THE HEALTH OF THE PRIVATE HEALTH INSURANCE MARKET

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

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THE HEALTH OF THE PRIVATE HEALTH INSURANCE MARKET

TUESDAY, SEPTEMBER 23, 2008

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

The Subcommittee met, pursuant to notice, at 10:16 a.m. in room 1100, Longworth House Office Building; Hon. Fortney Pete Stark, (Chairman of the Subcommittee), presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
September 16, 2008
HL–30

CONTACT: (202) 225–3943

Hearing on The Health of the Private Health Insurance Market

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) announced today that the Subcommittee on Health will hold a hearing on problems in the private health insurance market, with a focus on the need for reforms in the non-group or individual market. The hearing will take place at 10:00 a.m. on Tuesday, September 23, 2008, in the main committee hearing room, 1100 Longworth House Office Building. In view of the limited time available to hear 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 Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Over 46 million Americans are uninsured, and many cannot purchase coverage in the market today because it is too costly or unavailable at any cost because of pre-existing conditions. While most insured Americans under age 65 obtain health care through private insurance plans, too many face eroding coverage and high and increasing costs.

About 170 million people purchase insurance coverage through an employer and 16 million through the individual market.[1] Eight million Federal employees, dependents and retirees also get their coverage through publicly-subsidized private plans in the Federal employee health benefits program (FEHBP); the average Federal employee chooses coverage from among 5 to 15 available plans (depending on the region).[2]

In general, private plans attempt to control costs by minimizing risks and spending. Plans try to balance the financial and health care risks of very sick individuals with healthy individuals. Once people are covered, most plans control costs through cost-sharing strategies and by limiting coverage of services and providers. Some plans have used innovative cost control tools such as deployment of health information technology, focusing on more effective disease management treatment for people with chronic illnesses, and creating integrated health care delivery systems.

Rising health care premiums and rising numbers of employers dropping insurance coverage are a growing concern even for those with adequate coverage today. Furthermore, many small employers and those who try and purchase health care on their own are experiencing significant problems as they try to obtain coverage. To avoid adverse selection, individual and small group market insurance products use a patient's medical history to screen out those whose pre-existing medical conditions pose a risk for the risk pool. By refusing to cover people with pre-existing conditions or excluding all care for any related health problem, most insurers avoid risk at the onset. In practice, this means that people with even minor illnesses may find their coverage unaffordable, inadequate, or completely non-existent at any price. For example, removal of a small skin lesion could negate any coverage for cancer treat-

[1] Census data.
[2] CRS Report for Congress Federal Employees Health Benefits Program: Available Health Insurance Options, November 26, 2007.

ment. Simply being a woman of "child bearing age" often results in an insurer excluding maternity coverage in the small group and individual markets.

In announcing the hearing Chairman Stark said, **"As we seek to reform our health care system, we need to be sure our solutions meet the needs of the millions of Americans who have coverage today as well as the millions who are uninsured. While I expect private health insurance will remain part of any reformed system, the purpose of this hearing is to highlight that major changes will be necessary to ensure affordable, comprehensive coverage for everyone."**

FOCUS OF THE HEARING:

This hearing is focused on challenges of the private health insurance market.

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 "110th Congress" from the menu entitled, "Committee Hearings" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). 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." Follow the online instructions, completing all informational forms and clicking "submit". Attach your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Tuesday, October 7, 2008**. 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.

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 or WordPerfect 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.

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

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.

Chairman STARK. I apologize for the delay. We have just solved the Wall Street crisis here before we started on the second crisis for the day.

Thank you for being here, and we are going to talk about healthcare payment system through the private insurance companies, whether group or independent policies. And this is a segment of the payment industry through which most Members of Congress and our staffs receive their care. As we are trying to lay the groundwork for possible healthcare reform or healthcare payment reforms in the years ahead, it's important that we examine this very large sector of our payment system. As we do see from the events of this past week, the case for reasonable regulation, not relying totally on self-regulation or letting people just fend for themselves in a complex market, doesn't seem to be a very good solution to follow.

Right now, the payment market is failing some 40-odd-million uninsured for a variety of reasons. The people who are uninsured are not necessarily there because they don't want insurance. Many of them can't afford it. Many of them can't find it because of preexisting conditions. And we'll hear from witnesses this morning about how to deal with that problem.

Even those of us who enjoy a payment plan through large employers face problems. Premiums are increasing faster than wages. The employers are shifting some of those costs onto the beneficiaries who hire deductibles and copayments. And we'll hear today about issues in dealing with those problems. So I want to welcome the witnesses and I look forward to the witnesses informing us as both their definition of the problems we face and how they suggest that we deal with it.

Mr. Camp.

Mr. CAMP. Well, thank you, Mr. Chairman, and thank you for convening this hearing on the private health insurance market. And regardless of what happens in November, comprehensive healthcare reform should be near the top of our to-do list in 2009.

And I strongly believe that any plan for reforming our Nation's healthcare system must include conversations about how to reform the Tax Code so that every American, not just those who have employer sponsored health insurance, can benefit. And we must also look for ways to better utilize the private health insurance market to expand coverage to the millions of uninsured Americans. In doing so, we need to ensure that millions of Americans who are eligible for Medicaid and SCHIP, but are not yet enrolled, get the coverage to which they are entitled.

Every uninsured person in this country shares one common characteristic, and that is they receive no assistance under the Federal Tax Code to help them purchase health insurance in the individual market. We should use the part of the Tax Code to create personal healthcare just as the Tax Code created employer-sponsored healthcare. By equalizing the tax treatment, we can give the millions of Americans in the individual market the ability to purchase quality health insurance.

And I hope that my support for equalizing the Tax Code will not be misconstrued as a desire to move everyone into the private market. That is certainly not my intention. If you're lucky enough to

have employer-sponsored insurance, then you should be able to keep it. And, certainly, there are benefits of employer-sponsored insurance, such as effective risk pooling and administrative savings, which I know we'll hear about from our witnesses today.

However, employer-sponsored insurance also tends to shield consumers from the full cost of the care, which encourages over-consumption of health/sick care services. This in turn contributes to rapid spending growth and higher healthcare costs for everyone. For those people who have no other choice but to purchase insurance in the individual market, we ought to do something that will allow them to choose the health insurance that best meets their needs while receiving financial assistance through the Tax Code.

The generosity of the American taxpayer should not go to employers alone. It should apply to individuals, small businesses, and large corporations alike. But in order to make this work we must study the shortcomings of the private health insurance market, and I trust we'll hear about some of those today.

I welcome the opportunity to discuss what reforms might be needed to make private health insurance more affordable and more accessible to the uninsured, even if we're not comfortable with every suggestion that is put forward. We owe it to our constituents to have an open discussion about reforming the system, so that everyone has equal, affordable access to the best healthcare in the world.

Thank you, Mr. Chairman. I yield back.

Chairman STARK. This morning we will hear from a distinguished panel. Dr. Karen Davis, who is President of The Commonwealth Fund, whose work in the research, funding research in the delivery of medical care, is well known.

From my part of the world, Mr. Bruce Bodaken, who is Chairman and CEO of Blue Shield of California, and has been a proponent for many years for universal coverage for all Americans.

Dr. Roger Feldman, who is the Blue Cross Professor of Health Insurance at the University of Minnesota in Minneapolis.

And Ms. Mila Kofman, who is the Superintendent of Insurance from the state of Maine, the Maine Bureau of Insurance from Augusta.

We welcome you and look forward to you enlightening us in the order I mentioned your names and ask you to try to heed the 5-minute warning and that will give Members of the Committee an opportunity to let you expand on your testimony and your ideas during the periods of inquiry.

Karen, would you like to proceed?

STATEMENT OF KAREN DAVIS, PH.D., PRESIDENT, THE COMMONWEALTH FUND, NEW YORK, NEW YORK

Ms. DAVIS. Thank you, Mr. Chairman, Mr. Camp, and Members of the Committee.

Historically, the U.S. healthcare financing system has been based on shared, financial responsibility among employers, government and households. Unfortunately, the rise in healthcare costs this decade has coincided with an erosion in health insurance coverage and with rising economic insecurity for American families, caused

in part by the shifting of greater financial responsibility for coverage and healthcare directly to families.

Americans' mixed system of private and public health coverage has its strengths and it's worth preserving. However, the trend toward increasing the individual's responsibility for insurance and healthcare is shifting an unacceptable risk onto families. As a consequence, the number of Americans without adequate protection from healthcare expenses has been on the rise.

As the Chairman noted, the number of uninsured has increased 20 percent this decade, now at 26 million. The number of underinsured people has jumped 60 percent over the last 5 years, an estimated 25 million today. Low income adults are hardest hit. Private markets are simply not working for low income adults. The numbers of Americans who faced difficulty paying medical bills and have accumulated medical debt have also risen substantially.

A recent Commonwealth Fund study found that there are 79 million Americans who have difficulty paying medical bills or accumulated medical debt and many of those were insured at the time those expenses were incurred. Managed care plans have increased patient cost-sharing or limited benefits. There are no minimum standards on benefits to prevent people from being under-insured.

Nearly all private insurance in the group market is now some form of managed care; and, while non-profit integrated delivery systems often have superior performance on quality and have been among the leaders in adopting electronic information systems, many other managed care plans do little more than provide discounted fee-for-service plans.

Coverage for employees of small business is particularly troubling. It's eroding in terms of the proportion of firms that are offering any health benefits. It's eroding in the quality of those benefits. The rise in deductibles, especially in small firms shifts risks to patients and those higher deductibles are particularly a burden for the sickest Americans.

Individual health plans represent the weakest part of the health insurance market. Such plans are characterized by high administrative costs, poor benefits, and in most states they exclude poor health risk. Fortunately, the public programs, Medicare, Medicaid, and the State Children's Health Insurance Program, buffer some of the risk to families by covering the elderly, many of the disabled, low income children, and some very low income adults.

Ensuring stable, affordable health insurance coverage for all Americans will require significant increase in the role of government to set the rules for the operation of private markets and reverse the trend toward shifting greater financial risk to families who are unable to bear that risk. Steps should include providing health insurance premium assistance to low income and moderate income families, strengthening, not weakening employer coverage, setting national rules for the operation of individual health insurance markets or creating a national insurance connector such as the one implemented by Massachusetts.

I would also suggest offering a public plan modeled on Medicare to small businesses and individuals, which our studies estimate would lower premiums by 30 percent and increase the stability of insurance coverage. Building on Medicare, Medicaid, and SCHIP to

cover older adults, the disabled who are in the 2-year waiting period for Medicare, and low income adults, as well as children. Private insurance markets do not serve these populations well.

Finally, insurance reforms need to be part of a comprehensive strategy to bring about a high performance healthcare system that achieves better access, improve quality and greater efficiency.

Thank you.

[The prepared statement of Ms. Davis follows:]

Statement of Karen Davis, Ph.D., President, The Commonwealth Fund, New York, New York

The U.S. health care financing system is based on shared financial risk. Employers, federal and state government, and households all share in paying premiums for health insurance coverage. Such coverage is essential to protect individuals from potentially devastating medical bills and to ensure financial access to care. With rising health care costs, insurance is all the more important to prevent families' savings from being wiped out and to make sure that everyone can get the care they need.

Unfortunately, the rise in health care costs this decade has coincided with an erosion in health insurance coverage and with rising economic insecurity for American families caused by the shifting of a greater share of financial responsibility for coverage and health care directly to families. American's mixed system of private and public health coverage has its strengths and is worth preserving; however, the trend toward increasing the individual's responsibility for insurance and health care expenses is shifting an unacceptable level of risk onto families. As a consequence, the number of Americans without adequate protection from health care expenses has been on the rise:

- The number of uninsured Americans has jumped almost 20 percent between 1999 and 2007; today there are 45.6 million uninsured.
- The number of underinsured—people with inadequate coverage that ensures neither access to care nor financial protection—has jumped 60 percent between 2003 and 2007, from 16 million to 25 million.
- Low-income adults have been hardest hit. Nearly three-fourths (72%) of adults with incomes below twice the poverty level are uninsured or underinsured. Private markets are simply not working for low-income adults.
- The numbers of Americans who face difficulty paying medical bills and have accumulated medical debt have also risen substantially, with middle-income families earning less than $60,000 a year being particularly squeezed. In a recent Commonwealth Fund survey, 79 million Americans reported difficulties paying medical bills or accumulated medical debt. About 60 percent of those experiencing medical bill problems were insured at the time they incurred their expenses.
- Managed care plans have increasingly used tiered prescription drug copayments that limit access to more expensive medications. In addition, most managed care plans place limits on mental health outpatient visits and inpatient days.
- It should be noted that private managed care plans come in many shapes and sizes. Nonprofit managed care plans that are part of nonprofit integrated delivery systems—the best-known include Kaiser Permanente, Geisigner Health System, Henry Ford Health System, and Intermountain Health Care—have been found in Commonwealth Fund—supported case studies to have superior performance on quality and have been among the leaders in adopting electronic information systems and quality improvement care processes to deliver better results for patients.
- Coverage for employees of small firms is eroding—both in terms of the proportion of firms offering any health benefits and the quality of those benefits. The rise in deductibles shifts risk to patients; premiums are shared between employers and workers and spread equally among all enrollees but patients are fully responsible for deductible amounts and uncovered services. Higher deductibles are particularly a burden for the sickest Americans, who have the highest medical expenses; they also undermine their ability to get needed care.
- Individual health plans represent the weakest part of the health insurance market. Such plans are characterized by high administrative costs and poor benefits, and, in most states, they exclude poor health risks. Because health expenditures are so skewed—with 10 percent of people accounting for 64 percent of health care outlays—health insurers have a strong incentive to avoid covering

those with health problems, to charge much higher premiums, or to provide policies with very restrictive benefits.

- Fortunately, Medicare, Medicaid, and the State Children's Health Insurance Program buffer some of the risk to families by covering the elderly, many of the disabled, low-income children, and some very-low-income adults. In 1965, Medicare and Medicaid were enacted to cover those who were often left uncovered by private insurance: the elderly and low-income people. Medicare and Medicaid have low administrative costs. Medicaid expenditures per person are lower than costs for privately insured children and adults. Moreover, growth in Medicare spending has been somewhat lower than growth in spending by private insurers over time. Yet Medicare beneficiaries continue to report good access to health care services.

Ensuring stable, affordable health insurance coverage for all Americans will require a significant increase in the role of government to set the rules for the operation of private markets and reverse the trend toward shifting greater financial risk to families who are unable to bear that risk. Action is needed to guarantee affordable coverage that provides adequate financial protection and ensures that individuals can obtain needed care—the two essential functions of health insurance. Steps should include:

- Providing health insurance premium assistance to low-income and modest-income families who cannot afford family premiums, which now average over $12,000 even under employer plans.
- Strengthening, not weakening, employer coverage.
- Setting national rules for the operation of individual health insurance markets or creating a national insurance connector, such as the one implemented by Massachusetts, that makes affordable health insurance policies available to those without access to employer coverage. Structuring insurance choices through rules governing the operation of private markets, or through a health insurance exchange or connector, could ensure the availability of quality, affordable coverage to a larger number of individuals who are either uninsured or have inadequate or unstable coverage, or for whom premiums create major financial burdens.
- Offering a public plan modeled on Medicare to small businesses and individuals would lower premiums by 30 percent and increase the stability of insurance coverage.
- Building on Medicare, Medicaid, and SCHIP to cover older adults, the disabled who are in the two-year waiting period for Medicare, and low-income adults, as well as children. Private insurance markets do not serve these populations well.

Finally, insurance reforms need to be part of a comprehensive strategy to bring about a high performance health care system that achieves better access, improved quality, and greater efficiency. This will require fundamental changes in the way health care providers are paid—changes that help align financial incentives with these goals and create a more organized health system that takes full advantage of modern information technology and evidence-based medicine and spreads best practices. Rather than shifting more financial risk to families, public programs and private insurers alike need to do more, both independently and in collaboration, to slow the growth in health care costs and transform the delivery of health care services to improve quality and enhance value for the money spent on health care.

SHIFTING HEALTH CARE FINANCIAL RISK TO FAMILIES IS NOT A SOUND STRATEGY: THE CHANGES NEEDED TO ENSURE AMERICANS' HEALTH SECURITY

Thank you, Mr. Chairman, for this invitation to testify on private health insurance markets and how they are currently functioning within our nation's mixed system of private and public coverage; the major strengths and weaknesses of this system; and how private markets might be strengthened through the establishment of uniform rules governing the operation of insurance markets, including the benefit of an insurance connector to structure coverage choices for working families.

Unfortunately, the rise in health care costs this decade has coincided with an erosion of health insurance coverage and with rising economic insecurity for American families caused by the shifting of a greater share of financial responsibility for insurance and health care directly to families. The U.S. private—public insurance system has strengths and is worth preserving, but the trend toward increased individual responsibility for insurance and health care expenses is shifting an unacceptable level of risk to American families—with potentially serious consequences. Action is needed to guarantee affordable coverage that provides adequate financial pro-

tection and ensures that individuals can obtain needed care—the two essential function of health insurance.

Since most of the difficulties in the private market are experienced by employees of small businesses and by individuals without access to employer coverage, structuring insurance choices through rules governing the operation of private markets, or through a health insurance exchange or connector, could ensure the availability of quality affordable coverage to a larger number of individuals who are either uninsured or have inadequate or unstable coverage, or for whom premiums create major financial burdens.

Rather than shifting more financial risk to families, public programs and private insurers alike need to do more, both independently and in collaboration, to slow the growth in health care costs and to transform the delivery of health care services to improve quality and enhance value for the money spent on health care.

A Broken System: Growing Numbers of Uninsured Americans

Last month, the U.S. Census Bureau released the latest data on the number of Americans without health insurance. The number of uninsured individuals fell to 45.7 million in 2007, from 47.0 million in 2006.[1] While the new figure represents the first decline since 1999, there are still 7 million more uninsured people now than at the beginning of the decade. Moreover, the decline of 1.3 million uninsured people between 2006 and 2007 was entirely attributable to an equal growth in coverage under Medicaid, a shift that highlights the importance of the nation's safety-net insurance system. In contrast, employment-based coverage declined slightly, from 59.7 percent of the population to 59.3 percent.

The major bright spot in the last eight years has been the improved rate of coverage for children, with the proportion of uninsured children declining from 12.5 percent in 1999 to 11.0 percent in 2007. This improvement was a reflection of increased coverage for children under the State Children's Health Insurance Program (SCHIP). However, more than 8 million children remain uninsured, a figure that underscores the need to permanently reauthorize SCHIP and provide adequate funding to cover all low-income children.

By contrast, the proportion of uninsured adults ages 18 to 64 has increased markedly since 1999, from 17.2 percent to 19.6 percent. The gap between coverage rates for working-age adults and children has widened in the last eight years—in contrast with the 1990s, when rates for both rose in concert. The differential experience for adults, who are not covered by SCHIP, attests to the success of offering states fiscal incentives to cover low-income children. Extending federal financial assistance to states to cover low-income adults could have a similar impact in alleviating some of the most serious health care access problems created by gaps in coverage.

Some states have stepped up to the plate to find ways to cover both children and adults who are uninsured. Massachusetts, which enacted health reform in April 2006 with the help of a Medicaid waiver, has moved into first place, with the lowest uninsured rate in the nation in 2007. In that state, 7.9 percent of the population was uninsured in 2006—2007, compared with 24.8 percent in Texas, the state with the highest uninsured rate. A recent report from the Massachusetts Commonwealth Connector indicates that 439,000 residents have obtained coverage under the Massachusetts health insurance reforms.[2]

Inadequate Coverage: The Rise of the Underinsured

While numerous indicators point to the continued erosion of our employer-based system of health insurance coverage, these statistics fail to count the millions more who experience lapses in their coverage during the year, or the millions of "underinsured" people whose inadequate coverage ensures neither access nor financial protection.[3] Deterioration in insurance coverage and access to care is not limited to the uninsured. Even individuals with insurance coverage are increasingly at risk of being underinsured, defined as deductibles exceeding 5 percent of income, or out-of-pocket expenses exceeding 5 percent of income for low-income families (10 percent of income for higher-income families).[4]

As of 2007, there were an estimated 25 million underinsured adults in the United States, up 60 percent from 2003. Low-income adults are hardest hit. Nearly three-

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[1] C. DeNavas-Walt, B. Proctor, and J. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2007* (U.S. Census Bureau, Aug. 2008).

[2] J. M. Kingsdale, *Executive Director's Monthly Message*, The Massachusetts Commonwealth Connector, Aug. 25, 2008.

[3] C. Schoen, S. Collins, J. Kriss and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008, 27(4).

[4] C. Schoen, S. R. Collins, J. L. Kriss, M. M. Doty, How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007, *Health Affairs* Web Exclusive, June 10, 2008.

fourths (72%) of adults with incomes below twice the poverty level are uninsured or underinsured. Private markets are simply not working for low-income adults.

Only about one-third of working age adults have quality, affordable coverage. Others are uninsured at some point during the year, are underinsured, or report problems obtaining access to needed care or paying medical bills. Together, an estimated 116 million adults fall into one or more of these groups.

Underinsured people—even though they have coverage all year—report access to care and bill problem experiences similar to the uninsured. Both those who are uninsured at some point during the year and those who are underinsured report major difficulties obtaining needed care. Sixty percent of those who are underinsured reported one of four access problems: did not see a doctor when needed medical care, did not fill a prescription, did not see a specialist when needed, or skipped a medical test, treatment, or follow-up service. Seventy percent of those uninsured at some point during the year reported one of these four access problems, contrasted with 29 percent of those who were insured all year and not underinsured.

The economic consequences of being uninsured or underinsured are now well documented. A recent study by The Commonwealth Fund found that 79 million Americans have problems paying medical bills or are paying off accumulated medical debt.[5] About 60 percent of those experiencing medical bill problems were insured at the time the expenses were incurred. Adults who experienced medical bill problems face dire financial problems: 29 percent are unable to pay for basic necessities like food, heat, or rent because of their bills; 39 percent use their savings to pay bills; and 30 percent take on credit card debt.

These problems are widely reported by those who are uninsured or underinsured. Sixty percent of adults who are underinsured or uninsured report being unable to pay medical bills, being contacted by collection agencies for unpaid bills, changing their way of life to pay medical bills, or having accumulated medical debt.[6] In contrast, only one-fourth of insured adults reported financial stress related to medical bills. Medical bill problems and accumulated medical debt were greater when plans did not include prescription drug or dental coverage and when the deductible exceeded 5 percent of income.

