

**INSURED BUT NOT COVERED: THE PROBLEM
OF UNDERINSURANCE**

HEARING
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS
OF THE
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COMMERCE
HOUSE OF REPRESENTATIVES
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THURSDAY, OCTOBER 15, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 1:40 p.m., in Room 2123, Rayburn House Office Building, Hon. Bart Stupak [chairman of the subcommittee] presiding.

Present: Representatives Stupak, Braley, Markey, Doyle, Schakowsky, Christensen, Welch, Green, Sutton, Dingell, Waxman (ex officio), Walden, Burgess, Blackburn, Gingrey and Barton (ex officio).

Staff Present: Phil Barnett, Staff Director; Bruce Wolpe, Senior Advisor; Mike Gordon, Chief Investigative Counsel; Dave Leviss, Chief Oversight Counsel; Stacia Cardille, Counsel; Molly Gaston, Counsel; Erika Smith, Professional Staff Member; Scott Schloegel, Investigator; Ali Golden, Professional Staff Member; Jennifer Owens, Investigator; Ali Neubauer, Special Assistant; Ken Marty, HHS-OIG Detailee; Sean Hayes, Minority Counsel; and Alan Slobodin, Minority Chief Counsel, Oversight and Investigations.

OPENING STATEMENT OF HON. BART STUPAK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. STUPAK. This hearing will come to order.

Today we have a hearing entitled Insured But Not Covered: The Problem of Underinsurance. The Chairman, the Ranking Member and Chairman Emeritus will be recognized for a 5-minute opening statement. Other members of the subcommittee will be recognized for 3-minute opening statements. I will begin.

A few months ago our subcommittee held hearings on the health industry practice of terminating coverage after a policyholder becomes sick and files a claim. In our investigation we learned that if your insurance company believes you have an illness that may be costly, it will go back and reexamine your application for health insurance to find any excuse to cancel your coverage. As health insurance industry executives brazenly told us, this practice, called rescission, will continue until there is a national health care coverage for all Americans.

Today we continue our investigation of the private health insurance market focusing on the underinsured. An underinsured person is one who has health insurance coverage, but the policy does not adequately cover the health care costs or high medical expenses.

Underinsured individuals traditionally have high out-of-pocket expenses because of high deductibles and copays. In some instances people are uninsured because they can only afford a basic policy. In other instances policyholders believe that they have adequate coverage, only to find that there are limits buried within the policy, such as annual caps on the amount the insurance will cover or limits on the number of times the policyholder can receive certain services or treatments.

Regardless of how you define this financially fragile group, the sad consequences of being uninsured can be devastating; lead to financial ruin, bankruptcy and making medical decisions based on cost rather than care.

As the cost of health insurance skyrockets, more and more Americans are finding they can only afford bare-bone policies, leaving them one illness, one accident away from bankruptcy. According to the American Medical Association study in 2007, 62 percent of all bankruptcies filed in the United States were related to medical costs, and 78 of these filers had insurance. Many of these now bankrupt individuals were well educated, owned homes and had middle-class occupations. Unfortunately they were underinsured, and their health insurance did not cover their medical costs, forcing them to declare bankruptcy due to mountains of medical debt.

Still health insurers continue their unconscionable increase in premiums. Between 2000 and 2007, the annual family health insurance premium in Michigan rose 78 percent, while wages rose just 4.6 percent. I am currently receiving e-mails and letters from constituents reporting 22 to 40 percent premium increases in their individual health insurance policies. The average family health insurance policy now costs \$13,125, which is, by the way, 34 percent of the median household income in my congressional district. The Commonwealth Fund, which will testify today, recently reported that, as a result, more families are experiencing medical problems or cost delays in getting needed medical care. In 2007, nearly two-thirds of U.S. adults, 116 million people, struggled to pay their medical bills, went without needed care because of the cost, were uninsured for a time or were underinsured.

Our first panel of witnesses will put a face on the frightening statistics found in the Commonwealth Fund report. Catherine Howard was diagnosed with breast cancer at the early age of 29 and survived to tell her story. Being young and healthy with a limited income, Catherine chose a low-premium, high-copay health insurance that left her in financial shambles after her breast cancer. At the time of her illness, she was earning just \$20,000 a year, but her outstanding medical bills were \$40,000. And Catherine was unable to work through her surgery, chemotherapy and radiation. To her credit, Catherine did not declare bankruptcy and is paying \$1,800 per month on her outstanding medical obligations.

David Null will speak of his family and his daughter Tatem, who, at the age of 7, was diagnosed with liver failure. David bought health insurance for his family to cover emergency situations, not a policy to cover head colds. Still, when Tatem was on life support and needed a lifesaving \$560,000 kidney transplant, David learned his emergency policy would only cover between \$30,000 and \$40,000, and the hospital was demanding a \$200,000 deposit before

they would proceed with the transplant. Being underinsured left Tatem fighting for her life and David without a hope or a prayer.

Children's Hospital officials helped the Nulls qualify for a government-run, government-sponsored Medicaid health care program, and the entire hospital bill was retroactively covered. The catch is the Nulls could not earn more than \$1,614 a month or they would lose their Medicaid coverage, which paid for Tatem's medication to prevent organ rejection, which can cost thousands of dollars each month.

Nathan Wilkes will tell us about his employer-provided health insurance with a \$1 million limit for each family member. Unfortunately \$1 million does not go very far when his son was diagnosed as severe hemophilia. Even though the Wilkes have paid up to \$25,000 in a single year for out-of-pocket costs, Mr. Wilkes is unable to get a policy that will adequately cover his son's medical expenses. Now on his third insurance policy, Mr. Wilkes does not know how they will be able to afford his son's lifesaving medical treatments.

Each of these individuals and families did everything right; worked hard, purchased health insurance, paid their premiums, but were still left in financial ruin.

We will also hear, as I said, from Sara Collins of the Commonwealth Fund. She will discuss their study on how a number of uninsured have dramatically increased over the last few years and how now two-thirds, 116 million, of U.S. adults struggle to pay their medical bills, like the Nulls, the Wilkes and Ms. Howard.

Stan Brock is the director of the Remote Area Medical Foundation based in Nashville, Tennessee. He has spent his lifetime coordinating with physicians, dentists, nurses and other health providers to provide free health care services to the uninsured and underinsured Americans. Mr. Brock will provide his insight and experience on how more and more Americans are showing up at his foundation seeking basic health care because their insurance policies will no longer cover their health care needs.

Each of us know a family member, a relative, a friend who did not go to a doctor when sick, who skipped a dose of medication or failed to fill a prescription, intentionally missed a medical test or a follow-up appointment, or did not see a specialist when needed because they could not afford the service, the medication or the test. I would hope every American will now take time to look at their policy and really understand what medical conditions does my policy cover or not, what is your copay, what is your potential for out-of-pocket expenses, do you have a lifetime cap of dollars or services with your insurance company.

The U.S. House will soon vote on H.R. 3200, America's Affordable Health Choices Act of 2009. H.R. 3200 does not allow insurance companies to rescind your policies when you are sick, it does not have a lifetime cap, and it will cover all Americans. Only the passage of meaningful health care reform, then and only then, will two-thirds of all adults not have to worry about how to obtain medical care for their families while remaining financially secure.

I next turn to the Ranking Member of this committee, Mr. Walden of Oregon, for an opening statement.

OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. Thank you, Mr. Stupak, for convening this hearing.

As the Congress continues to debate ways to reform the health care system, the subject of this hearing should remain a top priority. As we will hear today, insurance does not always cover the complete cost of an illness or injury. This nagging question, if I get sick, will I be able to afford treatment, worries many Americans. Today, as we have heard from the Chairman, we will hear from several people who thought their insurance would be there when they needed it, and it was not.

David Null faced every parent's nightmare. His daughter fell into a coma as a result of a liver failure and needed a transplant within days. He thought his insurance would cover everything, but instead the policy only covered \$25,000 of a \$561,000 surgery. In order to pay for the transplant, Mr. Null had to turn away work in order to qualify for Medicaid.

