activities actually reduces their amount of spending on medical costs, making it even harder for them to reach the 80 or 85 percent threshold.

Consumers, not HHS and government bureaucrats, should be deciding what health care spending is appropriate and what health care spending is not appropriate for their plans.

Plans should be able to invest in waste, fraud, and abuse detection without worrying if that spending puts them in violation of a government regulation. And consumers should be free to select those plans that share *their* priorities, not the government’s.

Again, while the MLR has been billed as a tool to protect consumers from insurance companies, many states are clamoring for waivers to exempt their citizens from these “protections.”

The Secretary of HHS is empowered to grant MLR waivers to states that can prove that meeting the 80 or 85 percent thresholds will destabilize its insurance market.

Currently, HHS has granted MLR waivers to five states – Maine, New Hampshire, Nevada, Kentucky, and Iowa.

With these waivers, consumers in these states are now protected from one of the health care law’s key “consumer protections.”

Residents of North Dakota and Delaware are not as lucky. HHS rejected their waivers.

Nine more states – Florida, Georgia, Louisiana, Kansas, Indiana, Michigan, Texas, Oklahoma, and North Carolina – have determined that their insurance markets will be destabilized by having to comply with the MLR regulation and have applied for waivers.

They are still waiting to hear back.

The MLR regulation is also costing jobs at a time when unemployment remains stubbornly above 9 percent.

HHS’ interim final rule on MLR includes health insurance agent and broker commissions in the “administrative costs” category. Many plans, desperate to meet the 80 or 85 percent threshold simply cannot afford to use brokers and agents as they once did.

One estimate from the National Association of Health Underwriters suggests that more than 20 percent of agents will have to downsize their businesses as a direct result of this calculation.

I strongly support H.R. 2077, introduced by Dr. Tom Price and Rep. Cathy McMorris Rodgers, which repeals the section of the Public Health Service Act dealing with MLR requirements, which was added by the new health care law, and I would urge my colleagues to support it.

Finally, I would like to thank all of our witnesses for being here today, and I yield back my time.