Managed care plans have increasingly used tiered prescription drug copayments that limit access to more expensive medications. In addition, most managed care plans place limits on mental health outpatient visits and inpatient days. These restrictions on benefits may not be known by enrollees at the time they choose a plan, especially those enrollees who have a new health condition, such as cancer, that requires costly drugs.

Underinsured adults also report more problems dealing with their insurance plans. Nearly two-thirds of underinsured adults report they had expensive medical bills for services not covered by insurance, the doctor charged more than insurance would pay and they had to pay the difference, or they had to contact the insurance company because they did not pay a bill promptly or were denied payment.

Inadequate coverage can also lead to more costly use of emergency rooms, as well as to hospitalizations that could have been avoided with better primary care. Uninsured and underinsured people with chronic conditions, for example, are less likely to report managing their chronic conditions, more likely to report not filling prescriptions or skipping doses of drugs, and more likely to use emergency rooms and be hospitalized.[7]

It should be noted that private managed care plans come in many shapes and sizes. Nonprofit managed care plans that are part of nonprofit integrated delivery systems—the best-known include Kaiser Permanente, Geisinger Health System, Henry Ford Health System, and Intermountain Health Care—have been found in Commonwealth Fund—supported case studies to have superior performance on quality and have been among the leaders in adopting electronic information systems and quality improvement care processes to deliver better results for patients.[8]

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[5] M. M. Doty, S. R. Collins, S. D. Rustgi, and J. L. Kriss, *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families* (New York: The Commonwealth Fund, Aug. 2008).

[6] S. R. Collins, J. L. Kriss, M. M. Doty, and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001—2007* (New York: The Commonwealth Fund, Aug. 2008).

[7] S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, A. L. Holmgren, *Gaps in Health Insurance: an All-American Problem,* Findings from the Commonwealth Fund Biennial Health Insurance Survey (New York: The Commonwealth Fund, Apr. 2006).

[8] R. A. Paulus, K. Davis, and G. D. Steele, "Continuous Innovation in Health Care: Implications of the Geisinger Experience," *Health Affairs,* Sept./Oct. 2008 27(5):1235—45; A. Shih, K.

Coverage Eroding in Small Firms

Any American is at risk of losing health insurance coverage, with employees of small businesses being particularly vulnerable. While 99 percent of firms with 200 or more employees continue to offer health insurance coverage, the corresponding rate for the smallest firms (those with fewer than 10 employees) is, at 45 percent, far lower.[9] Coverage in such very small firms is down from 57 percent in 2000. Three of five workers who are uninsured are self-employed or working for a firm with fewer than 100 employees.

Smaller businesses face many disadvantages because they do not enjoy the economies of covering large groups with natural pooling of risks. Employees of smaller businesses, moreover, receive fewer benefits and often face higher premiums. For the same benefits, a firm with more than 1,000 employees paid an estimated premium of $3,134 for single employee coverage, compared with $3,579 for employers with fewer than 10 employees.[10] Small firms also pick up a lower share of the premium, further increasing costs to workers of small firms relative to those employed in larger firms.

Driven in part by a philosophy that individual responsibility for insurance and higher deductibles will slow the growth in health care costs, employer coverage and policies available in the private individual insurance market have shifted more of the cost of health care directly to households. Deductibles have risen particularly sharply in small firms with three to 199 employees—with the mean deductible for single coverage rising from $210 in 2000 to $667 in 2007. By contrast, for larger firms, deductibles increased from $157 to $382 over this period. Deductibles vary by type of plan, with high-deductible health plans having particularly large deductibles; health maintenance organization (HMO) plans which are more typically offered by larger firms, generally have lower deductibles than preferred provider organization (PPO) plans.

Not surprisingly, therefore, employees of larger firms are more likely to say that employers do a good job of selecting quality insurance plans. Of employees in firms with 500 or more employees, 76 percent give employers high marks for selecting quality plans, compared with 69 percent of workers in firms with fewer than 20 employees.[11]

Individual Insurance Market Works Less Well than Employer Coverage

Faced with declining rates of coverage driven by the erosion of employer-sponsored coverage, the only recourse for many people is to turn to the individual health insurance market. However, this is the weakest link in the U.S. health insurance system. The Commonwealth Fund Biennial Health Insurance Survey found that of 58 million adults under age 65 who sought coverage in the individual insurance market over a three year period, nine of 10 did not purchase coverage, either because they were rejected, they were unable to find a plan that met their needs, or they found the coverage too expensive.[12] Serious health problems are also a significant barrier to gaining coverage in the non-group market. More than 70 percent of people with health problems or incomes under 200 percent of the poverty level surveyed by The Commonwealth Fund said that it was very difficult or impossible to find a plan they could afford.

Although increasing numbers of adults lost access to employer-based coverage from 2000 to 2006, there has been virtually no change in the number of people covered by individual-market insurance. Loss of employer coverage has led to higher levels of uninsured individuals, not to higher levels of individual coverage.[13] Those who are covered by individual health insurance plans are much less satisfied with their coverage than those covered by employer plans, and they are likely to drop such coverage if and when more desirable coverage becomes available from employ-

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Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance* (New York: The Commonwealth Fund, Aug. 2008).

[9] S. R. Collins, C. White, and J. L. Kriss, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance* (New York: The Commonwealth Fund, Sept. 2007).

[10] J. Gabel, R. McDevitt, L. Gandolfo et al., Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down, *Health Affairs*, May/June 2006 25(3):832—43.

[11] S. R. Collins, J. L. Kriss, K. Davis, M. M Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

[12] S. R. Collins, J. L. Kriss, K. Davis, M. M Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

[13] C. DeNavas-Walt, B. D. Proctor, and J. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2006* (Washington, D.C.: U.S. Census Bureau, Aug. 2007).

ers or public programs. Only a third of those with individual coverage rate their coverage as excellent or very good.[14]

The fundamental problem with the individual insurance market is that insurers are concerned that only those expecting to have high medical expenses will seek out coverage. Health expenditures are highly skewed: 10 percent of individuals account for 64 percent of health care outlays.[15] Avoiding those who are sickest results in substantially greater profits for insurers.

Except in a few states that require insurers to have open enrollment and community-rated premiums, insurers typically screen applicants for health risks and exclude high-risk individuals from coverage or charge higher premiums.[16] By design, underwriting practices discriminate against the sick and disabled, making coverage often unavailable at any price, or only at a substantially higher cost than incurred by healthier individuals. Non-group premiums are 20 percent to 50 percent higher than employer plan premiums, and more than 40 percent of total premiums are estimated to go toward administration, marketing, sales commissions, underwriting, and profits.[17] Premiums typically climb steeply with age.[18] Benefits are often inadequate, and premiums and risk selection practices are difficult for states to regulate.[19]

Those fortunate enough to have employer coverage are much better protected financially than those buying in the individual market—both because the employer pays a share of the premium and because the risks are pooled across the workforce. Only 18 percent of those with employer coverage pay premiums of $3,000 or more, compared with 54 percent of those who buy on the individual insurance market.

Public Programs Work

As this Committee knows well, public programs today cover more than one of four Americans—83 million people—including elderly and disabled adults under Medicare; low-income families, the elderly, and the disabled under Medicaid; and low-income children under the State Children's Health Insurance Program (SCHIP). Covering many of the sickest and poorest Americans, these programs have improved access to health care for people who typically do not fare well in a private insurance market.

Medicare and Medicaid have much lower administrative costs than private insurance—averaging around 2 percent, compared with 5 to 15 percent for larger employers, 15 to 25 percent for small employers, and 25 to 40 percent in the individual market. Medicare and Medicaid expenditures are also comparable or lower than expenditures by private insurance. Medicaid spending on health services for those without health limitations is lower than for those covered by private insurance. Medicare expenditures are high because they cover the elderly and disabled—but the rate of increase over the period 1969 to 2003 has been one percentage point lower than under private plans for comparable benefits (annual increases of 9.0% vs. 10.1% for private insurance).

Extending a Medicare-like plan to small businesses and individuals without access to employer-sponsored coverage would provide them with a much more affordable option.[20] Estimated premiums for family coverage under a Medicare-like public plan (with benefits comparable to the standard Blue Cross Blue Shield option in the Federal Employees Health Benefits Program) would be $8,424 annually in 2008,

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[14] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

[15] S. H. Zuvekas and J. W. Cohen, "Prescription Drugs and the Changing Concentration of Health Care Expenditures," *Health Affairs*, Jan/Feb 2007 26(1): 249—257.

[16] N. C Turnbull and N. M. Kane, *Insuring the Healthy or Insuring the Sick? The Dilemma or Regulating the Individual Health Insurance Market* (New York: The Commonwealth Fund, Feb. 2005).

[17] D. Bernard and J. Banthin, *Premiums in the Individual Insurance Market for Policyholders under age 65: 2002 and 2005*, *Medical Expenditure Panel Survey Statistical Brief #202,* Agency for Health Care Research and Quality, April 2008; M.A. Hall, "The Geography of Health Insurance Regulation," *Health Affairs,* March/April 2000:173—184; M. V. Pauly and A. M. Percy, "Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets," *Journal of Health Policy, Politics and Law*, Feb. 2000 25(1):9—26.

[18] D. Bernard and J. Banthin, 2008.

[19] K. Swartz, *Reinsuring Health: Why More Middle Class People Are Uninsured and What Government Can Do* (New York: Russell Sage Foundation, 2006).

[20] C. Schoen, K. Davis, and S.R. Collins, "Building Blocks for Reform: Achieving Universal Coverage With Private and Public Group Health Insurance," *Health Affairs,* May/June 2008 27(3):646—57; G. Claxton, "Health Benefits in 2007: Premium Increases Fall to an Eight-Year Low, While Offer Rates and Enrollment Remain Stable," *Health Affairs,* Sept./Oct. 2007 26(5):1407—16.

compared with $12,106 in a typical employer private plan. This 30 percent reduction in premiums would go a long way toward making coverage much more affordable for small businesses and individuals than available either in the small business insurance market or in the individual insurance market.

This premium differential occurs in part because Medicare buys physician and hospital services at a discount to rates paid by private insurers. Yet, a Medicare Payment Advisory Commission survey finds that, if anything, Medicare beneficiaries have a better experience than the privately insured in finding a physician and in getting an appointment promptly.[21]

The Way Forward: Rules Governing Private Markets and Role of Public Programs

We can no longer afford to ignore the fact that the U.S. is the only industrialized nation that fails to ensure access to essential health care for all its population. Yet, the U.S. spends twice per capita what other industrialized nations spend on health care. Since 2000, the most rapidly rising component of health care outlays has been the net cost of private health insurance administration.[22] The U.S. leads the world in the proportion of national health expenditures spent on insurance administration, and the nation could save $102 billion annually if it did as well as the best countries.[23]

That expenditure does not buy us satisfaction. Americans are more likely to report hassles paying medical bills than those of other countries.[24] A survey of U.S. adults found that 28 percent said that spending time on paperwork or disputes related to medical bills and health insurance in the past two years was a serious problem.[25]

The growth in insurance administrative cost in the U.S. has coincided with a major consolidation of the insurance industry. Two-thirds of all managed care enrollees are now enrolled in the nation's 10 largest managed care plans. The largest three health plans control over 50 percent of the market in all but four states.[26] Operating earning margins for major insurers have also increased during this period, as increases in premiums have substantially outstripped increases in medical outlays.

Massachusetts has shown how organizing an insurance connector, offering choices of plans, and reviewing premiums for reasonableness as a condition of being included in the connector can improve benefits and lower premiums. For example, a typical uninsured 37-year-old male faced a monthly premium of $335 pre-reform, compared with $184 post-reform, with a $2,000 deductible instead of a $5,000 deductible pre-reform.[27] To provide choices but simplify decision-making, Massachusetts has offered three tiers of benefits—labeled gold, silver, and bronze—with actuarially equivalent policies within each tier.

Insurance market reforms—including minimum requirements on insurers to cover everyone, the sick and healthy alike, at the same premium—could ensure the availability of coverage in all states. By organizing a national insurance connector that builds on the experience of Massachusetts, we could expand insurance choices to small businesses and individuals.

The Federal Employees Health Benefits Program is another example of offering multiple plans. The most popular option is the Blue Cross Blue Shield standard option plan, which covers 58 percent of all enrollees.[28] However, FEHBP does not establish minimum benefits for all plan offerings. It has offered high-deductible plans that qualify for health savings accounts; only 30,000 individuals out of the 8 million covered have elected these plan options.

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[21] MedPAC Report to the Congress: Medicare Payment Policy, March 2006, p.85.

[22] K. Davis, C. Schoen, S. Guterman, T. Shih, S. C. Schoenbaum, and I. Weinbaum, *Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?* (New York: The Commonwealth Fund, Jan. 2007).

[23] The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008,* The Commonwealth Fund, July 2008.

[24] C. Schoen, R. Osborn, M. M. Doty, M. Bishop, J. Peugh, and N. Murukutla, Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007, *Health Affairs* Web Exclusive October 31, 2007 26(6):w717—w734

[25] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

[26] J. C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs,* Nov./Dec. 2004 23(6):11—24.

[27] Jon Kingsdale, Executive Director, Commonwealth Health Connector, "Design of Connector as an Element of NHI," July 23, 2008

[28] Mark Merlis, Personal Communication, September 16, 2008.

Offering small businesses and individuals without access to employer-sponsored coverage choice of insurance plans through an insurance connector has advantages as well as serious pitfalls. Attention needs to be given to how to design a framework for choice among plans that best achieves the goals of insurance—ensuring access to essential care and providing financial protection against burdensome medical bills—in a manner that is equitable and efficient. Structuring choices within such an insurance connector works best when:

1. A standard benefit adequate is defined and available to all. The benefits should be adequate to meet the two basic functions of insurance—ensuring access to essential care and providing financial protection from burdensome medical bills. A small number of choices of benefit packages can let enrollees pick plans closer to their needs, but a profusion of benefit packages undermines effective comparisons and choices. The Massachusetts system of three levels of benefits—gold, silver, and bronze—has much to commend it.
2. Premiums to the enrollee for a standard plan are affordable, regardless of income. Income-related premium assistance—whether sliding-scale premiums or tax credits set to ensure that no one pays a standard plan premium in excess of a given threshold of income—is essential to guarantee affordability.
3. Enrollees have and use comparable information on benefits, expected out-of-pocket costs, adequacy of physician and other provider networks, and premiums across plans to make informed decisions.
4. Marketing practices which mislead or discriminate against the sick are prohibited and strictly enforced.
5. Market rules set the framework for efficiency and equity, including that insurers cover everyone (guaranteed issue and guaranteed renewal) and charge the same premium regardless of health status of enrollee (community rating or age bands), and that all individuals obtain health insurance (individual mandate).
6. Premiums are risk-adjusted to ensure that insurers do not have a financial incentive to enroll healthier people and enrollees do not have an incentive to avoid plans with sicker enrollees.
7. Insurers compete on the basis of the added value they bring in fostering quality and efficiency in the delivery of health care services and administration of claims.
8. Premiums are reasonable and have low administrative overhead; this can be ensured through negotiation or review of premiums or offer of a competitive public plan alternative

To ensure stable, affordable health insurance coverage for all Americans will require a significant increase in the role of government to set the rules for the operation of private markets and reverse the trend toward shifting greater financial risk to families who are unable to bear that risk. Action is needed to guarantee affordable coverage that provides adequate financial protection and ensures that individuals can obtain needed care—the two essential functions of health insurance. This should include:

- Health insurance premium assistance to low-income and modest-income families who cannot afford family premiums, which now average more than $12,000 even under employer plans.
- Strengthening, not weakening, employer coverage.
- Setting national rules for the operation of individual health insurance markets or creating a national insurance connector, such as the one in Massachusetts, that makes affordable health insurance policies available to those without access to employer coverage. Structuring insurance choices through rules governing the operation of private markets, or through a health insurance exchange or connector, could ensure the availability of quality, affordable coverage to a larger number of individuals who are either uninsured or have inadequate or unstable coverage, or for whom premiums create major financial burdens.
- Offering a public plan, modeled on Medicare, to small businesses and individuals would lower premiums by 30 percent and increase the stability of insurance coverage.
- Building on Medicare, Medicaid, and SCHIP to cover older adults, the disabled who are in the two-year waiting period for Medicare, and low-income adults, as well as children. Private insurance markets do not serve these populations well.

Finally, insurance reforms need to be part of a comprehensive strategy to bring about a high performance system that achieves better access, improved quality, and greater efficiency. This will require fundamental changes in the way health care providers are paid, so that financial incentives for providers are aligned with these goals, as well as a more organized health care system that takes full advantage of

modern information technology and evidence-based medicine and spreads best practices. Rather than shifting more financial risk to families, both public programs and private insurers need to do more, both independently and in collaboration, to slow the growth in health care costs and transform the delivery of health care services to improve quality and enhance value for the money spent on health care.

Chairman STARK. Thank you.
Mr. Bodaken.

STATEMENT OF BRUCE BODAKEN, CHAIRMAN AND CEO, BLUE SHIELD OF CALIFORNIA, SAN FRANCISCO, CALIFORNIA

Mr. BODAKEN. Thank you, Mr. Chairman and Members of the Subcommittee. Thank you for this opportunity to testify about the health insurance market.

I am Bruce Bodaken, Chairman and CEO of Blue Shield of California, a not-for-profit health plan serving 3.4 million Californians.

While more than 200 million Americans have insurance coverage that gives them access to some of the best medical care in the world, our system has gaping holes: nearly 47 million uninsured, rapidly rising costs, and uneven quality. In my view the vast numbers of uninsured are root cause of the major problems afflicting the private, health insurance market. Only by extending coverage to all Americans can we solve those problems.

Let's start with an overview of what is and what is not working in today's market, which is actually three markets, and it's already been mentioned: large group small group, and individual. The large group market works pretty well. The sizeable number of members in each group assures a balanced risk of both healthy and less healthy enrollees. In this market, health insurance works as it is supposed to. The heavy medical expenses of a few are spread across a broad population that also includes lots of healthy people with minimal expense. The result is a reasonable, per enrollee health insurance cost.

The small group market works quite differently and not as well. Under Federal law insurers are prohibited from turning down any small business that applies for coverage based on the health status of their employees. For obvious reasons, employer coverage is more valuable for older and sicker employees, who may not be able to obtain coverage in the individual market.

Since employers are not required to offer coverage and employees are not required to buy it, those who need it most are disproportionately represented in the small group insurance pool. As a result, premiums are much higher than in the large group market and if every small business provided coverage of course, that very same overall risk would improve and costs would thereby improve as well.

Balanced risk is an even bigger concern for the individual market. Since there is no mandate to purchase insurance which would guarantee a broad risk pool, California and more than 40 other states, which allow insurers to deny coverage or impose limits on the coverage offered to people with pre-existing health conditions.

I can assure you that rejecting an applicant for coverage is not something I or any of my colleagues are comfortable with, but in a voluntary market in which people can go in when they're sick

and go out when they're not, medical underwriting is the only way to ensure a balanced risk pool. Without it, premiums would even be higher, spiraling upward, depriving even more people of coverage.

The only way to put the small group and individual markets on solid footing is through a universal coverage plan, covering all Americans, certainly covering all Californians. Since 2002, Blue Shield has supported a universal coverage plan with these basic elements. First, require every individual to have coverage and every business to contribute to their employee's coverage; provide subsidies to low income purchases, enroll everyone eligible for Medicare and SCHIP programs; and require insurers to accept all applicants, regardless of health status.

The benefits of this approach, which is often referred to as shared responsibility are it builds off what works. It doesn't interfere with the current large group market, which functions well, and it would allow the vast majority of insured Americans to keep what they have today. It spreads the cost of achieving universal coverage broadly; and, last but most important, it gets everyone covered. This will enable the small group and individual markets to function the way we expect insurance markets to function by spreading risk across a broad population.

While we don't have time today to explore the other benefits of universal coverage, I also believe that having everyone in the system is essential to reducing costs and improving the quality of care in the long term. For Blue Shield, it's an imperative based on the mission of our company, but it's also the right and economic thing to do to solve the issue of the uninsured.

Again, thank you for inviting me to testify today. Blue Shield of California is eager to work with you on solutions to the serious problems facing our current health insurance system.

[The prepared statement of Mr. Bodaken follows:]

Statement of Bruce Bodaken, Chairman & Chief Executive Officer, Blue Shield of California, San Francisco, California

Mr. Chairman and members of the subcommittee, thank you for this opportunity to testify about how the health insurance market functions. My company, Blue Shield of California, is a not-for-profit health plan serving 3.4 million Californians. Expanding access to health coverage for every Californians is Blue Shield's mission. And it is my personal mission as well.

While more than 200 million Americans have insurance coverage that gives them access to some of the best medical care in the world, our system has gaping holes.

- Nearly 46 million are without coverage, and tens of millions more have inadequate coverage.
- The cost of medical care is rising beyond the capacity of many Americans to afford coverage or to pay their share of the costs even when they have coverage. The federal government exacerbates this problem by underpaying hospitals and doctors for care provided through public programs, which results in cost shifting onto insured patients.
- Too often, Americans receive care that does not follow the best medical evidence, and prevention and wellness are not sufficiently valued.

In my view, any discussion of market reform needs to start with the uninsured. In addition to being the most glaring failure of our health insurance system, the vast numbers of uninsured are also a root cause of the major problems afflicting the private health insurance market. Only by extending coverage to all Americans can we solve those problems.

The State of the Market

Let's start with an overview of what is and is not working in today's market, which is actually three separate markets—large group, small group, and individual.

The large group market works pretty well. Groups are rated based on the medical expenses incurred by their members, but the sizeable number of members in each group, combined with insurer requirements that a minimum percentage of employees take up coverage, assures a balanced mix of both healthy and less healthy enrollees. In this market, health insurance works as it is supposed to: the heavy medical expenses of a few are spread across a broad population that also includes lots of healthy people with minimal expenses. The result is reasonable per-enrollee health insurance costs.

The fact that a very high percentage of large employers continues to offer health coverage is a testament to the success of this market. Since 1999, offer rates among employers with more than 200 workers have consistently remained over 98%.[1]

I do not mean to suggest that costs for large group coverage aren't high. At nearly $4,500 per year for a single worker and over $12,000 per year for a family, they most certainly are.[2] But in a country with average per-capita health expenditures of over $7,000, that's a comparatively good deal.[3] The affordability problems that large employers increasingly face are not a function of market problems, but rather of surging medical care costs.