Catherine Howard thought she had quality insurance. She had been happy with the coverage she had under a previous employer, so she purchased an individual policy for herself when she started working on her own. After being diagnosed with breast cancer, Ms. Howard learned that she would be paying approximately 30 percent of the treatment cost. Eventually she would end up \$100,000 in debt.

And Nathan Wilkes also thought he had great insurance through his employer, yet his newborn son's illness required a substantial amount of care, and Mr. Wilkes soon learned that his health care policy had a cap, and that cap would eventually cut off care for his son. Meanwhile the premiums for his health care were beginning to rise substantially. The increased cost of care for his son was also driving up the cost of premiums for his employer.

I want to thank our three witnesses on this panel today for testifying and making your stories known. Their experiences, yours, are incredibly personal, and I want to commend you for agreeing to testify before this committee.

We will also hear from Sara Collins of the Commonwealth Fund and Stan Brock from the Remote Area Medical. And I thank them for their testimony as well.

Beyond the astronomical costs the underinsured face, this committee will also hear about other problems in the industry affecting our witnesses. Mr. Null will testify that he was misled by the company salesperson when he purchased the policy for his family. He considered himself a savvy purchaser of insurance, and he would research plans, purchase the ones that had offered him the best rate and coverage, and switched to a new insurer if a better deal came along. He told the insurance salesperson that he was looking for a policy that would cover "the big oh no." Instead he was sold a policy that capped hospital stays at \$25,000, which in his daughter's case turned out to be only a few days.

Whether the salesperson's claims about Mr. Null's policy were fraudulent or mere sales puffery does not matter, because we can all agree that when selling something as important as health insurance, the American consumer needs to be protected from both fraudulent statements and over-the-top representations.

Two of the witnesses today are here to discuss the health care problems affecting their children. While these children are covered under family plans today, in the future their preexisting condition could limit the ability to obtain insurance themselves. Preexisting conditions affect many Americans, and I believe this committee and Congress need to work to make sure access to quality and affordable health care remains our top priority. We cannot ignore these problems, especially in light of rapidly increasing health care costs in the United States.

Over the last decade employer-sponsored health insurance premiums have increased 131 percent. Recent studies have found that in 1 year as many as 62 percent of all bankruptcies were linked to medical expenses, and 1½ million families lost their homes due to these costs.

I again thank our witnesses for joining us, and I thank you for holding this hearing, Mr. Chairman.

On a personal note I would say that my wife and I were parents to a son who was diagnosed with hypoplastic left heart syndrome. We faced many of the challenges you faced when it came to trying to deal with the transplant that he needed. Tragically he passed away before he could have that transplant, but we faced many of the same issues that you faced and dealt with them as a parent, so I am deeply sympathetic to what you are encountering.

Mr. Chairman, I would like to remind this committee that on June 25th of this year, Ranking Member Barton and myself sent a letter to both you and Chairman Waxman requesting additional investigation hearings to follow up on our June 12, 2009, hearing on GM and Chrysler dealership closures. Interest in the subject was intense, as you know, at the time, and I hope this committee will not shy away from its oversight obligations on this matter, especially considering how the American taxpayer is now substantially invested in these companies. And I again urge you to hold additional hearings, including inviting the auto czar to testify and making sure that those who did testify provide us with the documents and e-mails that they said they would when they testified. So I have got another copy of that letter, Mr. Chairman, for both of you, and I hope you will take a look at it and afford us that opportunity to do the oversight that this committee has so proudly done in the past.

Mr. STUPAK. Thank you Mr. Walden.

[The prepared statement of Mr. Walden follows:]

**OPENING STATEMENT OF THE HONORABLE GREG WALDEN,
RANKING MEMBER, SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS,
OCTOBER 15, 2009**

Thank you, Chairman Stupak, for convening this hearing.

As the Congress continues to debate ways to reform the health care system, the subject of this hearing should remain a top priority. As we will hear today, insurance does not always cover the complete cost of an illness or injury. This nagging question— If I get sick, will I be able to afford treatment? — worries many Americans.

Today, we will hear from several people who thought their insurance would be there when they needed it. It was not.

David Null faced every parent's nightmare: his daughter fell into a coma as a result of liver failure and needed a transplant within days. He thought his insurance would cover everything. Instead, his policy only covered \$25,000 of a \$561,000 surgery. In order to pay for the transplant, Mr. Null had to turn away work in order to qualify for Medicaid.

Catherine Howard thought she had quality insurance. She had been happy with the coverage she had under a previous employer, so she purchased an individual policy for herself when she started working on her own. After being diagnosed with breast cancer, Ms. Howard learned that she would be paying approximately 30% of the treatment costs. Eventually she would end up \$100,000 in debt.

Nathan Wilkes also thought he had great insurance through his employer. Yet, his newborn son's illness required a substantial

amount of care, and Mr. Wilkes soon learned that his health care policy had a cap. That cap would eventually cut off care for his son.

Meanwhile, the premiums for his health care were beginning to rise substantially.

The increased cost of care for his son was also driving up the cost of premiums at his employer.

I would like to thank Mr. Null, Mr. Wilkes, and Ms. Howard for testifying today. Their experiences are incredibly personal, and I want

to commend them for agreeing to testify before this Committee.

We will also hear from Sara Collins of The Commonwealth Fund, and Stan Brock from Remote Area Medical, and I thank them for their testimony as well.

Beyond the astronomical costs the underinsured face, this Committee will also hear about other problems in the industry affecting our witnesses.

Mr. Null will testify that he was misled by the company's salesperson when he purchased a policy for his family. Mr. Null considered himself a savvy purchaser of insurance—he would research plans, purchase the ones that offered him the best rate and coverage, and switch to a new insurer if a better deal came along. He told the insurance salesperson that he was looking for a policy that would cover the big “oh no.” Instead, he was sold a policy that capped hospital stays at \$25,000—which in his daughter's case turned out to be only a few days.

Whether the salesperson's claims about Mr. Null's policy were fraudulent or mere sales puffery does not matter, because we can all agree that when selling something as important as health insurance, the American consumer needs to be protected from both fraudulent statements and over-the-top representations.

Two of the witnesses today are here to discuss the health care problems affecting their children. While these children are covered under family plans today, in the future their preexisting conditions could limit the ability to obtain

insurance. Preexisting conditions affect many Americans, and I believe this committee and Congress need to work to make sure access to quality and affordable health care remains our top priority.

We cannot ignore these problems, especially in light of rapidly increasing health care costs in the United States. Over the last decade, employer-sponsored health insurance premiums have increased 131%. Recent studies have found that in one year as many as 62% of all bankruptcies were linked to medical expenses,

and that 1.5 million families lose their homes due to these costs.

I again thank the witnesses for joining us. I thank you again, Chairman Stupak, for convening this hearing and I look forward to today's testimony.

Also, I would like to remind this Committee that on June 25, 2009, Ranking Member Barton and myself sent a letter to both Chairman Waxman and Chairman Stupak requesting additional investigation and hearings to follow-up the June

12, 2009 hearing on GM and Chrysler dealership closures. Interest in this subject was intense at the time. This committee should not shy away from its oversight obligations on this matter, especially considering how the American taxpayer is now substantially invested in these companies. I again urge the Chair to hold additional hearings

I yield back the balance of my time.

Mr. STUPAK. Mr. Waxman, Chairman of the full committee, opening statement, please.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Mr. Chairman. I want to commend you for holding this hearing.

The primary purpose that people have in buying health insurance is to protect them when they get sick and not to have catastrophic costs of health care drive them into bankruptcy. You should not have to go broke because you get sick, so people buy insurance to protect themselves. Yet we are finding out in the investigation this committee is doing on private insurance for health care that there are a lot of schemes that the insurance companies have not to pay.

We had a hearing earlier this year on how there is a thing called rescissions. Now, we all have heard that insurance companies don't want to cover you if you have preexisting medical conditions, and that means a lot of people can't get insurance even if they could afford to pay for it. But what some of the insurance companies have been doing is that when you get sick, they go back and look for some error on the application and then decide that they are going to rescind the agreement and leave you just high and dry without the coverage.