The small group market works quite differently and not as well. Under federal law, insurers are prohibited from turning down any small business that applies for coverage based on the health status of their employees. Forty-six states also impose strict limits on health status rating in the small group market. In California, for example, the rate charged any small employer can't be more than 10% lower or higher than the average rate. Nonetheless, nearly half of all small businesses do not offer coverage to their workers, usually because they can't afford it.

For a small employer with a very sick employee—a three-employee print shop with a cancer-stricken worker, for example—the rules assure that coverage can be purchased and that the employee's medical condition will have little impact on the premium charged to that particular business. However, the average premium charged in this market must reflect the average medical costs incurred by the employees of the small businesses that choose to buy coverage.

For obvious reasons, employer coverage is more valuable for older and sicker employees who may not be able to obtain coverage in the individual market. Since employers are not required to offer coverage and employees are not required to buy it, those who need it most are disproportionately represented in the small group insurance pool. As a result, premiums are much higher than in the large group market. If every small business provided coverage, of course, the overall risk would improve, thereby moderating costs.

Not surprisingly, virtually all the decline in employer-sponsored coverage occurred in the small-group market. Between 1999 and 2007, the percentage of businesses with three to eight employees that offered coverage declined from 56% to 45%.

Unbalanced risk is an even bigger concern for the individual market. Since there is no mandate to purchase insurance, which would guarantee a broad risk pool, California and more than 40 other states allow insurers to deny coverage or impose limits on the coverage offered to people with pre-existing health conditions.

I can assure you that rejecting an applicant for coverage is not something I or any of my colleagues are comfortable doing. But in a voluntary market, medical underwriting is the only way to ensure a balanced risk pool. Without it, premiums would spiral upward, depriving many more people of coverage.

The high-risk pools that exist in California and many other states help to some extent to address the fallout from medical underwriting. But segregating the sickest people into a separate pool and then subsidizing their coverage with tax revenue or assessments on private insurance is neither efficient nor desirable. In California, chronic under-funding of the high-risk pool has resulted in high premiums, low benefit maximums, and frequent enrollment waiting lists.

In sum, the large group market works well because each group represents a balanced pool of risks that allows insurance to spread risk across a broad population. But in the small group and individual markets, individual purchasers don't by themselves constitute balanced risk pools, and only through broad participation in the market can insurance spread the risk as it's designed to do. Unfortunately, in

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[1] Kaiser Family Foundation and Health Research Educational Trust, Survey of Employer-Sponsored Health Benefits, 1999–2007.

[2] KFF/HRET, Survey of Employer Sponsored Health Benefits, 2007

[3] CMS, National Health Expenditure Data for 2006

the current voluntary markets, we don't get sufficiently broad participation—and the dynamics currently in place assure that the problem will only get worse.

Fixing the Current Market

The only way to put the small group and individual markets on solid footing is by covering everyone. It is good economics and frankly, it is the right thing to do. Blue Shield has been committed to universal coverage for a long time: In 2002, we proposed a plan we called "universal coverage, universal responsibility" that we continue to advocate. It consists of these basic elements:

- Require every individual to have coverage.
- Require employers to provide coverage or make a minimum contribution towards the cost of coverage—"play-or-pay."
- Provide subsidies to low-income purchasers.
- Establish regional purchasing pools or insurance exchanges to provide coverage options to individuals and employees of "pay" employers.
- Make greater efforts to enroll all who are eligible for Medicaid and SCHIP.
- Require insurers to accept all applicants regardless of health status and to eliminate health as a rating factor.

Our proposal closely resembles the coverage expansion legislation enacted in Massachusetts and the California plan sponsored last year by Governor Arnold Schwarzenegger and Assembly Speaker Fabian Nunez, which we strongly supported.

The benefits of this approach, often referred to as "shared responsibility" are:

- It builds on what works. It doesn't interfere with the current large group market, which functions well. And it would allow the vast majority of insured Americans to keep the coverage they have today.
- It spreads the cost of achieving universal coverage broadly. We believe that is the fairest and most practical way to finance coverage expansion.
- Last but most important, it gets everyone covered. And it will enable the small group and individual markets to function the way we expect insurance markets to work—by spreading risk across a broad population.

While we do not have time today to explore the other benefits of universal coverage, I believe having everyone in the system is essential to reducing costs and improving the quality of care over the long term. I look forward to other opportunities to discuss those issues.

Blue Shield of California is eager to work with Congress and the new Administration on solutions to the serious problems facing our current health insurance system.

Chairman STARK. Thank you.

Dr. Feldman.

STATEMENT OF ROGER FELDMAN, PH.D., BLUE CROSS PROFESSOR OF HEALTH INSURANCE, UNIVERSITY OF MINNESOTA, MINNEAPOLIS, MINNESOTA

Mr. FELDMAN. Mr. Chairman and Members of the Subcommittee, it is my pleasure to appear before you today to discuss the private health insurance market in the United States.

As you noted in the advisory for this hearing, most people under 65 obtain their health insurance through the employment of a family member. Employer sponsored insurance or ESI has many advantages, but it also enjoys the tax subsidiary that costs over $200 bill per year.

Today, I'll review the tax treatment of health insurance premiums and the history of the tax exemption for ESI, explain what's good about ESI and bad about the tax subsidy, and conclude that ESI can and should stand on its own without special tax assistance.

The tax system touches health insurance premiums in four ways. Premiums paid by employers are exempt from taxation. In addition some employees can pay their share of the premium with pre-tax dollars. Self-employed workers enjoy a partial tax exemption. They can deduct premiums from income taxes, but not from their self-employment tax. And, finally, individuals who itemize Federal income taxes can deduct premiums and medical expenses that exceed seven and a half percent of their adjusted gross income.

The tax subsidy for ESI arose almost by accident. During the second world war, employers needed more workers, but wages were controlled. Offering ESI was a way to attract workers. In 1943 a tax court ruled that employers could provide health insurance without violating the wage controls and in 1954 the IRS code made the tax exemption permanent. The percentage of Americans covered by ESI jumped dramatically, but some of that occurred by buying out or crowding out existing individual insurance coverage.

ESI has many advantages. It's available to everyone who qualifies, usually by working more than a minimum number of hours. No one is turned-down for coverage, yet protects people from premium increases due to changes in their own health risk, and it has low administrative cost compared with individual insurance.

[Chart. Insert not included. Waiting for a response from the committee.]

Mr. FELDMAN. This graph shows dramatically that the administrative cost of health insurance decreases as the size of the covered group increases. Large employers with more than 10,000 workers have by far the lowest administrative cost. While ESI has many advantages, the tax subsidy that supports it is expensive. It distorts the choice of where people work. It encourages people to purchase insurance policies that are too generous, which subsidizes the purchase of too much medical care, and the subsidy is grossly unfair.

In 2006 the tax subsidy cost over $200 billion. The largest part of the subsidy came from the Federal income tax exemption, but the exemption from Social Security and Medicare taxes was also significant. The tax subsidy was worth $1753 for one person and $3825 for a family. This will affect where people work. Once people take a job with ESI they can be locked into it. The subsidy reduces the number of people who go into business for themselves, and unequal tax treatment for the self-employed reduces entrepreneurial survival.

The tax subsidy encourages people to buy more generous coverage which leads to more medical spending. Free care has some benefits, but the Rand Health Insurance experiment found that it had little or no measurable effect on health status for the average adult.

The last issue here is tax fairness. Families earning more than $100,000 per year who comprise 14 percent of families in the United States have 26.7 percent of the benefit of the tax exemption. On the other hand, families earning less than $50,000 who comprise the majority of all families in the United States have only 28.4 percent of the tax advantage. In summary, any discussion of healthcare reform should include a close look at the current tax treatment of health insurance premiums.

ESI has many advantages, but these advantages are supported by an inefficient and unfair tax subsidy. Health economists agree, virtually unanimously, with these conclusions. I believe that ESI can and should stand on its own without special tax assistance; and, if a tax subsidy is offered to ESI, it should be extended equally to the self-employed and to people who buy insurance that is not related to work.

Thank you for letting me share these comments with you.

[The prepared statement of Mr. Feldman follows:]

Statement of Roger Feldman, Ph.D., Blue Cross Professor of Health Insurance, University of Minnesota, Minneapolis, Minnesota

It is my pleasure to appear before you today to discuss the private health insurance market in the United States. As you noted in the Advisory for this hearing, most people under age 65 in the United States purchase health insurance through the employment of a family member. This system of ?employer-sponsored insurance' or ESI provides many advantages to those who are covered. But it is also the beneficiary of a tax subsidy that cost the federal and state governments over $200 billion in 2006.

In these prepared remarks I will briefly review the tax treatment of health insurance premiums and history of the tax exemption for ESI. This is followed by an explanation of what is good about ESI: no one is turned down for coverage; ESI protects people from premium increases due to changes in their own health risk; and it has low administrative costs compared with non-ESI or ?individual' insurance. Despite these advantages of ESI, the tax subsidy for ESI is seriously flawed: it is expensive; it distorts the choices of where people work; it encourages them to purchase insurance policies that are too generous, thereby subsidizing the purchase of too much medical care; and it is grossly unfair. I conclude that ESI can and should stand on its own without special tax assistance. If tax assistance is offered to ESI, it should be offered equally to the self-employed and to people who buy insurance that is not related to work. These tax policy changes would contribute to our shared goal of a fair and efficient tax system.

Tax Treatment of Health Insurance

The most significant feature of the tax treatment of health insurance premiums is that premiums paid by employers are exempt from the federal income tax, state incomes taxes in 43 states, and Social Security and Medicare taxes.[1] To picture the exemption, you might think of a worker who earns $50,000 per year before taxes and who does not have ESI. That worker's combined tax bill would be $10,810 if he or she were representative of other workers at that income level. Now suppose the worker's employer offers to contribute 100% of the cost of an ESI policy with a $10,000 premium and it reduces the worker's wages to $40,000 to offset its contribution. The worker's tax bill would fall to $7,780, for a tax saving of $3,030. In other words, the tax subsidy reduces the cost of insurance for that worker by roughly 30%. On average, the tax exemption reduced the cost of ESI for all covered workers by 35% in 2006.[2]

In addition to the tax exemption for employer-paid premiums, many employees can pay their share of the ESI premium with pre-tax dollars through ?Section 125' plans (named for that section of the Internal Revenue Code). There is no national data on the number of employees who have Section 125 plans, but I think almost all self-insured firms that bear medical risk without relying on an insurance company are capable of offering them. Furthermore, some states have required or are considering a requirement that all employers above a minimum size must offer Section 125 plans.

People who are self-employed are subject to the federal income tax as well as a self-employment tax that is equivalent to Social Security and Medicare taxes. These people may deduct health insurance premiums for themselves and their families

[1] For detailed information on the tax treatment of health insurance, see the Henry J. Kaiser Family Foundation, "Tax Subsidies for Health Insurance: An Issue Brief," July 28, 2008, available at http://www.kff.org/Insurance/7779.cfm, and Leonard E. Burman, "Statement before the House Committee on the Budget," October 18, 2007, available at http://www.taxpolicycenter.org/publications/url.cfm?id=901121. My example of the worker who earns $50,000 is taken from the first source.

[2] Thomas M. Selden and Bradley M. Gray, "Tax Subsidies for Employment-Related Health Insurance: Estimates for 2006," *Health Affairs*, 25:6 (November, 2006), pp. 1568–1579.

from their federal income tax (up to the net profit of their business) but not from their self-employment tax. Thus, they have a partial tax subsidy compared with those who have ESI.

Any taxpayer who itemizes federal income tax deductions can deduct premiums and medical expenses that exceed 7.5% of their adjusted gross income. This is the only premium tax deduction available to those who do not have ESI or are not self-employed, and of course it is limited to taxpayers who itemize deductions, have large bills, and have federal tax liabilities.

History of the ESI Tax Exemption

The linkage of health insurance to employment in the United States arose almost by accident. During the Second World War there were critical domestic labor shortages, but wage controls prevented employers from offering higher wages to attract employees. Employers found they could circumvent these controls by offering unregulated fringe benefits, including health insurance. In 1943, a tax court gave its blessing to this arrangement. Following the War, the tax code was interpreted as continuing to favor employer-paid health benefits, but their legal status remained in limbo until 1954, when the Internal Revenue Code made the tax exemption permanent.

The permanent tax exemption for ESI transformed the private health insurance market in the U.S. An economist recently rediscovered two surveys from 1953 and 1958, before and after the permanent tax exemption was granted.[3] Respondents to each survey reported on their health insurance coverage during the prior year. The percentage of households in the U.S. with ESI jumped from 47% in 1952 to 66% in 1957, but overall health insurance coverage rose by a smaller amount, from 63% to 76% of households. Thus, the ESI tax exemption ?crowded out' 6 percentage points of the market for individual coverage, which shrank from 16% of households in 1952 to 10% in 1957. The individual market remains small today, with only about 13.6 million covered lives in 2006 among people under age 65, compared with 157.6 million covered lives in ESI.[4]

What Is Good About ESI?

As the economic study cited above showed, many people in the United States had ESI even before it had a tax exemption. The reason is that ESI has many advantages for those who are eligible. The first of these advantages is that no one is denied coverage. Everyone who qualifies for coverage, which is usually based on working a minimum number of hours and may involve a minimum duration of employment, will be offered coverage.

In contrast, people who apply for individual coverage may be turned down. We don't know how many applicants for individual coverage are turned down nationally, but several small-scale estimates have been made. In one of these, researchers posed as hypothetical applicants, asking insurers to consider them for coverage as if they were real consumers.[5] Of 420 applications for coverage, 154 were rejected. 'Bob,' a 36-year old consultant who injured his knee in college and had it surgically repaired 10 years ago, was turned down 12% of the time. ?Greg,' a 36-year old writer who is HIV-positive, was rejected 100% of the time. The number of truly uninsurable individuals such as Greg is probably about 1 percent of the population, but Bob should be able to obtain insurance, and the failure of the individual market to offer it is a serious problem. Another study using data from a large insurer in the individual market in one state found that 14% of the applications were rejected—also a much higher rate than the 1 percent who are likely to be truly uninsurable.[6]

Finally, the state high-risk pool known as the Minnesota Comprehensive Health Association (MCHA) offers an opportunity to view the actual health care costs for people who were turned down by private insurers. On average, over the years from 1994 through 2004, MCHA claims costs were about twice the normal premium rates for those who held coverage, adjusted by age, sex, and the number of covered de-

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[3] Melissa A. Thomasson, "The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance," *American Economic Review*, 93:4 (September, 2003), pp. 1373–1384.

[4] National Center for Health Statistics, *Health, United States, 2007 With Chartbook on Trends in the Health of Americans*, Hyattsville, MD, 2007, Tables 136 and 137, available at http://www.cdc.gov/nchs/data/hus/hus07.pdf

[5] Karen Pollitz, Richard Sorian, and Kathy Thomas, "How Accessible Is Individual Health Insurance for Consumers in Less-than-Perfect Health?" Kaiser Family Foundation, June, 2001, available at http://www.kff.org/insurance/3136-index.cfm

[6] Mark V. Pauly and Len M. Nichols, "The Nongroup Health Insurance Market: Short on Facts, Long on Opinions and Policy Disputes," *Health Affairs*, web exclusive, October 23, 2002, pp. W325–W344, available at http://www.healthaffairs.org. Other applicants in this study were offered insurance, but at premiums higher than the standard rate for low risks. It is impossible to determine whether these premiums quotes were actuarially fair.

pendents.[7] Thus, while those turned down for coverage had higher-than-normal costs, their costs were not so wildly high that they were uninsurable.

The second advantage of ESI is that premiums are based on the experience of the group, not the individual policy-holder. This means that ESI protects people, except those in very small groups, from premium increases due to changes in their own health risk. Economists refer to this protection as 'guaranteed renewability',[8] and in my opinion it is extremely important. Imagine a patient who is diagnosed with pancreatic cancer. In 1999–2000, the cost *per month* of this disease was $7,616.[9] ESI policy-holders are protected against increases in their premiums due to the onset of pancreatic cancer and other costly diseases.

Individual insurance can offer some of this protection, but not as effectively as ESI. The reason is that people who do not develop cancer can drop out of the individual-market pool and find lower premiums on their own. This prevents insurance policies in the pool from covering as much of the cost of cancer as patients would want. It is also worth mentioning that ESI provides guaranteed renewability only as long as the policy-holder remains employed, and that states may impose guaranteed renewability on the individual market through state insurance laws.

The third advantage of ESI is lower administrative costs compared with individual insurance. There is a strong, negative relationship between the number of employees covered by ESI and the administrative cost as a percentage of benefit costs. Interestingly, the most widely-cited source for this relationship is a study by a private consulting company that is over 20 years old.[10] It would be worth replicating this study to determine if the internet has reduced the administrative costs of individual insurance.

What's Bad about the Tax Subsidy?

Despite the advantages of ESI, the tax subsidy that supports it has several serious disadvantages.

It is expensive: The tax subsidy for ESI premiums is the largest federal income tax expenditure, exceeding the cost of the deductibility of mortgage interest on owner-occupied homes by 80% in fiscal year 2008.[11] The total cost of the ESI premium subsidy in 2006, including foregone Social Security and Medicare taxes and state income taxes, was $208.6 billion.[12] This does not include the tax subsidy for 'Section 125' plans used by some employees to pay their share of the ESI premium with pre-tax income.

It distorts the choices of where people work: In 2006, the average tax subsidy for each person with single-coverage ESI was $1,573 and the subsidy for family-coverage ESI was $3,825.[13] No one knows exactly how much the subsidy affects the choices of where people work, but the effect could be substantial. Suppose the average person is an auto repair worker who could earn $57,000 at a repair shop that offered ESI and $60,000 at one that did not offer ESI. By ?earn,' I mean the total value of his repair work before paying the health insurance premium would be $60,000 or $57,000. His potential earnings at the shop that didn't offer ESI are higher because that shop has more clients who need his special skills in auto body painting. If the worker was otherwise indifferent between the two jobs (e.g. they had the same hours, were equally distant from his home, etc.) and he valued family-coverage health insurance at its cost, he would take the job with health insurance because the tax subsidy made it more attractive. In doing so, he would lose $3,000 of earnings. The total loss of earnings throughout the economy could be very large.

While estimates of the effect of the tax subsidy on job choice are lacking, we do have evidence that it reduces *mobility* between jobs. Not all studies find this effect,

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[7] Minnesota Department of Health, "Minnesota Health Care Markets Chartbook, Section 5: Public Health Insurance Programs,2004," available at http://www.health.state.mn.us/divs/hpsc/hep/chartbook/section5.ppt

[8] Mark V. Pauly, Howard Kunreuther, and Richard Hirth, "Guaranteed Renewability in Insurance," *Journal of Risk and Uncertainty*, 10:2 (March, 1995), pp. 143–156.

[9] Stella Chang, Stacey R. Long, Lucie Kutikova, Denise Finley, William H. Crown, and Charles L. Bennett, "Estimating the Cost of Cancer: Results on the Basis of Claims Data Analysis for Cancer Patients Diagnosed with Seven Types of Cancer During 1999 to 2000," *Journal of Clinical Oncology*, 22:17 (September 1, 2004), pp. 3524–3530.

[10] Hay Huggins Co. estimate, 1987, reprinted in U.S. House Committee on Ways and Means, *Health Care Resource Book*, Washington, DC: U.S. Government Printing Office, April 16, 1991, p. 107.

[11] Office of Management and Budget (OMB), *Analytical Perspectives: Budget of the United States Government, Fiscal Year 2008*, Washington, DC: OMB, 2007, available at http://www.whitehouse.gov/omb/budget/fy2008/apers.html

[12] See reference #2.

but those that do indicate that people with ESI switch jobs about 25% less frequently than those without ESI.[14]

The ESI subsidy also reduces the number of people who go into business for themselves. One interesting study recently compared changes in self-employment among residents of New Jersey, after that state facilitated access to health insurance that was not linked to employment, with Pennsylvania where there was no change in access.[15] There was a substantial increase in self-employment in New Jersey, especially for unmarried, older, and less-healthy individuals.

Finally, the deductibility of health insurance premiums for the self-employed has a positive effect on entrepreneurial survival.[16] The effect of the deduction on married filers (who are often older and have dependent family members) is greatest. This research suggests that extending the same tax subsidy to the self-employed as to those with ESI would increase entrepreneurial activity in the U.S. economy.

It Encourages More Coverage and More Medical Spending: As I mentioned above, on average, the tax exemption reduced the cost of ESI for all covered workers by 35% in 2006. By reducing the cost of ESI, the tax subsidy encourages workers to buy more coverage, such as policies with free medical care at the point-of-purchase. One study suggests that the tax subsidy increases coverage (measured by total insurance spending) by 29%[17]

Other research shows that more insurance coverage leads to more medical spending. The classic RAND Health Insurance Experiment found that people with free care spent 40% more than those with a deductible of about $4,000 in today's prices.[18] In general, the benefits of the additional care were not worth the extra cost or they could be achieved at lower cost. The RAND researchers found that the additional care had beneficial effects on blood pressure levels for poor people with high blood pressure, but a one-time screening examination achieved most of the reduction that free care achieved. For the average adult, free care "had little or no measurable effect on health status." [19]

It is Grossly Unfair: Because upper-income families demand more generous insurance coverage and in most cases have higher tax liabilities than lower-income families, they get most of the benefits of the ESI tax exemption. In 2004, families earning more than $100,000 got 26.7% of the tax benefits, although they comprised only 14% of families in the U.S.[20] Families earning less than $50,000 got only 28.4% of the tax benefits although they comprised more than half (57.5%) of U.S. families. This is grossly unfair.

For another snapshot of the distributional effects of the ESI tax subsidy, we can look at the average subsidy by selected establishment characteristics. In establishments where more than half of workers earned less than $10.43 per hour in 2006, the average subsidy per employee was $637 and the average subsidy per covered employee was $2,268.[21] The difference is due to the fact that many low-wage establishments do not offer health insurance, or their workers do not take up an offer if they have one. In establishments where more than half of workers earned more than $23.07 per hour, the average subsidies were much larger: $2,525 per worker and $3,283 per covered worker. This also is grossly unfair.

Summary Comments

Any discussion of health care reform should include a close look at the current tax treatment of health insurance premiums. Currently, ESI premiums are exempt from income and payroll taxes, while insurance purchased by individuals and self-employed workers lacks some or all of these tax privileges. ESI has many advantages including guaranteed issue, guaranteed renewability, and low administrative costs, but these advantages are supported by an inefficient and unfair tax subsidy.

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[14] Jonathan Gruber and Brigitte C. Madrian, "Health Insurance, Labor Supply, and Job Mobility: A Critical Review of the Literature," National Bureau of Economic Research, NBER Working Paper No. W8817, March, 2002, available at http://www.nber.org/papers/w8817

[15] Philip Decicca, "Health Insurance Availability and Entrepreneurship: Evidence from New Jersey," McMaster University, Department of Economics, September, 2007, available at http://ssrn.com

[16] Tami Gurley-Calvez, "Health Insurance Deductibility and Entrepreneurial Survival," report prepared for the Small Business Administration under Contract No. SBAHQ–04–M-0536, April, 2006, available at http://www.sba.gov/advo/research

[17] Jonathan Gruber and Michael Lettau, "How Elastic Is the Firm's Demand for Insurance?" *Journal of Public Economics*, 88 (2004), pp. 1273–1293.

[18] Joseph P. Newhouse, et al., *Free for All? Lessons from the RAND Health Insurance Experiment*, Cambridge, MA: Harvard University Press, 1993.

[19] See reference #18, p. 243.

[20] John Sheils and Randall Haught, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs*, web exclusive, February 25, 2004, available at http://www.healthaffairs.org

[21] See reference #2.

These conclusions are not controversial among health economists, who agree, virtually unanimously, that excluding ESI premiums from taxable compensation causes workers to demand more insurance than they would in the absence of that exclusion.[22] There is also general agreement that this higher level of coverage leads to inefficiently high levels of health care spending, and finally, that the tax subsidy is ?upside-down' with the largest subsidies going to high-income taxpayers.[23]

I believe there is also general agreement that the tax subsidy should be reformed so that it does not encourage consumption of more insurance on the margin, and so it should not disproportionately benefit high-income taxpayers.

There is less unanimity that the subsidy should be extended equally to individual insurance as to ESI. The hesitancy to subsidize individual insurance is based on two premises: ESI has advantages compared with individual insurance; and ESI could not stand on its own without the subsidy. In my opinion these premises are self-contradictory: *ESI can and should be allowed to stand on its own because of the advantages it offers.*

I conclude that tax assistance should be offered equally to the self-employed and to people who buy insurance that is not related to work. On the whole, this would be a good thing. It would improve the efficiency of labor markets by promoting better matches between workers' skills and the jobs they seek. It would increase workers' productivity and the supply of entrepreneurs, both of which are needed at this critical time for our economy. Finally, it would make the tax system more fair and even-handed.

Thank you for allowing me to share these comments with you today.

Chairman STARK. Thank you, Dr. Feldman.

Ms. Kofman.

STATEMENT OF MILA KOFMAN, J.D., SUPERINTENDENT OF INSURANCE, MAINE BUREAU OF INSURANCE, AUGUSTA, MAINE

Ms. KOFMAN. Good morning.

Chairman STARK. Good morning.

Ms. KOFMAN. I am the superintendent of insurance in Maine. My agency serves and protects the public through regulation and oversight of the insurance industry. It is my job to ensure that insurance companies keep their promises.

We do that through vigil and financial oversight and licensing, examinations of insurers activities, and our review and approval of premiums and insurance products. Prior to my appointment I was an associate research professor at Georgetown University where I studied health insurance markets across the nation.

Mr. Chairman, I thank you and the Committee for your leadership and willingness to examine the private, individual health insurance market and its problems. It is both an honor and a privilege to be here today.

I believe it would be optimal for us to address the healthcare crisis in America in its entirety, and for the Federal government to ensure that all Americans have access to affordable, adequate, and secure health coverage.

Maine has been at the forefront of reforms, developing innovative initiatives to help finance medical care. Governor Baldacci has been a leader in establishing meaningful new health coverage options for individuals, coverage that actually works for people who are sick.

Today I will focus on the individual health insurance market. In most states it is inaccessible, unaffordable and inadequate. It is not

[22] Mark Pauly, "The Tax Subsidy to Employment-based Health Insurance and the Distribution of Well-being," *Law and Contemporary Problems*, 69:83, (Autumn, 2006), pp. 83–101.

[23] See reference #1, Burman testimony.

a free market where purchasers have meaningful options. A free market assumes that anyone and everyone who wants to buy a product can choose among sellers competing for their business. Insurance companies do not, I repeat, they do not compete to insure sick people.

An insurance company's success depends on its ability to minimize its risk. This provides incentives to cherry-pick healthy people and limit the number of unhealthy people covered. It creates an individual market, which many Americans cannot access, because they have or had a medical condition. Even minor conditions like an allergy could be the basis for not selling you a policy. In most states, insurers are allowed to charge higher rates for people with medical conditions. Assuming your are not rejected and can afford the high rate, the insurer may decide not to cover your existing condition, ever.

The individual market is not truly a free market. A free market assumes that the consumer has the information needed to make an informed decision and what you bargain and pay for you actually get. In reality, full contracts are not available prior to enrollment. Summaries may be misleading and conflicting and vague contract language makes it difficult to determine how medical care is covered.

Furthermore, insurers can change benefits after you enroll. Your drug benefit can be reduced and you're still paying the same premium. In addition, there are adequacy problems. For example, Mary, paying more than $500 a month in 2005 believed she was protected. Mary was diagnosed with cancer. Each chemotherapy injection was nearly $5500. Her policy had a maximum daily benefit of $1500 for both chemo and radiation.

Affordability is a problem also. Some argue that coverage would be cheaper without guaranteed issue and adjusted community rating requirements; however, states without these have much higher rates of uninsured. Texas, New Mexico, Oklahoma, for example, states without these consumer protections, one in five people are uninsured compared to one and ten in Maine.

For the last 20 some years, some have looked at high risk pools to address the cost. In reality, many have had significant funding problems: high premiums, waiting lists, inadequate benefits, exclusions for existing medical needs, and high out-of-pocket obligations. Although 34 states have these pools, less than 200,000 nationwide are enrolled.

Many factors contribute to the price of insurance: the cost of medical care, administrative costs and profits. In recent years, all three have increased. Profits have been very healthy. Nationally major health insurers reported combined profits of $12.6 billion last year. While American families struggled and made sacrifices to stay insured paying double-digit premium increases, it was reported that the former CEO of a large insurance company received a bonus of $1.6 billion worth of stock options in addition to salary.

In conclusion, all aspects of the individual market should fully be examined and better understood before significant coverage expansion efforts of this market are undertaken.

I thank you for your time.

[The prepared statement of Ms. Kofman follows:]

Statement of Mila Kofman, Superintendent of Insurance, Maine Bureau of Insurance, Augusta, Maine

Testimony of Mila Kofman, J.D.
Superintendent of Insurance, State of Maine

Before the
U.S. House of Representatives, Committee on Ways and Means
Subcommittee on Health
September 23, 2008

Good morning. My name is Mila Kofman and I am the Superintendent of Insurance for the State of Maine. Mr. Chairman, I thank you and the Committee for your leadership and willingness to examine the private individual health insurance market and problems consumers experience when forced to obtain insurance through this market.

It is both an honor and a privilege to testify before you on this matter. By way of background, I lead the State of Maine agency which serves and protects the public through its regulation and oversight of the insurance industry. It is my job to ensure that insurance companies keep their promises to their policyholders. We do that through vigilant financial oversight and licensing of insurance companies, examinations of insurers' activities, and our review and approval of premiums and insurance products. It is my job to make sure that claims are paid! I also chair the Consumer Protections & Innovations Working Group (D Committee) of the National Association of Insurance Commissioners. (I am here on behalf of the Bureau of Insurance not the NAIC).

Before becoming the Superintendent of Insurance in Maine, I was an associate research professor at Georgetown University's Health Policy Institute, with a research focus on private health insurance. I studied regulation of health insurance products and companies, state and federal health care and coverage reform initiatives, new products, and market failures. I was the co-editor of the Journal of Insurance Regulation. Before joining the faculty at Georgetown University, I was a federal regulator at the U.S. Department of Labor, where I worked on issues affecting ERISA health plans.

I believe it would be optimal for us to address the health care crisis in America in its entirety and for the federal government to ensure that all Americans have the same basic rights and protections related to health care no matter where one lives or works. All Americans should have access to affordable, adequate and secure health coverage.

Maine and other states have been at the forefront of health care reform, developing innovative new initiatives to help finance medical care, and to restructure the private and public insurance programs to cover more people. In Maine, Governor Baldacci has been a leader in establishing meaningful new health coverage options for individuals – coverage that actually works for people with medical needs.

Maine's Dirigo Health Reform Act of 2003 was intended to deal with system-wide issues of cost, access and quality. The DirigoChoice insurance product -- a public/private partnership between the State of Maine and a private insurance company -- was designed to be a bridge for people who are not eligible for Medicaid and who cannot afford private insurance coverage, and is available to both individuals and small business groups. As of August, 2008, 11,512 people were enrolled (this includes small business workers, individuals, and their families); over 23,000 people have been served since the DirigoChoice program opened for business.[1] With additional funding, many more Mainer's could be covered.

Despite such efforts, there are 47 million Americans without health coverage and millions more with inadequate coverage. We live in the wealthiest and most advanced country in the world, yet we allow 18,000 Americans to die preventable deaths each year because they lack coverage. The uninsured problem is estimated to cost our economy $60 to $130 billion annually.[2] The leading cause of personal bankruptcies in the United States is illness (the majority of those filers were insured).[3] The uninsured problem and the way we finance medical care handicaps American businesses in a global economy. The Big Three automakers spend more on health care than on steel. Our per capita spending on health is higher than Germany, Canada, France, Australia, and the United Kingdom (UK). Although we outspend those nations as a percentage of GDP, we have worse health outcomes: Americans report more problems with access to care than in the UK and Canada; in terms of life expectancy we rank lower than Japan, France, Australia, Canada, Germany, New Zealand, the Netherlands, and the UK.[4]

You've asked me to discuss the individual health insurance market. Health insurance in the individual market is inaccessible for many, unaffordable for many more, and inadequate for many of those who have it. It is not a "free market" where purchasers have meaningful, or in most cases, any choice of products.

BACKGROUND: ACCESS, ADEQUACY AND AFFORDABILITY

Nearly 160 million Americans have health coverage through their employers. However, some workers do not have access to job-based coverage because their employers do not offer coverage, they are not eligible for coverage, they can't afford the premium share, or they are self-employed. Many do not qualify for public insurance programs.

The individual market is like a "residual" market – purchasers do not choose it when other meaningful options are available. The individual market is not a true "free market" in the traditional sense. A free market assumes that every individual who wants to buy a product can choose among sellers competing for his/her business. No one competes to insure sick people.

The reality of the health insurance market is that a carrier's success depends on its ability to minimize the risk it assumes. This means that each company is better off if it only insures people who will not need medical care. This provides incentives to cherry-pick healthy people, and limit the number of unhealthy people covered. While the desire of insurance companies to reduce risk is rational from a free market perspective, it creates a market which many Americans cannot access.

Unlike job-based coverage, in the individual market, with few exceptions there are no guaranteed access requirements; insurers are allowed to deny coverage to people with past, present, or perceived future medical needs. In fact, people with relatively minor needs, like hay fever, have had insurance applications rejected.[5] Also in most states, insurers are allowed to charge higher rates for individual market policies based on ones health. Even if a person with less-than-perfect health passes medical underwriting and can afford being surcharged for having past or current medical needs, their conditions may not be covered by the policy (e.g., permanently excluded through a rider or temporarily excluded through a pre-existing condition exclusion period).

Five states – Maine, Vermont, New York, New Jersey, and Massachusetts (merged market) -- protect consumers in the individual market by prohibiting discrimination based on medical needs through guaranteed issue and adjusted community rating requirements.[6] But if a consumer does not live in Maine or one of the other four states, that person may not have access to a private market, leaving them sick and without insurance coverage.

Other characteristics of the individual market make it difficult to conclude that it is truly a free market. Consumers face various hurdles.

First, a free market assumes that the consumer has the information needed to make an informed choice. However, unless required by state law, I have found that insurers do not voluntarily make copies of policies available before a person enrolls. Imagine buying a car and being told you can't see the car, you can only look at the brochure of the car. Americans shopping for insurance must rely on summaries of coverage, which may not provide sufficient details for them to estimate their out-of-pocket costs and in some cases may have incorrect information or be misleading. Even when one has a copy of the full policy, it is not always possible to figure out what one's out-of-pocket liability may be. For example, a study on maternity coverage, which I co-authored, found that for any given plan, anticipating out-of-pocket costs is difficult in the best of circumstances, and even if consumers could accurately forecast their health care needs for the coming year, lack of transparency in contract language makes it hard to know what expenses a plan will cover.[7]

Furthermore, generally an insurance carrier can change its benefits after a policy has been purchased. So unlike buying a car, where you get the tires, the engine, and other parts and you get to keep them, an insurer can change benefits any time. For example, plans can and do change prescription drugs on their formulary list. This means that if you buy one policy over another because your medicine is originally covered, your coverage for the medicine may disappear – and you are paying the same premium price. Imagine, buying a new car and the following month the dealer takes out the engine while you are expected to continue making payments. Maine strives to protect its consumers from such changes by limiting changes in benefits to those which are required by law or those which qualify as minor benefit modifications. In the case of a decrease in benefits, a benefit modification is deemed minor if the insurer can show that the total of any decrease in benefits does not decrease the actuarial value of the total benefit package by more than 5%. This limitation does not apply to changes in formulary, however.

ADEQUACY

Individual market coverage is not adequate and may indeed even be illusory. For example, a case we intervened in involved a child who was hospitalized with a serious mental illness. The insurance company decided that the child no longer required inpatient care, and instead, approved coverage for appropriate level of care provided in a residential setting with a complete educational program equivalent to a regular high school. The problem was the residential setting to which the carrier believed it was discharging the adolescent did not exist in Maine at that time.

In another case, where we successfully assisted the patient, the cost of treatment was high but coverage limits were low. The insurance policy paid a daily maximum of $1,500 for chemotherapy and radiation treatments for cancer. The patient did not realize that this amount would not be nearly sufficient to cover the real cost of these treatments; the cost of the first month of chemotherapy treatments exceeded $17,000; one injection alone cost $5,419.12. Radiation therapy treatments followed chemotherapy for six and a half weeks, five days a week. Paying more than a $500 monthly premium in 2005, the consumer believed the policy would provide meaningful coverage.

AFFORDABILITY

Affordability has been a significant problem nationally and in Maine. Maine's policymakers have not shied away from trying to address it, with recent comprehensive efforts in 2003 (the Dirigo Reform Act).

Nationally, nearly half of people with individual health insurance coverage spend more than 10% of their income on premiums and medical care.[8]

Escalating premiums make coverage unaffordable for many and prompt many others to reduce their coverage by switching to less expensive catastrophic policies and/or policies with reduced benefits. As of 2006, approximately 72% of policies in Maine's individual market had deductibles of $5,000 or higher and the average deductible was approximately $7,000.[9] The community-rated annual family premium for a major medical plan with a $5,000 deductible is $9,919.32;[10] for that particular plan some families pay more depending on their age. This year and last, Maine's policymakers have continued to address this through creative and innovative, incremental reforms which include reinsurance and a demonstration project to attract 25-30 year-olds into the pool.

Some argue that coverage would be more affordable without guaranteed issue and adjusted community rating requirements. However, states without these consumer protections have much higher percentages of the population without health insurance. In Maine -- a state with guaranteed issue and adjusted community rating -- 10% percent of the population is uninsured; in Texas, New Mexico, and Oklahoma – states without these consumer protections – at least 20% of the population is uninsured.[11]

High-risk pools have also been discussed as a way to address cost. In reality, many high-risk pools have had significant funding problems. In addition, "uninsurable" people – that is people who were denied coverage in the private market because of existing medical needs -- have had a variety of problems with high-risk pool coverage. These problems include: premiums that are too expensive, waiting lists in some states, limits on eligibility, inadequate insurance coverage (e.g., an annual limit of $75,000 on benefits, no or low coverage for prescription drugs), exclusions from coverage for existing medical conditions, and high out-of-pocket obligations (e.g., annual deductible of $10,000).

Because of the funding issues and barriers to consumers, only a small percentage of people the high-risk pools are intended to assist are enrolled. Although thirty-four states have high-risk pools,[12] all these pools together cover less than 200,000 people.[13] A nationwide study of 900 diabetic people with insurance problems identified 344 people who lived in high-risk pool states, yet only 7 signed up for the risk pool.[14] In Maine, a high-risk pool established in 1988 was closed in the early 1990s due to funding problems; its enrollment never exceeded 450 people.

Health coverage is expensive because medical care is expensive. Many factors contribute to the price of coverage. The price reflects the cost of medical care, administrative costs, and profits.

- In Maine, between 1997 and 2007, per member medical expenses paid by HMOs each month increased from $125 to over $300; nearly $250 of the 2007 cost is for hospital/medical care.[15] Anthem Health Plans of Maine, the state's largest health carrier, saw its non-HMO per member per month medical expenses increase from $160 in 2001 (the earliest year that data is available) to $221 in 2007.[16]
- Administrative expenses among Maine's HMOs increased from approximately $22 per member per month in 1997 to $26 per member per month in 2007.[17] Anthem's non-HMO administrative expenses rose from $8 per member per month in 2001 to $20 per member per month in 2007.[18]
- Since 2006, Anthem has declared nearly $152 million in dividends (reflecting profits for all their business in Maine -- individual, small group, and large group markets).[19]

Nationally, almost all major health insurance companies saw their profits rise from 2003 to 2007; by the end of 2007, the companies had combined profits of $12.6 billion, an increase of 170% from 2003.[20]

Profits of the health insurance industry have been subject to public scrutiny. While the number of uninsured continued to increase and American families struggled and made sacrifices to stay insured,

paying double-digit premium increases, it was reported that the CEO of United Health Care received a bonus of $1.6 billion dollars worth of stock options (in addition to his salary).[5]

NEXT STEPS

There is a strong and appropriate role for federal policymakers. Americans need and demand meaningful health insurance coverage options to access and pay for necessary -- in many cases lifesaving -- medical care and services. Working with the states, together we can address the health care crisis facing our nation's employers, workers, and families.

I encourage you to build upon the foundation that you established in 1996 through the Health Insurance Portability and Accountability Act (HIPAA). HIPAA established a floor of consumer protections including guaranteed access requirements for small business, nondiscrimination protections and portability for workers and their families. Those same consumer protections should be extended to the individual market. All Americans deserve the same rights and protections, whether they have health insurance coverage through their employer or buy it themselves in the individual market. Federal reforms should be modeled on HIPAA – a federal floor recognizing that states have and should be allowed to create and enforce higher levels of consumer protections as their populations demand. The federal government could:

- Establish standards for individual "health insurance" – the label of "health insurance" is applied to policies that cover little and leave people exposed to significant financial out of pocket expenses, as well as limited or no access to needed medical care.
- Prohibit discrimination against people with medical needs. Guaranteed access and adjusted community rating must be basic consumer protections for all Americans, no matter where they live.
- Help people pay for meaningful health insurance coverage.
- Make a federal financial commitment to states to help fund expansion programs and develop strategies for system-wide changes to address medical cost drivers.

Thank you for your consideration of this important issue. I look forward to assisting you as you look for ways to address the ever growing problem faced by millions of Americans without adequate health insurance and the rising costs of coverage for all Americans. I hope that you will create new meaningful options to provide access to affordable, adequate and secure health insurance coverage for all Americans.

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[1] Information provided at meeting of the Dirigo Health Agency Board of Trustees, September 15, 2008, and the Governor's Office of Health Policy and Finance.

[2] For highlights see, Press Release, January 14, 2004, "IOM Report Calls for Universal Health Coverage by 2010; Offers Principles to Judge, Compare Proposed Solutions" available at www.nationalacademies.org/onpinews/newsitem.aspx?RecordID=10874.

[3] See David Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, "Illness and Injury as Contributors to Bankruptcy" Health Affairs Web Exclusive February 2005. Many insured debtors blamed high copayments and deductibles for their financial ruin.

[4] See Commonwealth Fund charts, Spending on Health, 1980–2004 (Data source: OECD Health Data 2005 and 2006) and Access Problems Because of Costs in Five Countries, 2004, available at www.cmwf.org.

[5] A Georgetown University study on the individual market in 8 locations around the country found that applicants were rejected 37% of the time, and when they were offered coverage, 85% of the time the coverage had benefit restrictions, 20% of the time it had premium surcharges, and nearly 20% of the time had both. This does not take into account the people who were discouraged from applying, so the number of people squeezed out of the private market is likely to be much greater, absent guaranteed access requirements. See Karen Pollitz, Richard Sorian, and Kathy Thomas, "How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?" a

report for the Henry J. Kaiser Family Foundation, Menlo Park, California, June 2001. Furthermore, with few exceptions, insurers are allowed to charge people with medical needs higher premiums. A GAO study on HIPAA implementation found that carrier pricing of HIPAA guaranteed access products could result in substantially higher rates, ranging from 140 to 600 percent of the standard rate. See United States General Accounting Office, "Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators", Report to the Chairman, Committee on Labor and Human Resources, U.S. Senate, February 1998, GAO/HEHS-98-67.

[6] "Guaranteed issue" laws prohibit insurers from denying coverage to applicants based on health status. "Community rating" means that insurers must set prices for policies based on the collective claims experience of everyone with such a policy, and are not allowed to vary rates based on health or claims of a business or a person. Mila Kofman, Karen Pollitz, "Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change," Journal of Insurance Regulation, National Association of Insurance Commissioners, Summer 2006, Vol. 24, No. 4.

[7] Karen Pollitz, Mila Kofman, Alina Salganicoff, Usha Ranji, "Maternity Care and Consumer-driven Health Plans", a report for the for the Henry J. Kaiser Family Foundation, Menlo Park, California, June 2007.

[8] Additionally, one in every four insured Americans (insured all year with group coverage) spend 10% or more of their income on premiums and out of pocket expenses for medical care. Sara Collins, et al, "Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families," September 14, 2006, The Commonwealth Fund.

[9] See Bela Gorman, Don Gorman, Elizabeth Kilbreth, Taryn Bowe, Gino Nalli, Richard Diamond, "Reform Options for Maine's Individual Health Insurance Market: An Analysis Prepared for the Bureau of Insurance", May 30, 2007.

[10] Maine Bureau of Insurance, "Consumer Guide to Individual Health Insurance", last updated: September 2, 2008.

[11] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements). Henry J. Kaiser Family Foundation, statehealthfacts.org.

[12] Academy Health, "High-Risk Pools", State Coverage Initiatives, an Initiative of The Robert Wood Johnson Foundation, Washington, DC, www.statecoverage.net/matrix/highriskpools.htm.