Today we are looking into another topic as we examine insurance company schemes, and this one is of underinsurance that people don't realize that they may face when they get sick. In recent years we have been looking at a lot of different problems, but we looked at rescissions. Now we are looking at underinsurance. But as we examine insurance practices, our committee has been looking into business practices in the small group market. And I am looking forward to the hearing on this topic next week where we will learn more about the challenges facing small businesses that seek to cover their employees. And they want to get quality, affordable health insurance for their employees, but the insurance companies will not cooperate and keep that insurance available to them.

But today's topic is underinsurance, and in recent years health policies have been costing more and covering less. The average cost of a family's premium has risen 131 percent in the last decade, while average wages have risen less than a third of that amount. Meanwhile benefits are declining, and employers are asking workers to shoulder more of the burden by paying higher premiums or other out-of-pocket costs.

Well, insurance companies ask you to pay more, but then there are a number of other ways they come up short. They can have caps or limits of the amount an insurer will pay for an individual's care over a lifetime or in a single year or for a particular service. And other plans exclude coverage for certain preexisting conditions or limit coverage in other ways. So in other words, what we are seeing are insurers increasingly shifting the risk to the individuals through greater cost sharing, such as higher deductibles, copayments or coinsurance. The risk should be borne by the insurance companies. That is why we are buying insurance in the first place.

So with skyrocketing health costs and skimpier coverage, we now see the ranks of the underinsured growing. In 2007, there were 25 million underinsured Americans, a 60 percent increase from just 2003. This is in addition to the 50 million people who are completely uninsured. Underinsurance is on the rise among both low- and middle-income Americans, and it often leads to medical debt that empties saving accounts and ruins credit scores. For many the medical debt is simply too much to bear. And a recent study found that 62 percent of all personal bankruptcies are related to illness or medical bills.

Underinsurance has grave consequences for a family's physical as well as financial well-being. I look forward to our hearing today from witnesses who have struggled with steep medical expenses despite the fact that they paid for health insurance. And I want to thank Ms. Howard, Mr. Null and Mr. Wilkes for agreeing to share their stories with this committee. And I also look forward to hearing from Sara Collins of the Commonwealth Fund and Stan Brock of the Remote Area Medical Volunteer Corps about the growing problems of underinsurance.

This hearing comes at a time when Congress is struggling for health care reform. One clear reform has to be insurance reform to stop these medical insurance practices from going on. People shouldn't be fooled into thinking they are covered and then find out when they need their health insurance coverage the most that they are, in fact, underinsured.

This is one of an ongoing series of hearings from this committee. I think it is important that we have these hearings in order to drive forward legislation to stop these kinds of practices from going on in the future.

Thank you, Mr. Chairman.

Mr. STUPAK. Thank you, Mr. Chairman.

Mr. Barton, opening statement, please.

Mr. BARTON. Thank you, Mr. Chairman. Thank you, Ranking Member Walden, for holding this hearing. I am going to put my official statement in the record and just speak extemporaneously.

We obviously, on both sides of the aisle, believe that it is time to reform our health care system, and it is just as obvious that a part of that reform should be insurance reform. Myself, Mr. Green and Mr. Stupak and others offered an amendment at the additional day of markup several weeks ago where we put a transparency amendment in for the health care system, which would include insurance companies. And in underinsurance there is nothing more important than providing transparency so that individuals know what coverage they are really getting and the companies are up front about what coverage they are providing and what those caps are before the fact. It is terrible to find out after the fact, like Mr. Null found out that his what he thought was a catastrophic policy really wasn't, or it wasn't in such a way that it covered his daughter. So I think this is a good hearing. It is a part of the record that needs to be made.

I do want to say in response to what Chairman Waxman said that in the overall effort for health care reform, I do not believe a solution is a mandatory coverage requirement for individuals, because some individuals will be impacted in a very negative way by

being mandated that they have to carry it. If we can get transparency and get competition and get reform across the board, then if you are not covered at work, and you want a private plan, and we set up with some of these pools, you will be able to choose from plans and know what you are getting.

But I have nothing but respect for the witnesses today that are going to give their case histories, because they are very moving. And I hope that a good thing will come out of this that will create a bipartisan consensus on some of the things that need to be done to reform the disingenuity in the private insurance market for plans like these folks have had to bear.

Thank you, Mr. Stupak.

[The prepared statement of Mr. Barton follows:]

**OPENING OF THE HONORABLE JOE BARTON
RANKING MEMBER, HOUSE ENERGY AND COMMERCE COMMITTEE
OCTOBER 15, 2009 O&I HEARING ON UNDERINSURANCE**

Thank you, Chairman Stupak. Over the past few months this Committee has investigated a number of issues as part of the Congress' efforts to reform the health care system. We have heard deeply personal stories from many Americans, and today is no exception. I want to thank Mr. David Null from Garland, Texas—just down the road from my own district—for appearing before this committee today. I also want to thank Mr. Nathan Wilkes and Ms. Catherine Howard for their testimony today.

I want to extend to all of you my very best wishes and I want you to know how much we appreciate your testimony today. You will be speaking not just for you and your family, but for the many Americans who worry about the very thing you have been through. This worry—that if you get sick your insurance will not be there for you—reminds me of the hearing we had this past summer on the practice of rescinding policies by insurance companies in the individual market.

Today we will hear from Texas native David Null. No one should have to go what his family has been through: when his daughter was 7 years old she was perfectly health on a Friday, and in a coma by Tuesday. She needed a liver transplant immediately. He thought his insurance would cover the surgery. In fact, he has specifically sought out and been sold a policy that was represented to him as covering a catastrophic event like this. Instead, he was told in the hospital that the policy had capped out after only a few days.

Ms. Catherine Howard reminds me of a good friend of this Committee, Ms. Robin Beaton. Ms. Beaton had her insurance policy rescinded days before she was supposed to undergo a double mastectomy. Similarly, Ms. Howard thought her insurance would cover her breast cancer treatment, but she found herself being asked to cut a substantial check on the day of her surgery. Eventually she would wind up \$100,000 in debt.

It is situations like these that led me to draft the Robin Beaton Amendment to Rep. DeLauro's Breast Cancer bill last year. This prohibits the rescissions of health insurance for the inadvertent omission of information, and will protect breast cancer patients like Ms. Beaton and Ms. Howard in the future. My amendment passed the House last year but died in the Senate. It has been reintroduced and hopefully it will pass this year.

I understand that there is another side to this story. I understand that the insurers will claim that the policies they sold explicitly detailed what would and would not be covered. Still, I reiterate my call that companies need to have open and clear disclosures about what their policies will specifically cover, so nobody is ever faced with a situation in which they purchase a policy believing it will provide services it ultimately will not.

This is an important hearing, Mr. Chairman, and I thank you for holding it.

Mr. STUPAK. Thank you.

For 3 minutes now we hear from the gentleman from Massachusetts Mr. Markey for an opening statement.

OPENING STATEMENT OF HON. EDWARD J. MARKEY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF MASSACHUSETTS

Mr. MARKEY. Thank you, Mr. Chairman, and thank you so much for having this very important hearing.

As we consider the urgency of expanding health care coverage and transforming our sick care system into a health care system in our country, this question of the underinsured is right at the heart of the matter, because there is an estimated 25 million Americans who are insured, but they are underinsured at the same time. And let us just focus in on this problem.

Medical bills are the leading cause of personal bankruptcy in the United States today. Sixty percent of all bankruptcies are because of medical bills, 60 percent. And of the 80 percent of people who went bankrupt because of their medical bills, 80 percent of them had insurance, and they still went bankrupt. Insured but not covered.

Now, I recently received a letter from a constituent in my district. He returned home from open-heart surgery and found a bill from the hospital informing him that his insurance company had denied coverage for the anesthesia used during the operation. They deemed the anesthesia, quote, "medically unnecessary," and demanded \$10,000 for the anesthesia. Now, he asked me, did the insurance company expect him to take a swig of whiskey and bite a bullet while they cut open his chest? Well, unbelievable, but they did, and they sent him the bill for \$10,000. Insured but not covered.

This is how we get 60 percent of all bankruptcies in America related to medical bills that people receive. It is unacceptable that patients must fight their health insurance companies for coverage while fighting disease at the same time as they are insured. It is unacceptable that parents have to help a child overcome a crippling illness while struggling to overcome crippling medical debt by postponing necessary treatment, skimping on food and even exhausting their savings so that they can qualify for Medicaid. It is wrong for health insurance companies to deny coverage for critical treatment when families need it the most. And I am pleased that the health reform bills that we are considering will make tremendous progress in this area.

The plight of the underinsured and the steady creep of the underinsured into the ranks of the middle class shows that health care affects each and every one of us, and now is the time for us to fix this sick care system and turn it into a health care system for all Americans.

Thank you, Mr. Chairman, very much.

Mr. STUPAK. Thank you, Mr. Markey.

Mrs. Blackburn for an opening statement, please, 3 minutes.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Mr. Chairman.

I want to welcome all the witnesses and thank them so much for giving their time and for being here to share their experiences. And I especially want to welcome these two beautiful young girls that are sitting on that front row. We are thrilled that they have taken the time out—I bet it is a day out of school—and we hope that they see this as a learning experience.

Mr. Chairman, I do thank you for the hearing today. We are all concerned about coverage for preexisting chronic conditions. We are so concerned about the rescission issue. I think that where you are going to see some differences is how we approach the badly needed insurance market reforms that are out there. I am one of those that wants to keep things patient-centered, patients first, free-market-oriented. And I would like to see more competition in the marketplace as we seek to address this, allowing purchase of insurance policies from across State lines so that families have more options and more choices.

Now, in Tennessee, where I am from, health savings accounts are very popular. We would love to see the contribution and allowance limits there enhanced and to see incentives for individuals with healthy lifestyles.

Liability reform has already been mentioned this morning. The practice of defensive medicine does drive up costs, but it also plays in sometimes to that rescission issue, and we are aware of this and seek to address that and to address it in good faith.

I want to give a special welcome to Mr. Brock who is here. You are going to love hearing from him, and I commend him to my colleagues. The RAM program is one that we are very pleased with in Tennessee. Quoting from page 2, the second paragraph of his testimony, I want to highlight one thing: The greatest impediment to the RAM program is regulation in 49 States preventing willing practitioners from crossing State lines to provide free care. Now, in Tennessee we have addressed this issue; Dr. Burgess has talked about that issue, it came to light after Katrina. I am looking forward to hearing from him and to welcoming them today, and I yield back the balance of my time.

Mr. STUPAK. Mr. Welch, opening statement, please.

OPENING STATEMENT OF HON. PETER WELCH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VERMONT

Mr. WELCH. Thank you, Mr. Chairman and Ranking Member Walden.

And the stories that each of you told really summarize, I think, what can only be described as the failure of the American health insurance industry. The health insurance industry, in fact, has served its own interests very well, but it has failed the American families and consumers, it has failed the small businesses that pay the premiums, it has failed our taxpayers, it has failed our doctors and our nurses and the health care providers.

What it has done is served its own interests very well: the CEOs, some of whom make \$24 million in a year; Wall Street analysts

who cheer every time the medical loss ratio goes down, meaning that each of every premium dollar has less spent on health care and more spent on dividends, on CEO salaries. It has served—because it served its own interest very well, because essentially it is based on a model that you have heard described here, and that model says that if you are healthy, and you are wealthy, and you are unlikely to need it, we will insure you, and we will keep increasing your rates. But if you are sick or likely to get sick, if you are older, we won't insure you; or if we do, we will make a policy so confusing and laden with so many loopholes that you won't get much benefit for the insurance that you thought you had. As Mr. Markey said, you are insured, but you are not covered.

And just another example to add to the laundry list here of horrors, this is much smaller and much more mundane, but it shows just the Alice in Wonderland world that the insurance companies operate in. We have a woman from Milton, Vermont, Cheryl, who had a policy that she thought had covered wellness screening. And she got a colonoscopy and was told that it would be covered, but lo and behold, a colonoscopy, in fact, diagnosed diverticulitis, and the insurance company said that procedure was no longer about wellness, it was diagnostic, and that was not covered, and they made her pay the \$1,000 bill.

I mean, those days we have to put behind us because the insurance company has had its chance, and it has failed. And when a person buys insurance, when a small business pays a premium to cover its workers, those folks should have assurance that they are getting something real, health care insurance and coverage, when they need it.

Thank you, Mr. Chairman, for this very important hearing, and I yield back.

[The prepared statement of Mr. Welch follows:]

Congressman Peter Welch
Statement before the House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
October 15, 2009

Mr. Chairman, Ranking Member Walden, and Members of the Committee, thank you for the opportunity to discuss the growing, insidious problem of underinsurance. While much attention in the debate over health care reform has focused on the 47 million Americans who are uninsured, far less has focused on the many more Americans who are underinsured.

As you know, too many insured Americans find themselves paying exorbitant premiums, deductibles, and co-pays – going into debt even with the health insurance coverage they have. Today I want to share with you the stories I've heard from two Vermonters struggling with this critical problem.

Susan, a resident of **Montpelier, Vermont**, has held private health insurance for more than 30 years. When her premiums increased last year to \$330 a month, she decided to save money by increasing her deductible to \$10,000.

On a snowy day this February, Susan fell and broke her wrist. After seeking treatment at the local hospital, she found herself with a \$1,000 bill for emergency room care and an additional \$900 bill for the surgery to set her wrist. Because her deductible was so high, Susan found herself – after 30 years of dutifully paying for health insurance – essentially with no coverage at all.

Like Susan, more than 25 million Americans have health insurance policies that do not adequately cover their health care expenses – sixty percent more than in 2003. According to the Commonwealth Fund, underinsured individuals are more likely to forgo needed medical services because of cost. Two-thirds of those with high medical expenses and low coverage went without necessary care.

The experience of another Vermonter, **Cheryl from Milton**, might explain why.

After her doctor suggested she have colonoscopy as a baseline screening, Cheryl found herself with more than \$1,000 in medical bills – even though her policy covered 100 percent of wellness screenings. She thought a mistake had been made, so she checked with the insurance company. What she learned was that because her colonoscopy resulted in a diagnosis for diverticulosis and was categorized as “diagnostic,” she was responsible for one third of the cost of the procedure.

It was the same test, the same lab work, and the same amount of care. But because the test did what it was supposed to do – diagnose an illness - she was responsible for a tremendously expensive medical bill.

Americans already struggling in these difficult economic times face the additional burden of overwhelming out-of-pocket medical expenses – and the problem is only getting worse. The number of American families struggling to pay medical bills in 2007 climbed to 57 million – or

one in five – up from one in seven in 2003. In my home state of Vermont, premiums for working families increased 75 percent from 2000 to 2007. Nearly 8 percent of working adults in Vermont reported spending 20 percent or more of their income on out-of-pocket health care expenses in 2004, an 85 percent increase from three years earlier.

Given these factors, a costly illness can lead to massive medical debt. Forty-six percent of underinsured adults report using all of their savings to pay their medical debt, and 33 percent took on credit card debt to address medical expenses. In the worst cases, medical debt forces Americans into bankruptcy, with the rate of bankruptcy due to medical expenses rising 50 percent between 2001 and 2007. Medical bills are the number one reason for personal bankruptcy today.

Unfortunately, the health insurance industry has established a record of valuing profits over care. They have resorted to saving money by denying those with preexisting conditions and limiting benefits while paying executives exorbitant salaries. One health insurance company CEO recently received nearly \$100 million in a stock option deal. The profits that he reaped from the exercise of one year's worth of stock options would not only pay the salary of the administrator of CMS but of every employee in the agency for more than three months.

Thank you again for the opportunity to convey these Vermont stories to you today. I look forward to working with you to ensure that any health reform legislation that is signed into law protects Americans against inadequate coverage and ends the burden of excessive medical costs. Nobody, rich or poor, should bear that burden.