[13] Laura Meckler, Anna Wilde Mathews, "McCain's Free-Market Health Plan Would Boost Role of High-Risk Pools", The Wall Street Journal, June 2, 2008.

[14] Karen Pollitz, Eliza Bangit, Kevin Lucia, Mila Kofman, Kelly Montgomery, Holly Whelan, "Falling Through the Cracks: Stories of How Health Insurance Can Fail People with Diabetes", Georgetown University Health Policy Institute and the American Diabetes Association, 2005.

[15] Maine Bureau of Insurance, "Maine HMO Aggregate Data – 2008 Quarter 2", last updated: September 12, 2008.

[16] Annual Statements made by Anthem Health Plans of Maine, Inc. to the Maine Bureau of Insurance; available upon request from the Bureau.

[17] Maine Bureau of Insurance, "Maine HMO Aggregate Data – 2008 Quarter 2", last updated: September 12, 2008. Anthem Health Plans of Maine for 2004 through 2007.

[18] Annual Statements made by Anthem Health Plans of Maine, Inc. to the Maine Bureau of Insurance; available upon request from the Bureau.

[19] Annual Statements made by Anthem Health Plans of Maine, Inc. to the Maine Bureau of Insurance; available upon request from the Bureau.

[20] Northwest Federation of Community Organizations, "Insuring Health or Ensuring Profit? A Snapshot of the Health Insurance Industry in the United States," July 2008.

[21] In order to settle a federal securities class action suit, William McGuire, former CEO and Chairman of UnitedHealth Group Corporation, returned 3.675 million shares of these stock options – originally brought to light in 2006 – in early September. See Bob Chlopak, "Dr. William McGuire Joins Settlement of UnitedHealth Group Federal Security Class Action," PRNewswire-USNewswire, September 10, 2008.

Chairman STARK. Thank you.

I want to thank all the witnesses. I think I'll just make a couple of comments and perhaps the witnesses would care to comment on my comments.

Bruce, I agree with you. You and I have talked often that if we allow medical underwriting, we can't have an individual market that will serve individuals very well, so that if you followed Dr. Feldman's advice and gave all of us a voucher or a tax deduction that we could go shopping, unless we really change the way that individuals receive their medical insurance they'd have problems.

I am concerned that this idea of doing away with the present tax structure it would do nothing to change what employers do. I think a survey recently showed less than 4 percent of employers said they would change their plans if the plans were not deductible by the employee. The employer gets to deduct it anyway.

One of the unintended consequences in the initial President's plan is that for very low income people their Social Security benefits would be reduced by about a third, because the new deduction given to them in a sense reduces the amount of salary in which they pay Social Security taxes; and, if it's a $12,000 deduction, you're making 30,000 bucks a year, it cuts into your Social Security benefits pretty severely. I guess that could be corrected with a tax deduction, but there are serious problems there.

The other issue is that we do get $200 billion in payments now out of this system for better or for worse; and, if we're going to spend $700 billion to bail out Wall Street, I don't know where we could get that 200 billion out of the employers without somebody up here on this Committee saying tax. And that's a very unpopular word on this Committee. So I see some structural problems on getting there.

Further, I think that programs that rely on consumer-driven plans tend to impact most heavily on low income. Those of us with generously taxpayer-paid salaries can afford to shop, can afford several thousands of dollars of co-pays under our generous benefits that we get, but people closer to a couple times the poverty level don't have that option. And, I think most studies, even Rand study back in the eighties, showed that when faced with higher deductibles or co-pays, people forego needed medical care and needed prescriptions. And I don't think we want to endorse plans that would drive people away.

Secondly, just to comment on the consumer driven plans, people have suggested more transparency in pricing. Many physicians have suggested that this puts the purchaser in the business of becoming a primary care doctor. It isn't a question of deciding how much a tests costs. It's what tests should you buy. And as Mr. Bodaken and I have discussed in the past, we want to expand the number of codes and the number of types of tests have expanded dramatically. And it would be beyond most of us without medical training.

It would be beyond our comprehension to decide what kind of a test we ought to buy. And then you get into the question, for example, if somebody decides they want to go to the low-cost hospital, but the low-cost surgeon, they find, can't practice at the low-cost

hospital; so we have an inter-relation between the providers of medical care.

And just starting to price this on the Internet could cause some problems that I don't think we're ready to deal with yet and could drive down the quality of our care, which is driven pretty much by our primary care doctor or whomever leads the direction of our medical care. So, while I am a great believe in shopping for the best price, I do find that in some of those areas we would have some problems, and I guess I would summarize it by suggesting that all the witnesses have brought forth some good suggestions in how we can improve what we are doing.

If the underlying goal is to first take care of the 46, 50 or 80 million people who are under-insured, my instinct is to leave the major plans in place, recognizing that over the longer run, and by that I would suggest 10 years, they will change. But I just could end these observations by suggesting that if anybody in this room could imagine a worse political situation than to have the Secretary of Health and Human Services announce that their health insurance plan—all 200 million Americans who have health insurance—would end next January 1st and that Pete Stark was writing a plan which they would receive in the mail, I can conceive of no one item that would be more apt to cause a revolution in this country against people who would just be afraid of what Washington would be doing.

So I think that states like Maine, Massachusetts—I wish California had been able to join them—Hawaii, who are moving toward plans to ensure coverage, are moving us gradually there. And I think anything we can do here to help it is important, and I appreciate all of your contributions in terms of suggestions of how we can facilitate that plan.

Unless there's anybody who has a burning desire to comment on that, I would recognize Mr. Camp for his inquiries.

Mr. CAMP. Thank you. Thank you all for being here.

And Dr. Feldman, you state that employer-sponsored insurance can and should stand on its own without special tax assistance. And what effect would eliminating the employer exclusion from employees' income of health benefits have on the number of employers offering health benefits?

Mr. FELDMAN. Some small firms would drop their health insurance coverage. A study by John Gruger and Michael Lettow at the Massachusetts Institute of Technology suggests that the percentage of small firms offering health insurance would fall from about 73 percent to 60 percent.

Gene Abraham from the Council of Economic Advisors and I predict that about 8.4 million workers and their dependents would lose their ESI coverage. Depending on how a subsidy for individual coverage was structured, however, we predict that about 90 percent of the workers who are dropped would take up individual coverage.

Mr. CAMP. And do employers have any incentives to offer health benefits, such as retaining quality workers or obviously having healthy workers?

Mr. FELDMAN. Yes, they do, Mr. Congressman.

The list of advantages of ESI that I presented is only a partial list due to time constraints. One of the strong advantages that em-

ployers have from offering ESI is that it improves the productivity of their workforce. Some studies have estimated that every dollar invested in employee wellness programs through health insurance can yield between two and three dollars of productivity savings. Fewer workers are absent and those who come to work are in better health and are more productive.

Mr. CAMP. This Committee has heard estimates of the number of under-insured in America. Are there any Americans who are over-insured because of incentives the Tax Code provides to over-purchase health insurance or over insure?

Mr. FELDMAN. I'll make a controversial statement, but one that I believe in. I think almost all workers who have ESI are over-insured, and that represents about 157 million individuals. The reason that they're over-insured is because the tax subsidy encourages them to buy policies that are more generous than they otherwise would buy.

One authoritative study suggested that the increase in insurance purchase raises costs by about 30 percent.

Mr. CAMP. A recent analysis of Senator John Edwards' healthcare plan by the Lewin Group found that imposing a mandate on employers to offer healthcare benefits or pay a tax would result in 52 million Americans losing their employer-sponsored health coverage.

Do you believe a play-or-pay mandate is a good idea?

Mr. FELDMAN. Well, I'm not going to respond directly to the Lewin results, because I don't know how much credibility a particular estimate has. But, I believe three things about a play-or-pay mandate. Number one, it's a tax on labor, and not a very particularly transparent tax either.

Number two, some employers would drop ESI coverage. They would find it would be more advantageous to pay the tax rather than continuing to offer ESI. And, number three, some low income workers would lose their jobs.

Mr. CAMP. All right.

Ms. Kofman, when Maine's health program went into effect it was to cover all 128,000 uninsured in Maine, but we're finding that fewer than 4,000 have been enrolled in the new program; and, in fact, the program has closed, I understand.

What would you attribute to this inability to be more successful in reaching the uninsured?

Ms. KOFMAN. Thank you for your question.

Dirigo Choice, which is a bridge program that helps people who don't qualify for public insurance like Medicaid and can't afford private coverage because it's too expensive, through Dirigo Choice, small businesses and self-employed people and others can access private coverage that is negotiated for by the state for them. There have been over 23,000 people who've been served by the program. The challenge, of course, is money, is financial. It's how to pay for the program.

You are absolutely correct that currently new enrollment is limited, and it's mostly because of the financial challenges that the program faces. And I welcome an opportunity to work with you to figure out a way to help us and other states to infuse more dollars into these innovative programs.

Mr. CAMP. Thank you.

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

Chairman STARK. Mr. Doggett, would you like to inquire?

Mr. DOGGETT. Thank you for your testimony.

Dr. Davis, you may be familiar with a report the National Women's Law Center is releasing today that shows that the overwhelming majority of these private health plans don't include maternity coverage. Or, if they do, it is in the form of a supplemental rider that has a long waiting period and is prohibitively expensive.

I recently received a communication from a realtor in Austin who said: ″I'm considering not having a baby because I'm concerned that as a self-employed person, I will have out-of-pocket expenses exceeding $10,000. I have health insurance, but it doesn't cover maternity. I'm a college-educated person, but I am afraid of the healthcare cost in this country.″

How can insurers in the individual insurance market claim to meet the needs of women if maternity coverage is so difficult to get and is so inadequate?

Ms. DAVIS. I think you've just pointed to one of the major differences between employer coverage and coverage in the individual market. When people get employer coverage, they get it by virtue of getting a job or being the spouse of a worker. And it would cover maternity care on the same basis as other services, perhaps even lower cost-sharing for pre-natal care.

But, as you point out, if you are buying coverage in the individual market, and as Mr. Bodaken stressed, the insurers are concerned that you're only buying coverage because you expect to be pregnant, expect to use the services. So, as a result, as you stress they either don't cover maternity benefits at all or they charge very high rates for that coverage.

I think we all know that investment in pre-natal care has high pay-off in terms of fewer low, birth-weight babies, fewer premature babies. A number of years ago, the Institute of Medicine estimated that every dollar spent on prenatal care saved three dollars because of having healthier babies. So I think this is exactly the kind of benefit that one would be very concerned that one would lose if one were to shift more people into the individual market.

Mr. DOGGETT. Let me ask you another question. Ms. Kofman may have some observations on this too.

There are actually people that sit on this side of the dais on this Committee who advocate a point of view that boils down to the fact that if you just charge high enough premiums on these high-cost policies with big deductibles to individuals, they'll make more rational healthcare choices.

I received another communication from a woman in Austin who consults with individuals and with corporations on how to cut their energy costs by being more energy efficient. And she says:

″I've been self-employed for 27 years. For 10 of those years I've had no health insurance due to the cost. Thankfully, I'm healthy and fit at 50 plus. I now have a catastrophic health insurance policy. It covers nothing unless I am hit by a train. There's a $5,000 deductible and so much mumbo-jumbo and who pays for what it would take a team of lawyers to figure out. So I avoid doctors,

check-ups, testing, and take the best care of myself as possible and pray that nothing unforeseen happens."

Do you find that with these high cost, private policies, like Brenda Cross has, the woman who wrote me there in Austin, that the nature of those policies affect the healthcare decisions that consumers are making?

Ms. DAVIS. You are absolutely right that those who are in a high deductible health plans are very dissatisfied with coverage. Only about a third are satisfied with their coverage. Most would not recommend the plan to a family Member or friend. Most would get out of those plans if they had any other alternatives available to them.

Those that are in the high deductible plans, whether they're with a savings account or without a savings account more likely to report not getting needed care. They are much more likely to report difficulty with medical bills, with medical debt. It's all part of this shifting more and more financial risk to families.

When it's covered by the plan, it's covered by the premium. It's shared between the employer and the worker. When it's in the deductible, only the worker pays for those deductible expenses. Some are fortunate enough to have employers making a contribution to a health savings account, but over a third have no contribution from their employers, and others have very modest amounts of money in their account. They are simply not able to handle the financial risk that this push toward skimpier and skimpier policies has created.

Mr. DOGGETT. Ms. Kofman, do you have experience with that?

Ms. KOFMAN. A couple of thoughts.

First of all, I think the higher cost, both for premiums and out-of-pocket costs, whether it's co-insurance or co-pays, or other out-of-pocket, it's like a silent disease that's killing off the middle class.

Mr. DOGGETT. Right.

Ms. KOFMAN. And we need help to stabilize, to keep families healthy, to keep workers at work. We need to help people financially and not take away what they have now. Many families are struggling. We know that the leading cause of personal bankruptcy in America is an illness, and we know that the majority of those filers had health insurance. It just wasn't enough to cover them.

While we are engaged in all this talk about, perhaps, some being over-insured and buying too much, we live in the wealthiest nation in the world, and arguably we provide the least for people who need it the most. We let 18,000 people die each year preventable deaths because they have no coverage; and, more and more people are struggling to pay their bills to maintain their health coverage.

I would argue that we need more financial resources, more real solutions to address the cost drivers to make sure everyone gets coverage and it's fair and just.

Mr. DOGGETT. Thank you for helping us lay the ground work for real reform next year with a new president.

Chairman STARK. Mr. Johnson, would you like to inquire?

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Bodaken, as part of your health reform plan, you advocated expanding Medicare and Medicaid, and in an interview you gave to

the San Francisco Gate you talked about how Medicare and Medicaid are significantly under funding hospitals and physicians.

You know, Medicare is slated to take another cut in physician payments by about 40 percent over the next decade. In your state, 50 percent of the doctors won't participate in Medicaid, according to our information, because of low reimbursement.

I think and I would like to hear what you think about fixing the problems in Medicare and Medicaid, which are both under funded and running out of money before we talk about expanding eligibility. Could you comment on that?

Mr. BODAKEN. What I was talking about, the expansion of Medicare and Medicaid, it was less about the expansion of eligibility and much more about getting the underlying reimbursement to physicians in hospitals to a level that is adequate so that they don't leave the system. What's happening with all of the public programs, including SCHIP, is that because of the levels of reimbursement, Medicaid is the lowest, and California in particular is one of the lowest states in terms of MediCal payments to physicians, and for that matter hospitals, but Medicare as well.

They in fact, because they are under funded, actually to make their bottom lines have to charge the private sector essentially the same contracts with companies like mine at a much higher level, which means that all of the private coverage is that much more expensive. We think it's about 15 percent more expensive because of what we call the cost shift from the under funding of Medicare and Medicaid to the private sector.

Mr. JOHNSON. Yeah, but where would you suggest we get the funds from?

Mr. BODAKEN. Well, it seems to me and one of the things we've said from the day we launched the proposal for universal coverage is that frankly we really do believe that it's not a matter of whether tax is a dirty word or not, it's not a matter of simply taking the current revenues and redistributing them, and somehow covering 48 million more people. It's going to cost more money, and we had thoughts about that at time.

We still have those thoughts, but the reality is we've got 48 million people uninsured nationally, 7 million in California uninsured, to get to levels of reasonable coverage and reasonable reimbursement to providers. I think it's going to take more money, and whether we call it fees or whether we call it participation to a greater extent on the part of the enrollee. There's lots of ways to do it, but frankly I think it's naive to think that we can meet the unmet needs of that many people and have it all come out as a zero sum game.

Mr. JOHNSON. Well, we may have to start charging people more. I think we can agree that making individual health insurance market more viable for more Americans will help decrease the number of uninsured in the country.

Mr. Bodaken, you said that an individual mandate would be one way to achieve that. What about equalizing the tax treatment for health benefits? For example, if the Tax Code treated health benefits that individuals purchased on their own the same way as those benefits purchased through the employer-sponsored system,

wouldn't that affect the individual insurance market? And I'd appreciate both of you answering that.

Mr. BODAKEN. Yeah, I think actually there is an inherent unfairness in the individual market versus the group market in terms of the tax treatment. And changing that unfairness I think is an appropriate thing to do. The only thing I would caution is that the adjustment of the underlying tax treatments, particular in the employer system, I think getting it equal in the individual system is fine.

To remove it from the employer system and the individual system I think has much more severe consequences in terms of actually increasing the problems of uninsurance and underinsurance. So I don't personally think in the near term that doing that is really a solution. But insofar as we have a Tax Code that says if I have a job and my employer gets a deduction and I get a deduction, If I'm individually employed, it seems to me that same deduction should apply.

Mr. JOHNSON. Dr. Feldman, would you care to respond?

Mr. FELDMAN. I think extending the tax subsidy to individual insurance would be the most significant tax reform that you could consider at this point. That would allow you to consider more significant, longer term reforms that Members of this panel and of your Committee all support.

You could require that insurers who accept the tax credit offered guaranteed renewability and guaranteed issue for all comers for their policies. You could also require that they offer several standardized packages, some of them including maternity benefits.

I would recommend that you allow insurers to designate between one and 2 percent of their applicants as uninsurable, because some folks, truly, can't be insured by a private market. Those people would go into a high risk pool subsidized by premiums levied on all the normal policies. But all of these things are contingent upon reforming the tax treatment of health insurance so as to create a level playingfield.

Mr. JOHNSON. Thank you very much for your testimony.

Mr. Speaker, my time has expired.

Chairman STARK. That's all right. I will accept the promotion.

Mr. Becerra, would you like to inquire?

Mr. BECERRA. Thank you, Mr. Chairman, and thank you to our panelists for their testimony.

Superintendent Kofman, Congressman Doggett asked some questions about the treatment of women when it comes to healthcare and I would like to expand on that a bit. We know that some plans are making some substantial profits these days, while at the same time we have a number of consumers who can't afford to purchase health insurance, and many are being denied health insurance or being removed from their plan because they have allergies.

We know that in many cases there has been an effort in the past years of this Congress to remove oversight and regulatory responsibilities to oversee some of the insurance industries activities in healthcare, and now we are beginning to see in the banking industry the results of some of the deregulation that occurred, the bailout of AIG, the default of companies like Lehman Brothers, and

now we're being told by the President that we must provide $700 billion to bail out Wall Street.

What is your sense of the need to provide some responsible oversight and regulatory authority over the health insurance industry to make sure that consumers indeed are receiving what they believe they are paying for?

Ms. KOFMAN. I don't think that the insurance industry can regulate itself; and, I think there is an important role for state insurance regulators. And I ask that you do not take my authority away to protect the consumers living in my state, whether it's through health insurance or other congressional interventions.

It is my job to make sure that companies stay solvent and claims get paid, and that there's a fair and predictable marketplace for companies to do business. Going back to your first point on discrimination against women, I just want to clarify that the problems identified in my testimony are problems in the individual market.

Many of those problems do not exist in the group market and the job-based market because Congress and the states have passed laws to protect women against discrimination. So I just wanted to clarify that. In many cases, you can't even buy, for instance, a maternity rider. In Maine, we don't require individual health insurance coverage to cover maternity.

We have two carriers. One of the carriers voluntarily offers that coverage; the other one does not. Even if you wanted to pay a million dollars for that rider, you couldn't buy it as a consumer. In the job-based market, especially for employers with more than 15 employees, that's not allowed. You have to cover maternity, and that's as a result of the Federal laws that we have.

Mr. BECERRA. And is it the case, especially in the individual marketplace, that you do find some stark disparities between the cost of insuring a woman, all else being equal, and the cost of insuring the man, to healthy 40-year-old individuals, one male, one female, in the same geographic area, trying to shop for an insurance policy as an individual could result in vast disparities in cost, usually a much higher cost for a woman than a man.

Ms. KOFMAN. That's correct. Maine is one of five states where we do not allow disparities based on gender. You cannot be discriminated against because you are a woman. Our rates are allowed to be varied based on age and tobacco use and geographic location and occupation. But insurance companies are not allowed to base their rates on one's health needs or perceived needs or gender. But we are in the minority.

Mr. BECERRA. And it seems that when you talk about healthcare and you talk about a system where there has to be some coverage for the need to recoup some of the cost and make some profit, there will always be a desire on the part of the entity, whether insurance company or a physician, to be able to make ends meet. So you have to have a little bit of a buffer at the end of the day, call it a profit, whatever you wish, to be able to offer services the next day.

That differs, of course, from the Federal government or any government-provided healthcare where at the end of the day that governmental entity, Federal, state, is not looking to make a profit, and, as a result, will cover the ill as well as the healthy at the

same time. So a woman who is about to become pregnant or who is pregnant is not going to find herself facing some discriminatory policy from the Federal government when it comes to receiving health insurance.

Usually, it's unfortunate that we are talking about a woman who is low income who receives that non-discriminatory treatment by the government. But it seems to me that there's a problem we have here in that the reason the government can be non-discriminatory is because it's not looking to make a profit on the private sector side, if you want to make a profit. And I can understand the need to make a profit.

You want to get the least ill, or in other words, the healthiest person, to become a Member of your plan. So a woman who is 30 years of age and still childbearing age wishes to be insured versus a man who is 30 years of age and obviously can't bear children. That insurance company probably looks at the two and says, the likelihood that the 30-year-old man is going to cost me less over the next 10 years than that childbearing age woman of 30 years of age as well.

Ms. KOFMAN. Yeah, if men could only have kids.

Mr. BECERRA. We might have had universal coverage quite some time ago, I suspect.

Ms. KOFMAN. I think to your point of different incentives that exist when the private market provides coverage, it's certainly true in a for-profit world, and it's not a value judgment. It's just the reality.

Mr. BECERRA. Right.

Ms. KOFMAN. Companies need to make profits, especially if they're publicly traded. They have responsibilities to the stockholders on Wall Street.

Mr. BECERRA. That's right.

Ms. KOFMAN. And it's a different type of incentive, then, for government. Certainly when employers provide coverage to their workers there is a built-in incentive to make sure the worker gets healthy as quickly as possible so he or she can return to work quickly. Well, I'm not sure that same incentive exists in the individual market. It's a different type of incentive. So, that's another reason we should be very careful if we decide to walk away from the job-based coverage system we have currently.

Mr. BECERRA. I am glad you distinguished it. We are not making value judgments here. It's a fact of life. If you are in the private sector, you have to survive, and that means you have to be able to make some profit at the end of the day.

So it's not that these industries are trying to short-change Americans. It's that they have to exist for the next day. And, so, that's difficult we have the four courses that we are talking about, the healthcare or the life of someone in the future. And maybe that's not the best way to make value judgments.

But, Mr. Chairman, I know my time has expired, and I appreciate it.

Chairman STARK. Thank you. We are going to have a vote in a few minutes and I would like to give as many people here.

Mr. Pomeroy, would you like to inquire?

Mr. POMEROY. Yeah, I would, Mr. Chairman.

Thank you for this excellent hearing. The panel has been superb.

I am trying to put this in the context of what we might see next year by way of a proposal from a new administration relative to healthcare.

Dr. Feldman, have you had an opportunity to compare your view on how this ought to go with the positions of the respective candidates?

Mr. FELDMAN. Yes, I have. I have not made these statements publicly before. In my comparison of the candidates' proposals, I think they would both be quite effective in reducing uninsurance and they would both be quite expensive.

Mr. POMEROY. The proposals are quite different. It seems to me as I hear you saying is the first thing we need to do is essentially dramatically change the tax support for employer-sponsored health insurance. Now, to me, is that more like the approach of Senator McCain as opposed to Senator Obama?

Mr. FELDMAN. Yes, it is.

Mr. POMEROY. Now, you offered some statistics that I am wrestling with. You think that those workers covered by employer-based health insurance are over-insured, and this rises the cost of health care?

Mr. FELDMAN. Yes, I do, Mr. Congressman.

Mr. POMEROY. So in your view if people were paying a lot more from their own pocketbook, then the prices would come down because people would be unable to afford those prices.

Mr. FELDMAN. I would like first of all to say that when we talk about the cost of employer-sponsored health insurance, ultimately all of it, whether it is paid by the employer on my behalf or whether I pay for it out of pocket, comes out of my productivity and out of my paycheck. This is a prediction from both economic theory and,

Mr. POMEROY. With time so short, we can't get into the theory part. But, basically, you think over-insurance means someone else pays the bill and that means you can charge more because the user of the service isn't paying the bill personally?

Mr. FELDMAN. Yes, sir.

Mr. POMEROY. And so we get at cost by having people pay more out of their own pocket.

Mr. FELDMAN. Yes, that's correct.

Mr. POMEROY. You would tax employees for the value of the health insurance they received, right?

Mr. FELDMAN. Yes, I would.

Mr. POMEROY. And is that similar to the McCain proposal?

Mr. FELDMAN. It is.

Mr. POMEROY. I am glad you clarified that, because I am looking at something I pulled off the web page: McCain-Palin. It says ″Straight talk on health system reform.″ And there's not a word about the new taxation on employees for the value of their health insurance benefit received.

Indeed, what is the value of health insurance commonly provided? Do you know, Dr. Feldman?

Mr. FELDMAN. In the testimony that I presented earlier I mentioned that the value of the taxes for a single person was $1753 and the value for a family was, I think $3800.

Mr. POMEROY. No. That's not the question. How much more tax would they have to pay? And I'm just looking, for example, at the Blue Cross testimony and you are estimating that the cost of coverage in a large group, which would be the most cost-effective insurance delivered, is $4500 per year for a single worker, $12,000 for a family. So a worker in the marketplace with family coverage can expect to pay taxes on $12,000 more income. Is that correct?

Mr. FELDMAN. It all depends on your position in the distribution of income.

Mr. POMEROY. No, actually. Again, theory versus just how this thing works. In terms of how it works part if you're paying income taxes on the value of your coverage and the average value of coverage is $12,000 a family, it looks like I just got $12,000 income figured into what I got to pay taxes on.

Dr. Davis?

Ms. DAVIS. Congressman, if I could just comment.

The Urban Institute, Brookings Institution, Tax Policy Center, estimates that Senator McCain's proposal would increase taxes by 1.3 trillion over 10 years, and that's not covering the cost of the high risk pools.

Mr. POMEROY. No. I'm saying in fairness to the McCain plan, it looks like he gets a tax credit, but the tax credit is $2500 for individuals and $5,000 for families. Now, someone that is going to have to go shop for coverage, how far is that going to go to covering the coverage you are going to have to shop for.

We might ask the expert, the guy that sells the insurance, Mr. Bodaken?

Mr. BODAKEN. Yeah, we think it would be about 50 percent inadequate in terms of covering what they have to buy on the open market.

Mr. POMEROY. I am going to cite here from a survey, and then I see that my time has elapsed, Dr. Feldman. By all means submit in writing further elaboration.

A survey conducted by the American Benefits Council sites 74 percent of employers responding that this changed tax treatment would have a strong, negative impact on their workforce and that some considerable portion of their workforce would actually find that coverage would then transition from the place of employment to the individual, and so people can be expecting to pay substantially more out-of-pocket dollars one way or the other under the McCain plan. It's not reflected in the straight talk.

Peace would seem like straight talk on these matters. We want to make note of that fact.

I yield back, Mr. Chairman.

Chairman STARK. Thank you.

Mr. Kind, would you like to inquire?

Mr. KIND. Thank you, Mr. Chairman.

Just to follow along the line of questioning of Mr. Pomeroy, the statistics that I am looking at, if we are focused on the ranks of the uninsured in this country, there is a large percentage of people working in small businesses or family farms and having a hard time getting coverage, because it is too expensive.

About 30 percent of the employees working in small businesses have to go without any type of health coverage, because of the ex-

pense involved. And, yet, getting back to what Mr. Pomeroy was alluding to, the average monthly premium for an employee in a small firm was roughly $379. That's roughly $4,553 in annual premiums. And then for family coverage it comes to $11,835.

Is that pretty close, Mr. Bodaken, the statistics that you are seeing? So the $2500 and the $5,000 tax credit would be about half of really what we are seeing nationwide, average premiums for individuals and family coverage today. It is quite a gap in order to make up.

I have been focused. You know, if you look at the 48 million uninsured in a given year, a lot of them working in small businesses or on family farms that can't afford coverage, how do we close that gap? Earlier this legislative session, I and Phil English and others introduced legislation called the Shop Act. It would establish a national purchasing pool to give small businesses and family farmers a chance to join that.

There are some tax incentives in order to offer coverage to it and also some of the other barriers. But one of the other aspects involved in the legislation is seeing what we can do to try to begin harmonizing rules across state boundaries. We've got 50 different states with 50 different sets of regs, 50 different sets of mandates out there.

How important would that be as far as establishing a pool for small businesses or family farmers to join in if we focus on just what's going on from state to state and then trying to harmonize those rules at some point?

Does anyone have an opinion or thought?

Mr. BODAKEN. I guess our thought is and perhaps similar to what was said earlier about state regulation, if we look at the overall regulation of the insurance market, the problems we have in the insurance market, at least in my opinion, are not primarily the result of inadequate state regulation. In fact, state regulators do a pretty good job on the whole. The problems are in the way the market has functioned, or should say, allowed to function, and there's lots that can be done at the state level to fix that.

And, so, for example, we talked about maternity early. We actually proposed, along with another health insurer, that we require maternity in our individual policies. It's the right thing that maternity not be part of an individual policy, ended up passing and vetoed by the Governor.

That said, there are even insurers that believe that coverage is too skinny, we ought to fix it. I don't think by putting it at the Federal level that we necessarily solve those problems.

Mr. KIND. I am not talking about Federal preemption here, but I am talking about seeing what we can do to try to harmonize across state boundaries.

Mr. Feldman?

Mr. BODAKEN. Yeah, and I guess the other suggestion that has been made is that we sell across state lines and our concern there would be just to make sure that there isn't a cherry-picking of states with the least regulation, and they aren't sufficiently solvent for a state like California.

Mr. KIND. Right. Our proposal is to have the Institute of Medicine take a look at this and see if we can come up with a basic benefit plan that would make sense.

Mr. Feldman?

Mr. FELDMAN. Mr. Congressman, number one, the tax exemption for self-employed people should be extended so that you can deduct as much of the tax as a person who gets ESI. Currently that exemption is limited to the extent of your taxable income, and you can't apply it against your self employment tax.

Mr. KIND. Yes, and I have legislation that would get rid of that self-employed tax that would voluntarily deduct their health insurance premiums. It's an anomaly in the Code and we should fix that.

Mr. FELDMAN. It's just an anomaly.

Number two, your pooling idea I think would have support from Members of this panel. The state of Minnesota operates two insurance pools; one for high risks and one for people who are getting a state subsidy. And both of those pools run at administrative costs of around five to 6 percent per year. So that's a very good idea. Number three, I would support allowing individuals to buy insurance across state lines.

Mr. KIND. Yes, just let me make a quick observation, and if anyone wants to comment, you can. But I have noticed when you look at the comparative rate of the uninsured from state-to-state, and I am not sure if there is a correlation. Maybe you do see one, but those states with the relatively lower uninsured rate for their citizens also happen to be states that have less utilization, yet higher quality of outcome.

I am talking about Minnesota, my state of Wisconsin, Iowa. Is there a correlation here where you are getting less utilization, higher quality of outcome? It just so happens in these states that one of the lowest in Federal reimbursement rates, too, and yet they have some of the lowest uninsured rates in the entire nation compared to the rest of the states.

Ms. DAVIS. Absolutely. The Commonwealth Fund issued a state scorecard on health system performance, and there is a very high correlation between the extent to which the people were covered by insurance and the quality of care, whether people got preventive care, whether they had their chronic conditions controlled. So definitely there is a high payoff for states that have high rates of insurance coverage in terms of better health outcomes, better quality of care.

Mr. KIND. Thank you.

Chairman STARK. Dr. McDermott, would you like to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I appreciate you having this hearing and letting me ask a question.

The Veterans Administration negotiates prices; and, I am really talking to Mr. Bodaken, because I think it was your testimony that talked about the woman who thought she had health insurance coverage and wound up finding that her insurance only covered $1500.

Was it yours? Excuse me. Then I got the wrong person. But the issue here that strikes me is that the Veterans Administration ne-

gotiates down to 40 percent on pharmaceuticals. Only when the government steps in and regulates can you get savings. It seems to me that buying in the private insurance market is hopeless, because the average person, this woman with her cancer treatments, has no way to negotiate or shop. She isn't going to go down to the pharmacy and say, I would like the cheap drug to stick into me for my cancer. She can't do that, and she has no way to drive down the price, because she is by herself.

And the insurance companies are never going to drive down the price. They're not going to buy. So explain to me how you control cost in the private market or do you not care as long as you can shift it onto the individual?

Mr. BODAKEN. Well, with respect to whether we control costs, costs are certainly going up at a higher rate as a result of hospitals, physicians, pharmaceuticals, all kinds of things, some of which is legitimate, some of which isn't. The reality is we probably pay on behalf of our subscribers, about 50 percent of what a private individual would pay without the discounts that we're able to negotiate, so it is pretty significant what we are able to negotiate on behalf of individuals.

But I don't discount the fact that certainly Medicare has got clout that no individual insurer has in terms of negotiating drug prices, and perhaps in other areas, we ought to take advantage of that. But in fact we do a very good job and I would say the Blues nationally do a very good job of getting more cost-effective rates than any other health plan across the nation in terms of the negotiations we have with hospitals and physicians.

Mr. MCDERMOTT. Mr. Kofman, what is your experience with this? You are running this insurance program in Maine. What is happening to people?

Ms. KOFMAN. Well, I don't run the insurance program in Maine. I lead the insurance department, and we have oversight over insurance companies.

I am not convinced that insurance companies could effectively negotiate on behalf of the policyholders. I think it depends on the providers, if in Maine for example many of the hospital systems have gotten quite large and they purchased physician groups. So about half of the physician groups are owned by a hospital system.

Mr. MCDERMOTT. So doctors are working for salaries rather than on a fee-for-service or performance production basis?

Ms. KOFMAN. There are different arrangements, but essentially the hospital system negotiates on behalf of the doctors that are in the system. And the salary structures vary.

Mr. MCDERMOTT. How big, how big does the system have to be? I mean we prohibited Medicare with 45 million people from negotiating, but how big does the hospital have to be to be able to drive the prices down by that kind of negotiation.

Ms. KOFMAN. Well, the carriers negotiate with the hospitals, and if the hospital system is quite large and there's only one hospital system in the area, then it's kind of hard to negotiate because you only have one player you're negotiating with. So I think it's a challenge for the private carriers to negotiate a huge savings when there is only one party to negotiate with.

I think looking at the whole system, system-wide, there are opportunities to save money, whether it's looking at the fee structure, looking at how we spend new technologies, new MRI machines. Why do you need five of those in a particular setting when the community is small.

For example, looking at the drug prices, why they had been going up, looking at how we use medical care, when do we access medical care. Is it in a timely fashion where we can get to the problem early before it costs a whole lot of money? There are lots of opportunities to do that and I certainly would agree that the government has been quite successful at looking at some of those opportunities and achieving cost savings, like what the VA does.

Mr. MCDERMOTT. Absolute global budget; it seems like it's an open-ended thing that's going on today. Being a physician, I know about the California relative value scale, and I lived with it for 20 years when I practiced medicine, so I know how physicians ratchet prices up. And the pharmaceutical companies seem to be doing the same thing and the device companies are doing the same thing at much higher than the actual rate of inflation to the rest of the economy.

So I find it very difficult to see how the private market could ever do for the individual what a government regulated system—and I know government regulation is the in-talk these days—since we've been watching the banks, but there does need to be some way it seems to me to put that on top.

I yield back the balance of my time.

Chairman STARK. Thank you.

And I want to thank our witnesses. I would like to have you be comfortable if Members, and I'm sure we all will think of something we wish we had asked this morning, if we could write to you sometime for your input on questions that will occur to us or that our staffs will remind us that we forgot to ask. It would be appreciated. You will make us look a lot smarter if we can impose on you.

Thank you for your testimony this morning and the hearing is adjourned.

[Whereupon, at 11:36 a.m., the hearing was adjourned.]

[Submissions for the Record to follow:]

American Academy of Actuaries, Statement

The American Academy of Actuaries is a professional association with over 16,000 members, whose mission is to assist public policymakers by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

INDIVIDUAL MEDICAL INSURANCE MARKET

Many recent proposals designed to reduce the number of uninsured would increase the reliance on the individual medical insurance market to provide coverage. As such, the American Academy of Actuaries'[1] Individual Medical Market Task Force has developed this statement to provide policymakers with a clear understanding of how the current individual market works, the relative ease or difficulty a person may have acquiring coverage in this market, and the cost implications once

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he or she is covered.Policymakers aiming to ensure that any "reformed" market is viable and sustainable over time should consider the information provided in this statement. A key to sustainability is managing the adverse selection in a voluntary market, which may require trade-offs between accessibility and affordability.

BACKGROUND

Insurance purchased in the individual market was the primary source of health coverage for about 5.4 percent of the nonelderly population, or 14 million people, in 2006.[2] The individual market is an important segment of the health insurance market. People who purchase coverage in the individual market include those who are self-employed, between jobs, or don't have access to either employer coverage or public coverage.

The individual market today is a mix of regional carriers and large national carriers plus independent or consolidated Blue Cross Blue Shield organizations. Within the past few decades, the number of insurance carriers has declined, due to carrier consolidations as well as some carriers leaving particular states due to changes in the regulatory climate. In recent years, some large carriers have been selectively entering the individual market; their considerable market share allows them advantages in provider-payment negotiations and economies of scale.

REGULATION

Like other forms of insurance, the individual market is regulated primarily by the states. Indeed, the individual market is considered to be the most heavily regulated health insurance market. States can regulate benefit-coverage requirements, underwriting and rating practices, and market conduct. While many benefit-coverage and insurance policy-administrative provisions can be relatively consistent across the country due to standardized contractual language in all states, regulations of other aspects of individual market products, including specific mandated benefits, can vary significantly from state to state. As a result, multi-state insurance carriers must comply with multiple sets of regulations, which can increase compliance costs.

Some insurance companies use associations or discretionary trusts to offer what is essentially individual insurance. These vehicles are regulated as "group" or "franchise" insurance, as they insure multiple unrelated individuals under a single master contract. This may allow insurance companies to avoid the rate approval processes (and sometimes other regulatory oversight functions) required of traditional individual policies. Many states have clarified the regulatory oversight for these types of arrangements. For those that haven't, the lack of clear rating and regulatory oversight can lead to situations in which consumers have no place to turn for redress.

In addition to state regulations, certain federal regulations also apply to the individual market, in particular, the Health Insurance Portability and Accountability Act (HIPAA). This law provides security that had not previously existed in the individual market. Previously, insurers could cancel blocks of policies without penalty. Under HIPAA, insurers may not cancel or non-renew policies, except for non-payment of premium as long as the insurer remains in the individual market. HIPAA also contains provisions requiring that qualified individuals leaving employer coverage have access to coverage in the individual market on a guaranteed issue basis. HIPAA does not specifically regulate the premiums for such coverage. This means that individuals who cannot satisfy underwriting criteria are still offered coverage, but at premiums that may be twice or more the rates for individuals who do satisfy underwriting criteria. Most states, however, have means to control these rates, such as offering HIPAA-eligible people coverage through a high-risk pool or some other state-regulated mechanism.

ISSUE AND RATING CONSIDERATIONS

States use insurance issue and rating regulations in an attempt to strike the appropriate balance between access to insurance and premium affordability.

Underwriting Rules and Guaranteed Issue

Insurance in the individual market is issued on either a guaranteed-issue basis or through medical underwriting. In most states, insurers require applicants to qualify for coverage through a medical underwriting process. This enables insurers to classify similar risks together and assign an appropriate premium. The underwriting process removes from a risk pool those individuals for whom large claims may be expected in the near future. Underwriting decisions are made on a person-by-person basis, even within families applying for coverage together. Some individ-

[2] "Health Insurance Coverage in America: 2006 Data Update," Kaiser Family Foundation, October 2007.

uals will be denied coverage and others may be able to obtain coverage but at a higher premium or with exclusions for certain pre-existing conditions.[3] Still, about three-quarters of underwritten applicants are accepted as standard risks.[4]

Importantly, the underwriting event is a one time process at the time of application. Individuals who pass underwriting and are issued a policy will not need to undergo any further underwriting in order to retain that policy, regardless of health status changes, as long as premiums are paid on time.

A handful of states prohibit insurers from medical underwriting and instead require guaranteed issue for all applicants, not just those eligible under HIPAA. In those states, all applicants must be issued coverage regardless of their health status or likelihood of large medical expenses. Compared to insurance pools comprised of individuals who pass medical underwriting, guaranteed issue provisions result in insurance pools with higher average expected claims and a higher share of insureds who are expected to have claims. Higher average premiums result. This arises not only because individuals at risk of high health spending cannot be denied coverage, but also because guaranteed issue provisions can reduce the incentives for individuals to purchase coverage when their expected medical spending is low. This is especially true when guaranteed-issue provisions are accompanied by community rating provisions, which is frequently the case. As will be discussed in more detail below, under community rating all insureds (or all in a certain demographic class under adjusted community rating) pay the same premium. Individuals who anticipate low medical needs may find it less costly to delay purchasing coverage until their medical needs rise.

Premium Setting

Similar to other types of insurance coverage, premiums for individual market business are set to provide for claims, administrative expenses, margins for adverse contingencies, profit/contribution to surplus, premium taxes and other applicable state fees, and federal taxes on earnings. How these components are included in setting premiums can vary by carrier, and competition can influence where premiums are set.

Typically, factors that are used to set premiums for an individual include the benefits selected, the selected provider network, age, gender, geographic location, and perhaps policy duration. Health status may also affect premiums, as can tobacco use.

Rating Structures and Restrictions

The most common state premium rating approach for the individual market is to permit premiums to vary not only by characteristics such as age and gender but also by the individual's health status at the time of issue. Even with this approach, however, there may be some limitations on premium variations. For instance, several states impose rating bands that limit the amount that premiums can vary according to health status.Certain states have implemented more restrictive rating requirements, which generally limit the extent to which premiums are allowed to vary among all or certain risk characteristics. General approaches that states use to restrict rating variations include:

- *Pure community rating.* Under pure community rating regulations, every participant in a particular insurance plan pays the same premium. Premiums cannot vary by factors such as age, gender, and health status. However, premiums can vary by family size and usually by geographic region within the state. With pure community rating, the low-risk individuals subsidize the costs of the high-risk individuals, essentially lowering the premiums for high-risk enrollees and raising the premiums for the lower-risk enrollees. New York and Vermont are two states that require pure community rating in the individual market.
- *Adjusted community rating.* Under adjusted community regulations, premium rates are allowed to vary, often within limits, by certain characteristics, such as age and gender. However, premiums are not allowed to vary by health status. Maine and New Jersey are two states that require adjusted community rating in the individual market.

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[3] Certain individuals who are denied coverage at the time of application may have access to state high-risk pools. According to the National Association of State Comprehensive Health Insurance Plans, 35 states operated high-risk pools in 2007, covering about 200,000 individuals (available at www.naschip.com, accessed on July 23, 2008).

[4] America's Health Insurance Plans. 2007. "Individual Health Insurance 2006–2007: A Comprehensive Survey of Premiums, Availability, and Benefits" (available at http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf).

A goal of imposing rating restrictions is to reduce the premiums for those at risk for high health costs, thereby increasing the affordability of their coverage. The compression of risk-based rates between ages, in which the rates for older individuals (e.g., over age 50) are set lower than their risk level would imply while the rates for younger individuals (e.g., below age 35) are set higher than their risk level would imply, is an example. This needs to be done carefully, however, or the rates for younger individuals will be so high compared to the perceived value of the policy that they will be disinclined to purchase coverage. This can result in an age distribution skewed more heavily toward older higher-risk ages, resulting in higher premiums for all insured individuals. As premiums increase, more of the low-risk individuals (of all ages) leave the market, causing premiums to increase even further and threatening the market's sustainability.

Yearly Premium Increases

Premiums for plans in the individual medical insurance market typically increase every year (and sometimes more frequently), primarily due to increases in claims costs. Numerous factors affect how average claims costs for a particular plan and insurer can change from year to year, and how those changes in claims costs that are factored into a plan's premiums can vary from insurer to insurer. The result is a wide variation in claims costs and in the resulting premiums between plans within an insurer and between insurers.