Mr. STUPAK. Mr. Burgess for an opening statement, please, 3 minutes.

**OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Dr. BURGESS. Thank you, Mr. Chairman. I will abbreviate my statement and submit it in its entirety for the record.

I do want to thank you for holding the hearing today. I really believe this is a twofold problem. On the one hand we have hard-working Americans who do the right thing day in and day out. They go to work, they buy health insurance, and then when they get sick, their medical insurance does not cover their bills. If they work harder, make tough choices in other areas of their life, they still struggle to pay their medical debt.

So I did my town halls this summer, as many of us did. One thing I heard over and over again, people are genuinely frightened of what Congress is going to do to health care in this country, and they are probably justified in that skepticism. But the one thing that everyone seems to agree on is the issue of excluding someone from insurance coverage because they have had a tough medical diagnosis, or the issue of excluding someone or the insurance rescission when a tough medical diagnosis is rendered for someone who is already insured. Those are the processes that have to stop. Nothing infuriates people more than thinking that somebody has played by the rules, paid their dues, and then when they actually need the service, they find it is withdrawn from them. People who are responsible and do what it takes to provide for themselves or their loved ones are, in fact, to be commended and are not to be put in positions that are just absolutely untenable.

And we do have the issue of insurance as a whole. You do want to protect people from those contingencies in life from which no one can anticipate, and no one can reasonably be expected to save the amount of money that would be required to pay for some very, very tough diagnoses. The cost of care has gone up significantly. There is no question there is the advancing complexity of what we are able to do. When I think of some of the saves that I saw during my medical career that—late in my medical career you have never seen in the beginning of my medical career, those things are very important. And we certainly don't want to—in our zeal to cap costs, we don't want to cap innovation or remove the innovation that has really set American medicine apart from medicine that is practiced in almost any other country.

Mr. Barton referenced transparency. Three Congresses ago I was charged by the Speaker of the House, who was then a Republican, to work on the issue of transparency, and I introduced legislation that year. It finally did find a place in H.R. 3200 as it left the committee this year in September. I don't know if it will survive the cutting room floor over in the Speaker's Office, but I am hopeful that it will, because transparency is important.

Another provision that was in the bill that I partnered with Mr. Dingell on was the issue of internal and external review boards. When you have a—whether it be a public option or a private insurance company, if they deny the coverage, a patient ought to have the right of appeal; they ought to be able to appeal to not just the

internal review board within the insurance company, but an external review board as well. And that is true whether it is Aetna, Signa, United or a new robust public option that is instituted by the United States Congress. If care is denied for whatever reason, patients ought to have the right of appeal. It doesn't mean that we need to be spelling out everything that is involved in someone's health care.

And I told the Chairman I would abbreviate my statement and submit the balance for the record, and that is what I will do. I do thank the witnesses for being here today. It is an important part of the process. I will just say I think we would have done the American people a service if we had concentrated on more how do you get around these nettlesome problems with preexisting conditions and rescissions without resorting to mandates, which really have no place in a free society and only ultimately enrich the insurance companies.

I will yield back the balance of my nonexistent time.

Mr. STUPAK. Nonexistent? Your summary was longer than your statement.

[The prepared statement of Mr. Burgess follows:]

**STATEMENT OF
CONGRESSMAN MICHAEL C. BURGESS, M.D.**

BEFORE THE

**SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON ENERGY AND COMMERCE**

OCTOBER 15, 2009 HEARING

“Insured but not covered: The Problem of Underinsurance”

Thank you, Mr. Chairman, for holding this important hearing.

The problem of the underinsured is a two-fold issue.

On the one hand, we have hard-working Americans who do the right thing day-in-and-day-out. They go to work; they buy health insurance; and when they get sick -- and their insurance doesn't cover all their bills -- they work harder, and make tough choices in other areas of their life, to pay their medical debts.

They are responsible and they do what it takes to provide for themselves and for their loved ones.

Then, on the other hand, we have the issue of insurance as a whole.

There is this idea, that Republicans have long protected and now Democrats are embracing too, that by giving the American people health insurance, this will solve the problem of health care.

But health insurance doesn't prevent health care costs from consuming 16% of the gross domestic product, as it does now, and health insurance doesn't prevent our entitlement programs of Medicare and Medicaid from going bankrupt before my grandson gets his driver's license.

It's the cost of health care.

Our panelists would have been able to pay their costs for cancer, their child's transplant or treatment for severe hemophilia A themselves if the costs for either weren't \$100,000, \$750,000 and over a million dollars respectively.

But I do not believe we need to cap the cost of the delivery of service. Quality and innovation should be rewarded by the marketplace.

What we need is transparency. What we need is consumer protections so we know that state insurance commissioners are doing their jobs.

We need a transparent appeals process like the one I authored and had added to HR 3200 with Rep. Dingell and Barrow -- based on the Patient's Bill of Rights -- that allows plan holders in consultation with their doctor to appeal a coverage determination and know what their rights to review are. I don't want any bureaucrat -- whether they work for an insurance company or the federal government -- to get in the way of a doctor and patient making a medical decision.

But that doesn't mean we need the federal government to be spelling out what soup to nuts coverage looks like. People need to know what they are buying and perchance the plan that is best for them that is adequate to their level of risk.

The cost of health care should also be transparent so just like when you go to a grocery store and walk down the cereal aisle you can see who made it, what's in it and how much it costs, every doctor, with every procedure, should have their costs as transparent and easy to understand and find. Then individuals can pick and chose based upon their person needs -- financial and otherwise.

Most importantly, we can readily cap the cost of care right now through medical liability reform. Doctors who are afraid of being sued because they didn't run every procedure possible, thus run every procedure possible. Defensive medicine takes a \$1,000 evaluation into a \$10,000 one. Texas has medical liability reform and the rest of this country should too. The CBO just scored the savings to the federal government alone at \$54 billion and I think that is a low estimate.

We need to make sure health care is accessible, it is affordable and it is adequate for constituent's needs.

Thank you.

Mr. STUPAK. Let's go to Mrs. Christensen, please.

OPENING STATEMENT OF HON. DONNA M. CHRISTENSEN, A REPRESENTATIVE IN CONGRESS FROM THE VIRGIN ISLANDS

Mrs. CHRISTENSEN. Thank you, Chairman Stupak, and thank you, Ranking Member Walden, for holding this hearing, both of you.

It is important to highlight why health care reform and providing affordable, secure insurance coverage without caps to everyone is so critical; not just the physical, but also the economic well-being of our families and our country.

I also want to welcome the witnesses and their families for being here this afternoon and to share those very personal, very painful stories and provide more insight on the need for affordable, adequate insurance coverage.

Underinsured Americans far too closely resemble the uninsured, but they are often the forgotten faces of the health care debate. Currently 25 million Americans, as we have heard, cannot afford to pay the gap left by weakened insurance coverage and large medical bills. And I was surprised to learn recently that even end-stage renal disease patients may find themselves uninsured even though they are covered by Medicare.

Underinsurance is also a contributor to health disparities. Despite the presence of full-time workers, in the vast majority of their households, racial and ethnic minorities are disproportionately underinsured or lack coverage altogether and, therefore, less likely to receive quality health care. It causes a vicious cycle, as we will hear, in our health care system that forces far too often people to forego medical treatments and prescriptions after they have already paid for insurance, resulting in poor outcomes.

Even more dramatic is the fact that people don't realize they are underinsured until they are already sick and facing those mounting health care bills. As we will hear, the average working family can faithfully pay their insurance premiums for years, but still go into medical debt or face bankruptcy when they get sick.

A study released this summer by the American Journal of Medicine found that in 2007 a family filed for bankruptcy every 90 seconds due to excessive medical bills. If that is not shocking enough, 75 percent of those Americans already had health insurance. These are hardworking Americans that did not choose to wake up one morning with an injury or an illness that would not only deplete their productivity, but also deplete their bank accounts.

The insurance companies have profited millions by ensuring that their policies are structured to defy the very purpose, as Chairman Waxman said, of having health insurance. So underinsurance and underinsurance is unacceptable, period. I look forward to passing and having the President sign a health care reform bill that ends it once and for all.