- *External factors driving medical-cost increases:* These factors reflect increases in the per-unit costs of health services (e.g., the price for a given physician visit, hospital visit, or prescription drug) as well as increases in the utilization and intensity of medical services received. These external factors, which recently have been in the 8 to 10 percent range, are common to all health insurance markets.
- *Cost-containment factors mitigating cost increases:* Insurers use various techniques, such as utilization management and provider-payment negotiations, both of which may become more stringent as insurers try to offset the claim cost increases that arise due to external factors. Conversely, any reduction in the stringency of these capabilities will increase the growth in claims costs.
- *Policy duration (for medically underwritten business):* As discussed above, where allowed, medical underwriting is used in the individual market to assess an individual's relative risk for incurring near-term health costs and to assign a premium commensurate with that risk. Coverage for undisclosed pre-existing conditions is also limited for a specified period. The result is a pattern of increasing claims costs by year since issue, commonly referred to as policy duration. In the first two policy durations, claims costs are typically low. In later durations, individuals develop health conditions and incur more claims. The extent to which these expected increases in claims costs translate to yearly premium increases depends in part on the insurer's pricing strategy. Some insurers will evenly spread these expected annual increases over all the premiums for the length of time an average policy will be in force, including the initial premium. This produces higher initial premiums, but lower premium increases over time. Other insurers will set lower initial premiums, but have higher premium increases to reflect more closely the pattern of these expected increases in each year. The degree to which carriers reflect the expected durational increases within each year's premiums varies considerably, and can depend on the state. Some states limit the durational effect on premiums by requiring that a larger portion of the later-year expected claims costs be included in initial and early-year premiums. Other states do not have such limits, and allow the balance between initial and renewal premiums to be adjusted by market forces.
- *Policyholder lapses:* In developing the initial premiums, as well as annual premium increases, insurers assume a certain percentage of policyholders will lapse, that is drop coverage. Some may secure employer-based coverage. Others, especially those at low risk for claims, may not be willing to pay the annual premium increases. They will either go without coverage or seek other coverage costing less. Lapse and re-purchase is more common if premiums increase substantially with duration. Individuals who are at lower risk for health claims may be able to purchase a new policy at a lower premium either from the current insurer or a different insurer. As a result, the average claims costs, and premiums, of those individuals retaining coverage will increase over time.
- *Plan design effects:* A plan's deductible levels can affect how its claims costs change over time. When total health spending increases but the deductible level is held constant, the deductible each year represents a smaller share of the services used by the insured. Therefore, the plan's claims costs will increase more on a percentage basis than the increase in total spending. In addition,

more individuals will have spending that exceeds the deductible amount. This increase in claims costs, and the associated increase in premiums, is referred to as deductible leveraging and the higher the deductible, the greater the leveraging effect will be, all other things being equal. To offset this increase, insureds who do not expect immediate health care needs may elect to increase their deductible levels in order to match their premium increase to, say, their wage increase. This practice is often referred to as a benefit buy-down.

It is important, however, to consider the effects of deductible changes in conjunction with policyholder choice and adverse selection. Individuals usually have knowledge about their expected health care expenses in the near term. They will use this knowledge to time a change in their deductible to maximize the benefits they receive. Because lower deductible plans pay a higher share of medical expenses, they tend to attract individuals who expect to incur claims in the near future. And higher deductible plans will tend to attract individuals who expect fewer claims in the near future. Some policyholders with low-deductible plans who expect low future health care needs will decide to increase their deductibles. This selection results in higher average claims costs for those remaining in the low-deductible plan. Moreover, the addition of the policyholders who are increasing their deductibles to the pool of individuals with higher deductibles could reduce the average cost of that pool. As a result, it is not uncommon for many insurers to increase premiums for low-deductible plans at or above the overall average premium increase rate while instituting the same or slightly lower premium increases for higher deductible plans. In other words, the impact of selection can offset the increases resulting from deductible leveraging of higher deductible plans.

In setting annual premiums, insurers consider the above factors. Since several of the factors operate together, the effects of a single factor on the overall trend in claims costs may be difficult to estimate. The goal is to develop the best estimate of the claims costs for the next year. Part of the process involves the correction of prior estimates; these corrections may increase or decrease the current estimate of the claims and the resulting rate increase. These help account for why premium increases can fluctuate over time and differ not only between insurers but also between plans within an insurer.

BENEFIT PACKAGES/COVERAGE

In the early days of the individual market, medical coverage offered only a limited benefit package, to keep premiums and rate increases low and to manage adverse selection. Coverage for hospitalization was limited to a fixed daily benefit payment, sometimes with a limit on the number of days per admission or per year and also a list of set-dollar fee payments for surgical procedures, with only those procedures on the list being covered. Many benefit packages did not cover office visits or prescription drugs. Over time, the benefit packages became more comprehensive in the amount and type of medical expenses covered, approximating those in the group market. Nevertheless, coverage in the individual market generally has higher out-of-pocket expense amounts than in the group market. Although lower-deductible policies are available, individuals typically choose policies with deductibles in the range of $1,000 to $1,500, with some choosing deductibles as high as $5,000 or $10,000.[5] Once the deductible is met, coverage is typically very comprehensive, unlike earlier limited benefit packages. For instance, a typical plan may require 20 percent coinsurance, but eliminates cost sharing altogether once an annual out-of-pocket threshold is reached.

In addition to higher deductible levels, medical coverage in the individual market commonly differs from typical group coverage in some areas, including:

- Normal maternity coverage (except for complications) is often excluded from benefit packages in the individual market, or offered with dollar limits and waiting periods of more than nine months before benefits are paid.
- Where allowed by a state, treatment for substance abuse, alcoholism, and mental conditions typically have annual and lifetime coverage caps.
- Pre-existing conditions for impairments unknown to the insurer at the time of application are excluded for the first one or two years following issue, as allowed by state. (Impairments known to the insurer are either covered, if minor, excluded permanently, or covered but with a premium surcharge.)

[5] America's Health Insurance Plans. 2007. "Individual Health Insurance 2006–2007: A Comprehensive Survey of Premiums, Availability, and Benefits" (available at http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf).

Because they pay the full premium, without any subsidies from employers, consumers in the individual market are more sensitive to premiums. As premiums have continued to climb, the individual market has reacted to this price sensitivity by reintroducing limited benefit plans. These plans, which are purchased as either the primary source of coverage or as supplemental coverage, are a small but growing share of the market. These products are modeled on some of the earlier benefit packages and do not provide comprehensive coverage or catastrophic protection. The underlying philosophy is that some coverage is better than no coverage. Some of these products provide limited outpatient benefits only, whereas others provide inpatient benefits that are limited to a fixed-dollar amount per day and/or are capped at a specific number of days per year. The desire for lower premiums is driving the demand for these types of benefits. Some states prohibit these types of policies and some require that policies with limited benefits properly disclose that to consumers.

ADMINISTRATIVE COSTS AND OTHER CHARGES

Administrative costs and other charges include those used to cover the costs of marketing and selling the insurance and the managing of the policy after it is sold. Because administrative costs, risk/profit charges, and state fees are higher in the individual market, a lower share of premiums goes to pay benefits in the individual market compared to that in employer-sponsored group insurance.

Loss ratios, which are the measure of premiums that go to health claims, provide information on the share of premiums that go to administrative costs and other expenses. Typical loss ratios in the individual market, which is the share of premiums that go toward paying claims, average about 65 to 70 percent. That means on average 30 to 35 percent of the premium is used toward administrative expenses, risk charges, premium taxes, and profit/contribution to surplus. In comparison, loss ratios average about 75 to 85 percent for employer-sponsored group coverage and can be as high as 95 percent for very large self-funded plans.

Comparing the loss ratios for employer-sponsored group insurance to those in the individual market can be misleading, however. Large employers have human resource departments that support employees and dependents with benefit questions. In the individual market, these are handled by the agent/insurance company. The costs of the human resource departments are not reflected in the administrative costs for the large employers, but the analogous costs for individual contracts are reflected in the premium.

Distribution costs, which cover the costs of advertising, member acquisition, and commissions to agents and brokers, can make up a large share of administrative costs, particularly in the individual market. Individual health coverage has traditionally been sold through salaried employees of the carrier, or more typically, through independent commissioned agents. Commissions can either be level over the life of the policy, say 5 to 10 percent of the premium, or can be tiered with higher commissions in the first year, as high as 20 to 30 percent in the first year, 5 to 10 percent for the next few years, and then as low as 0 to 2 percent thereafter. Even with the advent of insurance sales over the Internet, insurers need to provide licensed agents on staff in their administrative offices to respond to applicant questions relating to benefit options on the application.

In addition to distribution costs, insurers also incur administrative costs for billing and enrollment, underwriting, claims adjudication, customer service, information technology support, and regulatory compliance.

PUBLIC POLICY IMPLICATIONS

In an attempt to reduce the number of uninsured, many recent federal health reform proposals would expand or restructure the individual market. For instance, some proposals would extend the favorable income tax treatment of health insurance to the individual market, or otherwise make the tax incentives for health insurance more consistent between the individual and group markets. Other proposals would allow for the purchase of insurance across state lines or allow for cross-state insurance pooling. And others would merge the individual and small group markets.

Whether such attempts would succeed depends, in part, on how changes to the rules and regulations governing the individual market are structured. It is important to strike the appropriate balance between access to coverage and premium affordability. This is especially important in a voluntary market, where a key to sustainability is managing adverse selection.

Currently, states have chosen varying regulatory strategies with respect to the individual market, with disparate effects on access and affordability. To increase access to health insurance for higher risk individuals, some states have imposed guaranteed issue and community rating requirements. Because these provisions can exacerbate adverse selection, however, higher average premiums result. Other states

allow insurers to underwrite and to incorporate health status factors into the premium rates charged to individuals. These provisions can help keep average premiums lower by managing adverse selection risk. On the other hand, they can also decrease access to insurance for higher-risk individuals.

Increasing overall participation in health insurance plans, in particular among those with average or lower-than-average claims costs for their risk class, would be one of the most effective ways to minimize adverse selection. In that way, there would be enough healthy participants over which to spread the costs of those with high health costs. Aside from mandating coverage—which wouldn't necessarily guarantee 100 percent participation—potential options to help minimize adverse selection include providing premium subsidies or penalizing delayed insurance purchase through higher premiums (as it is with Medicare Parts B and D) and/or lower benefits. Implementing risk-adjustment mechanisms could also be used to mitigate the impact of adverse selection on a particular insurer.

Nevertheless, efforts to reduce the number of uninsured through any insurance reforms may be in vain if the growth in health care costs is not addressed. Doing more to control the growth in health spending is essential to a more sustainable health insurance system.

Statement of American College of Obstetricians and Gynecologists

On behalf of the American College of Obstetricians and Gynecologists (ACOG), representing nearly 52,000 physicians and partners in women's health, thank you for holding this hearing on the private health insurance market. As the health care decision-makers of their families, women are uniquely impacted by our broken health care system, as purchasers, providers and patients. We look forward to working with the Committee in the next Congress to reform the health care system to ensure comprehensive and affordable coverage for all that meets the goals of H. Con. Res. 400 and S. Res. 638, a resolution by Representative Jan Schakowsky and Senator Debbie Stabenow.

As women's health care physicians, we experience the problems of the private health insurance market in many ways. We struggle together with our patients to understand their complicated insurance coverage limitations, and we fight with insurers to ensure that our patients are covered for necessary and appropriate care. We treat women without coverage and know that too many women with serious medical problems only receive needed care when they face a medical crisis. We experience the problems, too, that many employers do, in coping with the rising cost of purchasing health insurance for ourselves, our employees, and our families.

Women and Health Care Use & Outcomes

Women have distinct health care needs and use more health care than men throughout their lives, including regular visits for reproductive health care. Women are more likely to seek preventive and routine care, are more likely to have a chronic illness that necessitates continuous health care, and are more likely to take a prescription drug on a daily basis than men.

Without insurance, health outcomes for women suffer. Uninsured women are three times less likely to have had a Pap test in the last three years and have a 60% greater risk of late-stage cervical cancer. Uninsured women with breast cancer are 30-50% more likely to die from the disease. And 13% of all pregnant women are uninsured, making them less likely to seek timely prenatal care and 31% more likely to have an adverse health outcome. In general, the uninsured receive less preventive care, are diagnosed at more advanced disease stages, receive less therapeutic care, have higher mortality rates, and are less likely to have a regular source of care.

Women and Health Care Costs

Affordability of health insurance and services is a key issue for women because they have greater annual health expenditures, but also have, on average, lower incomes than men. In 2007, the median income earnings for women was $35,100—$10,000 less than the median income for men. Insured or not, women have greater out-of-pocket costs, are more likely to avoid or delay needed services due to cost, and face greater medical debt than men. As a result, women are disproportionately affected by higher medical costs that eat up more of their wages. And, since women already pay 68 percent more than men for out-of-pocket health care costs, higher cost-sharing adds to an already serious financial burden.

Women also are financially vulnerable because they are more likely to obtain coverage through their spouse—putting them at risk in the case of divorce or death of a husband or their husband's employer cutting dependent coverage. Also, when a husband moves from job-based coverage to Medicare, his wife, if not Medicare-eligible herself, may lose her coverage at the same time.

Women are more likely to find that the services they need are not covered by their insurers. High-deductible plans are often marketed to young women but fail to cover pregnancy-related care, the leading cause for hospital stays and the most expensive health event most young families face.

Affordability and Availability of Insurance in the Non-Group Market

Women without group insurance face enormous problems in obtaining and affording coverage in the individual insurance market. Underwriting laws in most states allow women seeking insurance coverage in the individual market to be subject to higher costs because of their gender or health status or face pre-existing condition exclusions that limit their coverage for the services they most need. Exempted from the requirements of the federal Pregnancy Discrimination Act, small groups and individuals may be denied coverage for maternity care, or require the purchase of expensive riders for this coverage, often more than a year in advance. Women who are already pregnant or are in less-than-perfect health may be denied coverage altogether.

As health care costs have risen, so have denials of coverage and insurance industry gaming. For instance, some insurers recently started denying pregnancy coverage—or any policy at all—to women who have had a previous cesarean section. And recently, California's largest health insurer was forced to pay a number of fines and penalties to nearly 1,000 former members whose policies were canceled only after they filed claims.

High-Deductible Plans Leave Out Maternity Care

High-deductible health plans, or so-called "consumer-directed health plans" (CDHPs), offer lower premiums than traditional insurance but with higher cost-sharing requirements. These plans are often an attractive option for young, healthy individuals who are enticed by low monthly premiums, but maternity care is rarely covered. While many CDHPs advertise first-dollar coverage for preventive services, a recent study found that prenatal care was usually not considered a preventive service, requiring considerable out-of-pocket expense. In addition, because pregnancy usually spans 2 plan years, women often must satisfy two annual deductibles before any costs are covered.

Elements of Reform

ACOG supports reforms that guarantee a core package of essential services available nationwide, under all coverage options, to give all women access to meaningful and affordable coverage.

- **Guarantee Essential Benefits for All Women:** An insurance card does not guarantee access to needed services. Without coverage for the services they most use, underinsured women could face the same cost burdens as those without any insurance, with predictable results: delayed or missed care leading to worse health outcomes. Defining a core set of benefits will guarantee that no woman with insurance is denied basic care or burdened with the unaffordable out-of-pocket or catastrophic health care expenses that drive millions of Americans into bankruptcy every year. A core benefit package will cover preventable and primary care services to keep women healthy and keep health care affordable.
- **Essential Coverage Should Be Uniform and Affordable under All Insurance Nationwide:** Most women who get their insurance from large employers or public plans already have comprehensive benefits. Women who get their insurance in the small group and individual markets are vulnerable to wide fluctuations in benefits and affordability, depending on employment status, where they live, age, gender, and health status. Health care reform that guarantees a core package of essential services available nationwide under all coverage options will give all women access to meaningful coverage. Out-of-pocket expenses should be minimized and women should not be charged higher premiums than men for equivalent services.
- **Invest in Primary and Preventive Care:** ACOG supports benefits that emphasize and promote prevention—especially prenatal care and contraception—continuity of care, and a medical home for women. Prenatal care and risk-assessment are critical preventive services for all pregnant women and contraception is a medical necessity for women during three decades of their life span and should be covered to the same extent as other prescription drugs and services. Continuity of care—seeing the same health care provider over time—enhances quality of care and

patient satisfaction. Costly and burdensome "gatekeeper" rules that deny or delay women's direct access to obstetric, gynecologic, primary care services must not be permitted.

• **Eliminate Health Disparities:** Health system reform should recognize and eliminate disparities in health care coverage, treatment and outcomes related to a patient's culture, race, ethnicity, socioeconomic status, disability and sexual orientation.

• **Protect Existing Access and Coverage:** ACOG believes that existing access and coverage guarantees—such as state benefit mandates and Pregnancy Discrimination Act protections—should be maintained and strengthened until comprehensive health reform and universal coverage are achieved. Health reforms should not compromise or reduce existing benefits for women.

National Small Business Association, Letter

Dear Chairman Stark:

On behalf of the National Small Business Association (NSBA), the nation's oldest nonpartisan small-business advocacy group reaching more than 150,000 small businesses nation-wide, I would like to provide comments to a recent hearing held by the House Ways and Means Committee, Subcommittee on Health titled, "*The Health of the Private Health Insurance Market*." The hearing examined problems in the private health insurance market, with a focus on the need for reforms in the non-group or individual market.

Attached is a document, *Small Business Health Care Reform: A Long-Term Solution for All*, that NSBA has worked on for several years with small-business owners and health care experts to address problems with the U.S. health care system. The principles outlined in this document would benefit the group and non-group market by making the necessary and appropriate reforms to the entire U.S. health care system. We trust that you will take them into consideration as the Committee continues to engage in the health care reform discussion.

Mercer, a leading human resource consulting firm, recently released preliminary data from their *National Survey of Employer-Sponsored Health Plans 2008* that indicates health insurance costs for all employers will rise about 5.7 percent in 2009—the lowest annual rise in the past decade. However, for small employers—those with between 10 and 499 employees—costs are expected to rise 10 percent. The Small Business Administration's Office of Advocacy report, "Structural Factors Affecting the Health Insurance Coverage of Workers at Small Firms" cites the two most important factors associated with being uninsured are wages and firm size. According to the *2008 Employer Health Benefit Survey* by the Kaiser Family Foundation and Health Research and Educational Trust, workers at small businesses paid 27 percent more on premiums annually for family coverage than workers at large firms. The disproportionate burden small businesses face in providing health insurance must be a priority in the health care reform debate.

As 99 percent of all employers, small-business owners are a very important piece to the overall health insurance puzzle. Of the approximate 47 million uninsured people in the US, roughly 20 million are small-business owners or employees. The trend of spiraling health care cost, and the current financial markets crisis makes this hearing all that much more important to health care consumers in the non-group and group health insurance market.

The small-business owners that make up NSBA repeatedly rank health care among their top concerns. According to the recent NSBA Survey of Small and Mid-Sized Business, only 38 percent of respondents—nearly 90 percent of whom employ less than 19 workers—offer their employees health insurance. That is down 3 percent from one year ago, down 11 percent from 2000, and down 29 percent from 1995. Despite the low-rate of offering health insurance, 69 percent of respondents rated health insurance as the top benefit they want to offer.

If the goal of Congress and the next administration is to achieve systemic reform to the U.S. health care system, then we must not isolate one segment of the health insurance marketplace from the rest of the system. The challenges that face individuals in the group and non-group market must be addressed through comprehensive reforms to the insurance and deliver systems.

It has become clear to NSBA that, to bring meaningful affordability, access, and equity in health care to small business and their employees, a complete reform of the health care and health insurance systems is called for. The small business community needs substantial relief from escalating health insurance premiums. This

level of relief can only be achieved through a broad reform of the health care system with a goal of universal coverage, focus on individual responsibility and empowerment, the creation of the right market-based incentives, and a relentless focus on improving quality while driving out unnecessary, wasteful, and harmful care.

Finding a fix to the failing health care system is not an easy task, but I welcome the opportunity to be at the table representing the needs of small business as the Committee works to find solutions to American's health care needs.

Sincerely,

Todd O. McCracken, President

Small Business Health Care Reform

A Long-Term Solution for All

In attempting to create positive health care reform for small businesses, one quickly bumps up against the reality that the small business problems cannot be solved in isolation from the rest of the system. Since small businesses purchase insurance as part of the overall small group (2 to 50 employees), the decisions of others directly affect what a small business must pay and the terms on which insurance is available to them. It has become clear to NSBA that, to bring meaningful affordability, access, and equity in health care to small businesses and their employees, a broad reform of the health care and health insurance systems is called for. This reform must reduce health care costs while improving quality, bring about a fair sharing of health care costs, and focus on the empowerment and responsibility of individual health care consumers.

The Realities of the Insurance Market

Small employers who purchase insurance face significantly higher premiums from at least two sources that have nothing to do with the underlying cost of health care. The first is the cost of "uncompensated care." These are the expenses health care providers incur for providing care to individuals without coverage; these costs get divided-up and passed on as increased costs to those who have insurance. It is estimated that this practice, known as "cost-shifting", adds another 8.5 percent to the cost of health care for those who purchase insurance. Second is the fact that millions of relatively healthy Americans choose not to purchase insurance (at least until they get older or sicker) due to cost. Almost four million individuals aged 18–34 making more than $50,000 per year are uninsured. The absence of these individuals from the insurance pool means that premiums are higher for the rest of the pool than they would be otherwise. Moving these two groups of individuals onto the insurance rolls would bring consequential reductions to current small business premiums.

Implicit in the concept of insurance is that those who use it are subsidized by those who do not. In most arenas, voluntary insurance is most efficient since the actions of those outside the insurance pool do not directly affect those within. If the home of someone without fire insurance burns down, those who are insured are not expected to finance a new house. Not so in the health arena. Any individual with injuries or illnesses will receive care from an emergency room, regardless of whether or not the individual is insured. It is simply sound business sense that the hospital will then look to other avenues to ensure the cost for that uninsured injury or illness is recouped. Moreover, individuals' ability to assess their own risk is somewhat unique regarding health insurance. People have a good sense of their own health, and healthier individuals are less likely to purchase insurance until they perceive they need it. As insurance becomes more expensive, this proclivity is further increased, which, of course, further decreases the likelihood of the healthy purchasing insurance.

Individual Responsibility

There is no hope of correcting these inequities until we have something close to universal participation of all individuals in some form of health care coverage. NSBA's plan for ensuring that all Americans have health coverage can be simply summarized: 1) require everyone to have a basic level of coverage; 2) reform the insurance system so no one can be denied coverage and so costs are fairly spread; and 3) institute a system of subsidies, based upon family income, so that everyone can afford coverage.