And I thank you and yield back the balance of my time.

Mr. STUPAK. Thank you.

Mr. Gingrey, opening statement, please.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Dr. GINGREY. Thank you, Chairman Stupak.

First, I want to thank all the witnesses who joined us today, and I certainly look forward to hearing your testimony.

As a physician who practiced medicine for over 30 years, one of the most important lessons I ever learned was that a medical solution for one of my patients was not necessarily the best solution for another patient. Each and every one was unique, but their needs, of course, were the same ultimately, to get better. So as this Congress debates the nuances of health insurance reform and what type of insurance American patients should have, I believe that we must frame the debate in terms of what is best for the patient.

With respect to the debate, H.R. 3200 and every other iteration of the Democratic Majority reform proposals purports to create access to affordable health care, certainly a worthy goal which I agree with. However, they do so by requiring that all health insurance products meet a one-size-fits-all mode through various Federal mandates, and, yes, cost-sharing limits. Unfortunately studies have shown that these same mandates and limits on cost sharing will drive up the cost of all health insurance products by as much as \$4,000 a year for a family of four.

In their plan my Democratic colleagues, they seek to combat these cost increases with affordability credits. Unfortunately, in H.R. 3200, it does nothing to curb the cost of health care in this country. In fact, the CBO recognized that H.R. 3200 would actually increase the cost of health care in this country. So these affordability credits they give patients today will be worth less tomorrow, while the overall price of health insurance will continue to climb, as it has done so for decades, as has already been pointed out, only now at a much greater rate. One doesn't have to have a medical license to figure out that my colleagues are setting up a framework of an unsustainable system.

Where does this leave American patients? If we were to use the State of Massachusetts as an example, we would find patients losing their health care benefits to offset increased cost of care. Just this past June, 92,000 low-income patients lost their dental insurance because the State needed to trim the cost; 92,000 lost their dental insurance. Now, using the definition of underinsurance—I couldn't find it in the dictionary, by the way—would those 92,000 low-income individuals who lost their dental benefits qualify as underinsured? If so, I might suggest that mirroring a health reform plan after the Massachusetts model could end up hurting those patients who truly need help in the long run.

Mr. Chairman, while we do need reform to increase access to care for patients like those before us here today, we cannot simply slap the term "reform" on just any bill and assume that it will improve the quality of health care. In fact, the wrong kind of reform creates a system where these testimonies are the rule and not the exception.

And I yield back.

Mr. STUPAK. Mr. Doyle, opening statement, please.

OPENING STATEMENT OF HON. MICHAEL F. DOYLE, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. DOYLE. Thank you, Mr. Chairman. Thank you for holding this hearing on the issue of underinsurance at such a relevant time.

For the last few months, Congress and the country have been engaged in a debate largely focusing on the 45 million uninsured Americans, and often leaving out of the conversation the 25 million Americans that are underinsured. I look forward to our witnesses' testimony that will shine light on the problem of underinsurance in our country, a problem that unfortunately is growing at an alarming rate. In just six years, from 2003 to 2007, the number of uninsured Americans rose 60 percent. This is a problem that must be highlighted and will be addressed in the health care reform legislation that will go before the House soon.

Underinsurance is when a policyholder believes they have adequate health care coverage, and then, when it is too late, they are proven wrong. When individuals buy insurance or are provided with plan options from an employer, the small print of their contracts is often overlooked, text which contains vital information about their coverage. This is exactly where people need to be paying the most attention because it is here that often information on lifetime or even annual limits, copayment requirements, treatment exclusions and other limits on coverage is hiding.

We all know we are supposed to read the fine print, but we also know that people don't always do it, which brings us back to the big picture. People don't know what they need to know until it is too late. I believe if you buy an insurance policy, you should know what you are getting and not have to hire a lawyer to understand it. Hidden traps, fine print and, at times, misleading marketing ploys prevent the consumer from making an educated decision about their health coverage, and this is precisely why it is so important that we pass meaningful health care reform this year that will require insurers to provide a minimum set of benefits that will take care of patients' needs, limit out-of-pocket expenses and prohibit insurers from imposing annual or lifetime caps on coverage.

I look forward to hearing from our witnesses.

Mr. Chairman, I want to thank you for this hearing today, and I want to thank the committee for highlighting this very serious problem.

I yield back.

Mr. STUPAK. Thank you, Mr. Doyle.

Chairman Emeritus of the committee Mr. Dingell for an opening statement, please.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. DINGELL. Mr. Chairman, thank you. And I commend you for holding this very important hearing on an issue of great importance in our consideration of health reform benefits and health reform efforts. I want to commend you for the hearing, and I want

to thank our panel of witnesses for being here today. We are grateful for your assistance, and I thank you.

In our fight for health care reform, we focus on the 46 million Americans without health insurance. That is very important, but as has been observed already, underinsurance is an all too common problem that must also be addressed. In fact, by some estimates 25 million Americans were underinsured in 2007. These 25 million people are paying at least 10 percent of their income for medical expenses in addition to the cost of the premiums. In more simple terms, there are far too many Americans paying for insurance policies that do not cover the medical care they need, some of which policies are sold by practices close to fraud.

Now, whether the underinsurance is caused by annual or lifetime caps or excessive cost sharing, or whether the policy doesn't cover the needs of the policyholder, the result is the same: Underinsurance creates an undue financial burden on far too many American families. In 2007, 28 percent of American adults reported carrying medical debt. Of the underinsured, 46 percent reported using all of their savings toward their medical debt. With statistics like these, it should come as no surprise that over 60 percent of personal bankruptcies are due to health care expenses.

These numbers are staggering, but the personal stories are even more moving. Just this week the Detroit Free Press ran a story about uninsured and underinsured Michiganders in my home State. One of the families profiled was the Hurleys of Canton, Michigan. The Hurleys have employer-sponsored insurance, but are forced to buy extra policies to cover the needs of their children, one a 7-year old with severe asthma, and another a 10-year old with skeletal disorder. Without the extra insurance policy, they could not afford the \$50,000 spine surgery their son needs every 4 months.

I am particularly grateful for our first panel and to them for having joined us today to tell their story of hardships due to underinsurance. I want them to know that their testimony is going to remind us and others of why it is so critical and so crucial that we pass comprehensive health reform legislation this year.

Finally, I would be remiss if I did not mention the aggressive steps we take in H.R. 3200 to make underinsurance a thing of the past. This bill would, one, remove all annual and lifetime caps; two, limit the out-of-pocket expenses for everyone; three, provide affordability credits for low- and moderate-income people to assist them with premiums and cost sharing; and lastly, it would enable all to know that all insurance policies provide a minimum level of health benefits to all Americans. And, of course, we would see nasty little things like rescission of policies and preexisting conditions. So I am—we would see them end. So I hope today's hearings will serve as a call to action and remind us of the importance of the task before us.

Thank you, Mr. Chairman.

Mr. STUPAK. Thank you.

We have two votes on the floor. I would love to get all the opening statements in before we break if we could. So next, Mr. Green, please, for opening. Mr. Green.

**OPENING STATEMENT OF HON. GENE GREEN, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Thank you, Mr. Chairman. I ask unanimous consent for my full statement be placed into the record.

Underinsurance is when an individual actually has insurance, but their policy does not adequately cover their health-related expenses. That is such an important topic that I am glad we are having this hearing. And last month when our committee worked on or has been continuing to work on the health care reform bills, we addressed a great deal of that in H.R. 3200.

As our dean—Chairman Emeritus and dean of the House said, insurance premiums have risen steadily over the years, 131 percent over the past decade, and individuals are uninsured are paying at least 10 percent of their—underinsured—10 percent of their income, out-of-pocket expenses on top of their premiums. And according to the Commonwealth Fund, who we will hear with the second panel, 25 million Americans are underinsured in 2007, which is a 60 percent increase over 2003.

All of us have constituents who call us and assist them with their insurance company policy problems, whether it is very low caps—in some cases in our district it was \$25,000—and either that or they do not provide coverage for certain services, such as experimental cancer treatments, certain prescription drugs, and those who have been denied coverage for a condition that is deemed pre-existing. That is why I am so glad to have our first panel here today to talk about real-life experiences.

But again, our committee has made a great step on H.R. 3200, and hopefully we will get the vote on that sooner than later. And we can solve a lot of these problems not only with the uninsured 47 million, but the millions of underinsured we have in our country.

And, Mr. Chairman, like I said, I will put my full statement in the record. Thank you.

Mr. STUPAK. Thank you, Mr. Green.

Ms. Schakowsky for an opening statement, please.

**OPENING STATEMENT OF HON. JANICE D. SCHAKOWSKY, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS**

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

First let me thank the witnesses. I read all your testimony, and I read it shaking my head. I have heard these stories before, but yet to hear the particulars are so disturbing. And I really look forward to you telling those stories yourself.

Here is one that was on the front page of the Washington Times yesterday. It says, Ian Pearl has fought for his life every day of his 37 years. Confined to a wheelchair and hooked to a breathing tube, the muscular dystrophy victim refuses to give up, but his insurance company already has. Legally barred from discriminating against individuals who submit large claims, the New York-based insurer simply cancelled lines of coverage altogether in entire States to avoid paying high-cost claims like Mr. Pearl's.

In an e-mail, one Guardian Life Insurance Company executive called high-cost patients such as Mr. Pearl “dogs” that the company

could get, quote, "rid of," unquote. By the way, in the meantime his parents are paying \$3,700 and have been a month for his care. These are the kinds of horror stories that people face every single day in our country.

And, Mr. Null, you asked in your testimony, is that American? And I want to say that I hope at the end of 2009 you will be able to look at the kind of health care we provide Americans and your daughter Tatem and say, yes, this is American. And the kinds of things that we are going to do, I hope, are going to resolve the problems of all three of you and millions more in our country.

We address the problem of high deductibles and cost sharing by giving individuals access to group rates through the exchange, with annual out-of-pocket limits of \$5,000 for individuals and \$10,000 for families. We assure that coverage is adequate, eliminating pre-existing condition exclusions and establishing a basic benefit package. We require that plans meet network adequacy requirements so that consumers, especially those with disabilities or ongoing health care needs, have access to the providers they need. Four, we eliminate annual and lifetime limits that leave health care consumers with huge medical bills when their coverage runs out, but their health needs continue.

I believe that your testimony today will contribute to getting these kinds of reforms. I thank you, and I yield back.

Mr. STUPAK. Thank you, Ms. Schakowsky.

Mr. Braley for an opening statement, please.

**OPENING STATEMENT OF HON. BRUCE L. BRALEY, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA**

Mr. BRALEY. Mr. Chairman, I want to thank you and Ranking Member Walden for holding this important hearing. I think all of us have learned that when health care policy is abstract, the American people run away.

And the reason why your appearance here today is so important to us and the entire country is because until health care policy becomes personal, people don't realize how broken our health care delivery system is in this country.

This little boy that you see up here on the screen is the face of health care for me and my family. This is Tucker Wright. He lives in Malcom, Iowa. His father, Brett, is my nephew. When Tucker was 18 months old, he was diagnosed with liver cancer. He had two-thirds of his liver removed. He was lucky that he survived, but every day he has an ongoing lifetime medical challenge of survival.

He continues to accumulate exorbitant medical costs, many of which are not covered by his insurance policy. His family has already incurred tens of thousands of dollars of uninsured medical costs. They hold fund-raisers to try to raise the money that is not covered by their insurance policy. And his parents are both employed full time and had what they thought was good health insurance.

By the age of 20, he is 90 percent likely to have another form of cancer. He goes to Des Moines, Iowa, every month to have expensive diagnostic imaging studies to monitor his health condition. And until we start looking at health care as this type of face and the faces that you present to us today, we are never going to get

the American people to rally behind the need for comprehensive health care reform.

Your voices here today, Tucker's face and the people in this country just like him and just like you are going to be the unifying forces we need to transform health care delivery and the way we pay for it and the way we insure it in this country; and that is why I am personally so grateful that you took time out of your busy lives to help us put a human face on health care reform.

I yield back the balance of my time.

Mr. STUPAK. Thank you, Mr. Braley.

[The prepared statement of Mr. Braley follows:]

BRUCE L. BRALEY

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Statement of Congressman Bruce Braley
Subcommittee on Oversight and Investigations
"Insured But Not Covered: The Problem of Underinsurance"
October 15, 2009

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Thank you, Chairman Stupak and Ranking Member Walden for holding this important hearing today on underinsurance and medical debt. As we continue to debate and move forward on healthcare reform in Congress, this is yet one more problem that highlights the urgent need to pass comprehensive healthcare reform that will ensure that all Americans receive the complete healthcare coverage they need without being burdened by debt.

As with many of the problems with our current healthcare system, the statistics of underinsurance are staggering. It's unacceptable that 25 million Americans were underinsured in 2007, a 60 percent increase from 2003, due largely to rapidly rising healthcare costs. But for me, the problems of underinsurance and medical debt are also very personal.

My nephew has a child who was diagnosed with cancer as an infant. Because of his child's illness, my nephew and his family are

now faced with tens of thousands of dollars in medical debt. My nephew can't change jobs because a new insurance plan would deny coverage based on his son's cancer, which would be considered by the insurance company to be a preexisting condition.

These are the immediate problems my nephew and his family are facing because of underinsurance. But, unless we in Congress act, these and related problems promise to burden them far into the future. Because of his diagnosis at such a young age, my nephew's child has a high probability of getting other forms of cancer by the time he's 20 years old. This means that he could very likely exceed the lifetime cap of his insurance policy by the age of 20. What is he supposed to do when he's exceeded his lifetime coverage cap at that very young age? How is he supposed to pay for the care and treatments that he'll likely need?

I'm sure many of the witnesses who will be testifying today have similar stories to tell about the hardships they and their families have endured because of limitations in their insurance policies. I've already heard similar healthcare horror stories from hundreds of my constituents, many of whom have been left without coverage or mired in debt because of annual or lifetime caps, caps on payments for

specific services, cost-sharing, pre-existing conditions exclusions, and limitations on what insurance companies consider to be “medically necessary.”

My nephew’s experience has made it clear to me that we need to pass a comprehensive healthcare reform bill which will eliminate denials based on pre-existing conditions and which will eliminate lifetime caps on coverage in *all* insurance plans as soon as possible. I’m looking forward to hearing the testimony of the witnesses today, and to hearing their perspectives on what else needs to be done to ensure quality, affordable, and complete healthcare coverage for all Americans.

Mr. STUPAK. Ms. Sutton from Ohio, opening statement, please.

**OPENING STATEMENT OF HON. BETTY SUTTON, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO**

Ms. SUTTON. Thank you, Mr. Chairman. And I too want to thank the witnesses for coming forward to tell us your stories because, with your voices, you speak for so many Americans who are facing similar situations. That is why we are so intent in this committee and in this Congress to make health care work for you and the people that you love, and all of those out there who aren't in this committee room, but whose voices you bring by your presence.

During the August district work period I held many meetings with constituents and I heard their views about health care reform. Among those whom I met with were Dash and Kathy Sokol in Lorrain, Ohio. Dash just turned 56 and his wife Kathy is 53.

In February of 2007, Dash was diagnosed with prostate cancer, and as he fought that cancer and was fighting back, later that year Kathy was diagnosed with breast cancer. The Sokols had health insurance coverage through Dash's job at the steel mill.

However, with Dash and Kathy both receiving treatment for cancer, the costs began to add up. Their out-of-pocket spending became overwhelming, and the Sokols are now using their pension funds to pay for their medical bills instead of saving those funds for retirement.

Kathy told me that she felt guilty about having their family pay out of pocket for her cancer treatments in spite of the fact that they have insurance coverage. I want to repeat that: She felt guilty because their insurance plan did not provide adequate coverage.