Required Coverage

Of course, the decision to require coverage would mean that there must be some definition of the insurance package that would satisfy this requirement, as well as a system of penalties for those who chose not to comply. Such a package must be truly basic to ensure both affordability and choice are inherent in the overall sys-

tem. The required basic package would include only evidence-based, scientifically sound benefits that would be determined on a federal level. The process for defining the basic package must be nonpolitical and incorporate an appropriate array of stakeholder involvement including state insurance commissioners, state legislative representatives (governors or legislators), insurers, actuaries, small and large businesses, consumer groups, providers, and those insured. This group shall be responsible for not only defining the initial package offering, but also for evaluating, on an ongoing basis, a broad cost-benefit analysis of benefits offered, as well as evaluating such analysis of any proposed additional benefits.

Fair Sharing of Costs/Market Reforms

Incumbent on any requirement to obtain coverage is the need to ensure that coverage is available and affordable to all. In coordination with the requirement that all individuals have coverage, insurance companies would operate on a guaranteed issue basis—the requirement to provide coverage to all seekers. A coverage requirement on individuals would make insurers less risk averse by broadening the makeup of their covered individuals, thus bringing to fruition the goal of health insurance being paid for through fair-sharing rather than through cost-shifting. The importance of a penalty for individuals who seek not to purchase health insurance is imperative in preventing individuals who only purchase health insurance when they get sick. The guaranteed issue requirement on insurers must be accompanied by safeguards in the form of an individual mandate and penalty systems that prevent such behavior.

It follows, then, that the methods by which insurance companies price or "rate" their product could reasonably withstand more rigorous standards. The rating for the basic package would be based on a modified community rating system with defined rate bands and only limited allowable actuarially-sound rating characteristics, including defined geographic regions. In addition, insurance companies would be allowed to provide certain, limited discounts or benefit enhancements to individuals or companies, or both (depending on who pays for the cost of the plan) who implement a certified, evidence-based and actuarially-sound wellness programs. Insurance companies would operate within narrow rate-bands and no additional charges or discounts could be given outside that band.

Modified community rating would apply only to the federally-defined basic package, any additional services purchased above the federal package would be subject to market-based rating rules and would not be eligible for preferred tax treatment. Although not subject to the modified community rating rules, those additional services should not be used as a means to game the system.

While the onus should no longer reside with employers to provide health insurance, the option ought to remain open to those employers who chose to carry out the administrative work for individuals in securing health insurance. All market rules and regulations would apply equally to the insurance plan regardless of who does the administrative work.

As another method to balance the market and infuse a greater level of choice, higher deductibles for those able to afford them would be implemented. The shape of the package would help return a greater share of health insurance to its role as a financial backstop, rather than a reimbursement mechanism for all expenses. More robust consumer behavior will surely follow

Subsidies

Due to the requirement that individuals purchase health insurance, without exemption for low-income individuals, there would be available federal financial assistance for individuals and families based upon income.

Finally, it should be clear that coverage could come from any source. Employer-based insurance, individual insurance, or an existing public program would all be acceptable means of demonstrating coverage.

Reshaping Incentives

There currently is an open-ended tax exclusion for employer-provided health coverage for both the employer and employee. This tax status has made health insurance preferable to other forms of compensation, leading many Americans to be "over-insured." This over-insurance leads to a lack of consumer behavior, increased utilization of the system, and significant increases in the aggregate cost of health care. Insurance now frequently covers (on a tax-free basis) non-medically necessary services, which would otherwise be highly responsive to market forces.

The health insurance tax exclusion also creates equity concerns for small employers and their employees. Since larger firms experience less volatile rate increases, and have greater bargaining power than a small firm, their health insurance packages are typically richer than what a small business can afford. Therefore, a large

firm can build very rich benefit packages which are tax exempt for the business and are considered a piece of the employees' compensation package. This gives large employers a significant competitive edge over small businesses with regards to both their tax treatment as well as their ability to recruit employees. Furthermore, many small business employees are currently in the individual insurance market, where only those premiums that exceed 7.5% of income are deductible.

For these reasons, the individual tax exclusion for health insurance coverage should be limited to the value of the basic benefits package. But this exclusion (deduction) should also be extended to individuals purchasing insurance on their own. Moreover, the tax treatment of both health insurance premiums and actual health care expenses should be the same. These changes would bring equity to small employers and their employees, eliminate the federal subsidy for over-insurance, induce much greater consumer behavior, and reduce overall health care expenses.

Reducing Costs by Increasing Quality and Accountability

While the above steps alone would create a much more rational health insurance system, a more fair financing structure, and clear incentives for consumer-based accountability, much more must be done to rein-in the greatest drivers of unnecessary health care costs: waste and inefficiency. More accountable consumer behavior can help reduce utilization at the front end, but most health care costs are consumed in hospitals and by chronic conditions whose individual costs far exceed what any normal deductible level is likely to be.

Health care quality is enormously important, not only for its own sake, but because medical mistakes, waste and inefficiency add billions to our annual health care costs. Medical errors, hospital-acquired infections, and other forms of waste and inefficiency cause additional hospital re-admissions, longer recovery times, missed work and compensation, increased strain on family budgets and, in the most severe cases, death. In fact, medical errors are the eighth leading cause of death in the United States. The medical costs alone probably total into the hundreds of billions of dollars.

What financial pressures are we bringing to bear on the provider community to improve quality and reduce waste? Almost none. In fact, we may be doing the opposite, since providers make yet more money from re-admissions and longer-term treatments. It is imperative to reduce costs through improved health care quality. Rather than continuing to pay billions for care that actually hurts people and leads to more costs, we should pay more for quality care and less (or nothing) when egregious mistakes occur.

Insurers should reimburse providers based upon actual health outcomes and standards, rather than procedures. Evidence-based indicators and protocols should be developed to help insurers, employers, and individuals hold providers accountable. These protocols—if followed—could also provide a level of provider defense against malpractice claims.

Through digital prescription writing, individual electronic medical records, and universal physician IDs, technology can reduce unnecessary procedures, reduce medical errors, increase efficiency, and improve the quality of care. This data also can form the basis for publicly-available health information about each health care provider, helping patients make informed choices. The implementation of electronic patient records played a significant role in the seismic shift in the Veterans Health Administration from being a highly criticized system to being one of the best around today—receiving a 67 percent rating for overall quality as compared with the 51 percent ranking for a sampling of non-government health care providers in a recent report from the Annals of Internal Medicine.

The U.S. medical system can also benefit from thinking outside the box. While traditional doctors' offices and hospitals remain the primary mechanism of health care delivery, creative and effective alternatives should also be taken into consideration. There are myriad programs in existence today, such as Volunteers in Medicine, community and retail clinics, urgent-care and 24-hour clinics, that can offer near-term relief to many individuals in underserved communities, and to uninsured individuals.

Availability of Information

Small businesses are particularly disadvantaged when it comes to being able to access information. While large businesses that self-insure conduct quality studies and compile provider information, small businesses are at the mercy of their insurance carrier to provide them with such data. As a result, little to no provider information with regards to cost or quality is made widely available. This disadvantage will be a heavy burden on individuals as well, if they are not armed the information needed to make important health care decisions.

Insurance companies and health care providers should take the lead of the Centers for Medicare & Medicaid Services (CMS) in compiling provider information and quality rankings, and making them publicly available, easily accessed and understandable. Also included in these rankings should be common-sense pricing lists. Increased information flow to consumers will ensure better decision making and improve the long-term health status of Americans by empowering them as a partner, with their primary care provider, in their own health. Engaging consumers in their own care requires accurate and abundant information that will help individuals evaluate the options and make their own best decision.

With the increased attention many health providers are paying to prevention and wellness programs, quality measurements must be a key part to ensure their success and scientifically-proven benefit. Prevention and wellness programs ought to be held to the same high standards regarding the tracking and reporting of outcomes. Additionally, health care providers should carefully track chronic disease management and report on the risk-adjusted outcomes of such programs. Tracking this data should enable doctors nation-wide to share best-practices and adjust treatments for optimum outcomes in their patients.

NSBA calls on hospitals and doctor's offices to make publicly available, a plain-language list of the top 20 in-patient and out-patient procedures' costs and risk-adjusted outcomes. This information should be updated at least annually and the number of procedures included incrementally over time until all procedures' cost and outcomes are publicly listed. Under the lead of CMS, all health care providers will compile the data in universal forms enabling the consumer to easily compare providers against each other.

Reform Medical Liability

There is an enormous array of financial pressures and incentives that act upon the health-care provider community. Too often, the incentive for keeping patients healthy is not one of them. Our medical malpractice system is at least partly to blame. While some believe these laws improve health care quality by severely punishing those who make mistakes that harm patients, the reality is that they simply lead to those mistakes—and much more—being hidden.

In addition to instituting reasonable limits on medical liability awards, NSBA supports the creation of so-called "health courts." Health courts would serve as administrative courts to handle medical injury disputes. Judges would be health-care trained professionals assisted by independent experts to settle malpractice disputes between patients and health care providers.

Plaintiffs would receive full economic damages, as well as non-economic damages based on a compensation schedule. This new process for medical liability would also provide the injured party with an avenue to appeal with further review in the traditional court system. In addition to easing the medical liability burden, health courts would establish a mechanism that clear and consistent standards be developed based on cases and the opinions of the judges.

Conclusion

The small business community needs substantial relief from escalating health insurance premiums. This level of relief can only be achieved through a broad reform of the health care system with a goal of universal coverage, focus on individual responsibility and empowerment, the creation of the right market-based incentives, and a relentless focus on improving quality while driving out unnecessary, wasteful, and harmful care.

Statement of The National Association of Health Underwriters

The National Association of Health Underwriters (NAHU) is a professional trade association representing more than 20,000 health insurance agents, brokers and employee benefit specialists all across America. Our members work on a daily basis to help individuals and employers of all sizes purchase health insurance coverage. They also help their clients use their coverage effectively and make sure they get the right coverage at the most affordable price.

All of this experience gives our membership a unique perspective on the health insurance market place. Our members are intimately familiar with the needs and challenges of health insurance consumers, and they also have a clear understanding of the economic realities of the health insurance market. They have had the chance to observe the health insurance market reform experiments that have been tried by

the states and private enterprise, and are in a unique position to report on which of these efforts have worked the best.

NAHU access and cost issues in the individual health insurance market are certainly a problem with our current private health insurance marketplace, and we currently have a group of individual market health insurance benefit specialists working on detailed reform recommendations. Once these reform ideas are finalized in early 2009, we look forward to sharing them with both the Committee and the entire Congress. However, in the interim, NAHU would like to share with you some of our long-standing policy ideas relative to the individual health insurance market.

The members of NAHU believe all Americans deserve a health care system that delivers both world-class medical care and financial security. Americans deserve a system that is responsible, accessible and affordable. This system should boost the health of our people and our country's economy. That being said, the system must also be realistic.

We believe the time is right for a solution that controls medical spending and guarantees access to affordable coverage for all Americans. We believe this can be accomplished without limiting individuals' ability to choose the health plan that best fits their needs and ensures them continued access to the services of independent state-licensed counselors and advocates. We also believe that the federal government could adopt several key reform measures that would go a long way toward making individual health insurance coverage more affordable and more accessible to millions of Americans.

The vast majority of privately insured Americans receive their health insurance coverage through their employer or the employer of their spouse or parent. The employer-based system currently provides more than 160 million Americans with reliable and efficient access to high-quality health coverage, and as we look to improve our nation's private market health care delivery system, we should build upon its many strengths. NAHU strongly supports employers making voluntary contributions toward the cost of their employees' health insurance coverage, and we believe the preservation of the current federal employer deduction and employee exclusion is critical in ensuring a healthy insurance market. We would oppose any attempt to alter the current tax treatment of employer-sponsored health insurance, including proposals to cap the exclusion or replace it with either an individual income tax credit or deduction.

But as important as employer-sponsored health insurance is to our national coverage system, NAHU realizes it does not work for everyone. As such, federal tax laws should be updated to provide the same tax deductions to individuals and the self-employed that corporations have for providing health insurance coverage for their employees, although not at the expense of the existing employer coverage income tax exclusion. Congress should remove the 7.5 percent of adjusted gross limit of medical expenses on tax filers' itemized deduction Schedule A form, allow the deduction of individual insurance premiums as a medical expense, and equalize the self-employed health insurance deduction to the level corporations deduct by changing it from a deduction to adjusted gross income to a full deductible business expense on Schedule C.

Additionally, the federal requirements regarding individual policies sold on a list-bill basis—whereby the employer agrees to payroll-withhold individual health insurance premiums on behalf of its employees and send the premium payments to the insurance carrier but does not contribute to the cost of the premiums—need to be clarified regarding the establishment of Section 125 plans, HIPAA group insurance protections, and the applicability of state-based individual health insurance laws and regulations.

Another issue Congress should address with regard to individual health insurance coverage is making sure that people with serious medical conditions no access to employer-sponsored health insurance can buy a private health insurance product. Right now, in a number of states there are people who cannot buy individual health insurance at any price. Most states, but not all, have independently established at least one mandatory guaranteed purchasing option, the most common and effective of which is a high-risk health insurance pool. The federal government should require that all states have at least one private guaranteed purchasing option for all individual health insurance market consumers.

In addition, to support state high-risk pools, who serve this population in 34 states, the federal government should continue to provide financial support to keep risk-pool premiums stable and allow states to provide risk-pool premium subsidies to low-income citizens and older beneficiaries (who tend to be charged the highest rates) to help ensure continued coverage for early retirees.

Much of the national variations in individual market costs and access are caused by differences in state laws and regulations relative to individual market coverage.

Therefore, Congress should actively encourage the states to create regulatory climates that ensure the availability of many affordable coverage options, and should offer premium subsidies to targeted populations in need of such support. One way that Congress could do this would be to make federal block grant funds available to states that encourage and reward health insurance innovations that utilize the strengths of the existing private marketplace. Examples of positive actions states can take to positively reform their individual health insurance markets include:

- Create broadly funded high-risk pools to serve individuals with serious medical conditions purchasing coverage in the individual health insurance marketplace.
- Allow for the assessment of insurable risk in the individual market for effective risk-management.
- Limit the cost-impact of unnecessary health insurance mandated benefit requirements through the creation of effective independent state mandated benefit review commissions and/or allowing the availability of limited mandates health benefit plan options.
- Create state-level subsidies of private health insurance premiums. Subsidies could target individual purchasers or employers offering coverage to employees, or both. Subsidies could also be indirect through a private and voluntary reinsurance mechanism.
- Modify their state Medicaid and/or State Children's Health Insurance Programs to allow for the subsidization of private health insurance coverage for eligible beneficiaries. Such subsidies could be created for use in either the employer-sponsored health insurance market (if such coverage was available to the beneficiary) or through the individual health insurance market. For individual market purchasers, Medicaid dollars could be used to fund individually controlled health care accounts, which could be used to purchase health care coverage in the private market, as well as to pay any health care related expenses that might not be covered by the private market plan due to deductibles or other cost-sharing arrangements.
- Provide state-level income and payroll tax incentives for the purchase of health insurance coverage. This could include refundable tax credits for the purchase of private market health insurance coverage, allowing for the deduction of health insurance premiums for individual and group health insurance purchasers, exclusion of Health Savings Account contributions from state income tax liability and/or other means determined by the states.

Finally, NAHU must stress that by far, the greatest access barrier to health insurance coverage in America today, particularly in the individual health insurance market, is cost. NAHU believes that any successful comprehensive health reform plan will need to address the true underlying problem with our existing system—the cost of medical care. Constraining skyrocketing medical costs is the most critical and vexing aspect of health care reform. The cost of health care delivery is the key driver in rising health insurance premiums and it is putting the cost of health insurance coverage beyond the reach of many Americans.

As such, NAHU urges the Committee to consider cost with every single health insurance market reform proposal you entertain. Not just whether or not the market reform idea includes cost containment elements, but also whether or not the market reform idea itself would cause health insurance premiums to increase. Great care needs to be taken when implementing market reforms on a national level to not inadvertently induce cost increases in the existing private market system. No matter how "fair" a market reform idea might seem on its surface, it's not at all "fair" if it also prices people out of the marketplace.

A greater focus on medical cost containment will help lower health insurance premiums nationwide, since premium costs are directly related to medical care expenditures. But we also need to make sure that all Americans have access to affordable health care coverage. As important as affordability, is choice. There needs to be choice of providers, choice of payers and choice of benefits, with many price and coverage options. The reality is that we are a diverse nation with diverse needs. One size does not fit all when it comes to health care.

NAHU believes that if serious steps are taken both to reduce overall medical care costs and increase consumer access to private insurance, the result will be will be greater degrees of health plan competition, more consumer plan choices, lower health insurance rates and a lower number of uninsured Americans. NAHU urges Congress to carefully consider the cost and market impact of all potential reforms to America's health insurance marketplace. Our private health insurance plans are innovative, flexible and efficient, and our marketplace is up to the task of responding to well-structured reforms. We look forward to working with you to both fill the

gaps in our nation's coverage system and also to make private health insurance more affordable and accessible for all Americans.

Statement of The National Association of Insurance Commissioners

The NAIC represents the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. The primary objective of insurance regulators is to protect consumers and it is with this goal in mind that the members of the NAIC submit these comments today on the health of the private insurance market.

To begin, we recognize the failures in the current market, they are well documented. Over 15 percent of Americans, almost 46 million people, go without coverage. For most, coverage is simply too expensive, a result of medical spending that has run out of control and consumes 16 percent of our economy. For others, those without coverage through an employer and with health problems, coverage is not available at any price. For Americans lucky enough to have insurance, premiums take ever larger bites out of the monthly paycheck, even as rising deductibles and co-payments shift more of the financial burden of sickness to the patient. Insurance Commissioners see this every day, and we welcome Congress' interest in helping the states tackle this challenge.

State insurance commissioners believe it is important to ensure that affordable, sufficient health coverage is available to small business owners, their employees, and individuals. The NAIC offers its full support in developing federal legislation that will reach this goal—a goal that can only be attained through federal-state coordination. We offer the experience and expertise of the states to Congress as it attempts to improve the health insurance marketplace.

STATE EXPERIENCE

States led the way in requiring insurers to offer insurance to all small businesses in the early 1990s, and the federal government made guaranteed issue the law of the land in 1996 [1] for all businesses with 2–50 employees. Federal law does not limit rating practices, but forty eight states have supplemented the guaranteed issue requirement with laws that limit rate variations between groups, cap rate increases, or impose other limitations on insurer rating practices. These rating laws vary significantly in response to local market conditions, but their common objective is to pool and spread small group risk across larger populations so that rates are more stable and no small group is vulnerable to a rate spike based on one or two expensive claims.

In addition to requiring insurers to pool their small group risk, many states have established various types of purchasing pools and have licensed associations to provide state-approved insurance products to their members.

States continue to experiment with reinsurance, tax credits and subsidies, and programs to promote healthier lifestyles and manage diseases as they pursue the twin goals of controlling costs and expanding access. These state-based reforms are, of necessity, very distinct—based on both the specific needs in the marketplace and the strengths and weaknesses of the marketplace. For example, the State of New York implemented the very successful "Health NY" program, a reinsurance-based program that addresses many of the problems identified in New York's individual and small group markets, but utilizing its strong HMO networks. Likewise, the Commonwealth of Massachusetts has implemented broad reforms built on past reforms and the unique insurer, provider and business environment.

As always, states are the laboratories for innovative ideas. We encourage federal policymakers to work closely with their state partners, as well as with health care providers, insurers and consumers, to identify and implement reforms that will make insurance more affordable to small businesses. And remember, all significant reforms will have significant consequences—both positive and negative.

KEYS TO REFORM

Based on the experience and expertise of the states, we encourage Congress to consider these four keys for successful health insurance marketplace reform:

Address Health Care Spending. Any effort to increase access to insurance will not be successful over time unless the overriding issue of rapidly rising health care costs is also addressed. While the health care challenge in this country is generally expressed in terms of the number of Americans without health insurance coverage, the root of the problem lies in the high cost of providing health care services in this country. According to the most recent National Health Expenditures data, health

care spending reached $2.1 trillion in 2006, 16 percent of GDP and $7,026 for every man, woman and child in the United States.[2] This level is twice the average for other industrialized nations.

This level of health care spending has badly stressed our health care financing system. Health insurance reform will not solve this problem, since insurance is primarily a method of financing health care costs. Nevertheless, insurers do have a vital role to play in reforms such as disease management, enhanced use of information technology, improved quality of care, wellness programs and prevention, and evidence-based medicine—all of which have shown promise in limiting the growth of health care spending. Whatever is done in insurance reform should be done in a manner that is consistent with sound cost control practices.

Protect the Rights of Consumers. States already have the patient protections, solvency standards, fraud prevention programs, and oversight mechanisms in place to protect consumers; these should not be preempted by the federal government. As the members of this committee know all too well, the preemption of state oversight of private Medicare plans has led to unethical and fraudulent marketing practices and considerable harm to thousands of seniors. In similar fashion, the Employee Retirement Income Security Act of 1974 (ERISA) severely restricts the rights of employees covered by a self-insured plan. We urge federal policymakers to preserve state oversight of health insurance and avoid preempting or superseding state consumer protections.

Avoid Adverse Selection. Any program that grants consumers the choice between two pools with different rating, benefit, or access requirements will result in adverse selection for one of the pools. For example, if a national pool does not allow rating based on age or health status, while the state pool does allow rating based on those factors, then the national pool will attract an older, sicker population. Such a situation would be unworkable. While subsidies or incentives could ameliorate some of the selection issues, as costs continue to rise and premiums increase the effectiveness of such inducements could erode.

Promote State Innovation. The NAIC urges Congress to review current federal laws and regulations that hinder State efforts to reform the health care system. As mentioned earlier, laws such as ERISA curtail consumer protections and supersede State laws, limiting the reform options available to states. In addition, inadequate reimbursement payments in federal health programs have led to shifting of costs to the private sector. This has resulted in higher overall costs and decreased access for many consumers, and limits the ability of states to implement reforms.

To promote innovations and eliminate these barriers, the NAIC supports legislation like H.R. 506, the Health Partnership Through Creative Federalism Act, that provides funding for state initiatives and establishes procedures for waiving federal requirements, such as certain ERISA provisions, that impede state innovation.

Just as important, Congress must carefully consider the impact of any new federal reforms on the states' ability to be effective partners in solving our health care crisis.

CONCLUSION

Years have been spent talking about broad health care reforms that will ensure that all Americans have access to affordable health insurance coverage and the peace of mind that goes with it. Action is long overdue.

The NAIC encourages Congress and the Members of this Committee to work with states and learn from past reforms. Together, we can implement successful initiatives that will truly protect and assist all consumers.