Many insurance plans out there today are far from adequate, and when the Sokols came to my office, they brought with them stacks and stacks of insurance invoices. They had bills, explanations of benefits and records of what they had paid for, in addition to explanations about why most of their treatments were not adequately covered. Dash showed me that aside from being sick, aside from emptying their savings, they also were keeping full-time records to make sure that they kept up with their payments as best they could. Dash has been working on arrangements with providers to pay what he can when he can. He tells them, "I am willing to pay, but it will take time."

He continues to work to make sure that they keep the inadequate coverage that they have. And in these uncertain economic times, he is concerned about whether his job will be there tomorrow. He told me that he would like to retire, but is fearful of doing so before the couple becomes eligible for Medicare. And if the job does go away, they worry, they live in fear about what will happen because they won't be able to get insurance having had cancer. He could not imagine, he explained, what individuals who get sick without coverage do and how they cope.

The Sokols came to my office to offer their story and to offer their help, just like you here today. They want to do all they can to make sure that meaningful, comprehensive health care gets passed.

Dash told me—when I asked about using his story to convey what they were experiencing, he said, "Absolutely. I am willing to do whatever it takes." Well, I don't think that we in Congress

should offer any less than what Dash is willing to offer: whatever it takes to pass meaningful health care reform.

We have to do what it takes to make sure that American families are not spending their retirement funds just to stay alive. That is what far too many insured and uninsured Americans are facing. We have to do what it takes to hold insurers accountable for the benefits they promise us and, in many cases, that people pay for. We have to do what it takes to pass health care reform this year.

I yield back.

Mr. STUPAK. Thank you. That concludes the opening statements by all the members of the subcommittee.

We are going to stand in recess. We have 3 minutes remaining on this vote, and then we have another vote. Let's try to be back by 2:50, 2:55.

[Recess.]

Mr. STUPAK. The committee will come to order. We will now hear from our first panel of witnesses. Our first panel of witnesses, we have Ms. Catherine Howard, who is a policyholder from San Francisco, California.

Welcome.

Mr. David Null is a policyholder from Garland, Texas, and his daughter, Tatum, has joined him at the table.

Thank you for being here.

And Mr. Nathan Wilkes is a policyholder from Englewood, Colorado.

Thanks for being here.

STATEMENTS OF CATHERINE HOWARD, POLICYHOLDER, SAN FRANCISCO, CALIFORNIA; DAVID NULL, POLICYHOLDER, GARLAND, TEXAS; AND NATHAN WILKES, POLICYHOLDER, ENGLEWOOD, COLORADO

Mr. STUPAK. It is the policy of this subcommittee to take all testimony under oath. Please be advised that you have the right under rules of the House to be advised by counsel. Do you wish to be represented by counsel?

Everyone is shaking their heads "no," so I will take it as a "no." Therefore, I am going to ask you to rise and raise your right hand to take the oath.

[Witnesses sworn.]

Mr. STUPAK. Let the record reflect that the witnesses replied in the affirmative.

You are now under oath. We will begin with opening statements. Ms. Howard, if you don't mind, we will start with you. You may submit a longer statement for inclusion in the hearing record.

Ms. Howard, if you would start. Your light is on, I take it. Five minutes, please. And thank you again for being here.

STATEMENT OF CATHERINE HOWARD

Ms. HOWARD. Thank you, Mr. Chairman, members of the subcommittee. Thank you for inviting me to testify today.

My name is Catherine Howard, and I am from San Francisco. Five years ago, I was working as a documentary film producer. I wasn't making a lot of money, but I knew that maintaining my health coverage was a big priority.

My employer didn't offer coverage, so I went out and I bought myself a private plan; and this plan seemed perfect for a young, healthy person. And it was affordable, only \$140 a month, but I had no idea what it would really cost me. I was afraid that I would get hurt in some minor way, take a fall snowboarding, need a couple of stitches, not living with a life-threatening illness like cancer.

After my breast cancer diagnosis in August of 2004, I thought I was covered. You know, I thought, I am so glad I have insurance. But, boy, was I wrong. I discovered that the health plan that I was paying for didn't cover a large part of the cancer care that I needed, and I was on the hook for tens of thousands of dollars in uncovered expenses.

I had chosen one of those low-premium but high-deductible plans, and I had to pay for 30 percent of all my treatments in the hospital. And it didn't even cover all the services that I needed. I remember staring at this one shot, Neulasta; it cost \$2,100 per shot, and the insurance company said, well, that is 30 percent for you. So right there in that needle is \$600.

I endured surgery, grueling chemotherapy, and radiation regimes that left me too weak to work full time. I was told all along that the key to my recovery was to minimize the stress in my life. And, tell me, how do you minimize stress when you owe the hospital more than you have earned in the past year?

As the expenses piled up, I was able to pay for some of them. My family helped me. Other things, I just put them on my credit card and I thought, if I don't die, I will just deal with this later.

Well, I didn't die, and this is later. So I find myself almost \$100,000 in debt between the medical expenses and living expenses for while I was sick and couldn't work. By the end of my treatments, I owed \$40,000 in medical expenses alone, and I have been paying this off over time slowly, using payment plans, paying down on those credit cards. But rather than saving money to put a down payment on a house, buy a car, or even have a savings account, I spend \$1,800 a month, essentially all the money I have after the basics, to pay towards my debt. I live like a pauper because—to pay for the privilege of surviving cancer.

People have asked me why I don't just declare medical bankruptcy and wash my hands of all of this. But bankruptcy to me really seemed like a cop-out, and I don't cop out on my commitments.

I have made recovering from cancer my mission for the last 5 years. And as I look ahead to the next 5, I would like to see myself out of debt, and I would also like to make sure that this doesn't happen to anyone else.

In my work as an innovator at Jump Associates, I know that things can be different. I am fortunate that my employer offers comprehensive coverage, because if they didn't, if I was back on the private market, I would be totally uninsurable because of my pre-existing condition. I couldn't even afford to buy the same crummy coverage that left me in this financial devastation.

The kind of health reforms in the House proposal would have kept me out of this devastating debt and the financial circumstances I am in now despite my best efforts. Limiting annual

out-of-pocket costs and prohibiting junk policies will save other young people from facing the same circumstances I am in now.

Thank you.

Mr. STUPAK. Thank you.

[The prepared statement of Ms. Howard follows:]

**Statement of Catherine Howard
before the
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives**

October 15, 2009

Mr. Chairman, Members of the Subcommittee:

Thank you for inviting me to testify today. My name is Catherine Howard and I'm from San Francisco.

Five years ago, I was working as a documentary film producer. I wasn't making a lot of money, but I knew that maintaining my health insurance was really important. I bought a health insurance policy I thought was perfect for a young, healthy person. And this private plan seemed affordable — only \$140 a month — but I had no idea what it would really cost me. I was afraid I'd get hurt in some minor way, like snowboarding and need a few stitches—not that I'd be dealing with a life-threatening illness like cancer.

After my breast cancer diagnosis in August of 2004, I thought I was covered. I had done the right thing; I had insurance.

But I discovered that the health plan that I was paying for didn't cover a large part of the cancer care that I required, and I was on the hook for tens of thousands of dollars in uncovered expenses. I had chosen one of those low premium, but high deductible plans. I had to pay for 30 percent of all the services that the policy covered in the hospital. And it didn't even cover all the services I needed. I remember staring at the needle of one shot. It cost \$2,100, and thinking, "I have to pay \$600 dollars for this today."

I endured surgery, grueling chemotherapy and radiation treatments that left me too weak to work fulltime. I was told all along that the key to my recovery was to minimize stress in my life. Do you know how stressful it is to owe more money to the hospital than you've made in the last

year? As the expenses piled up, I was able to pay for some, but other bills I just put on my credit card, because I thought, "If I don't die, I will deal with this later."

Ultimately I wound up \$100,000 in debt, between the medical expenses and the living expenses for while I was sick and couldn't work. By the end of my treatments, I owed \$40,000 in medical expenses alone. I've been paying it off slowly, using payment plans and my credit cards. Rather than saving money for a down payment on a house, buying a car, or even having a savings account, I spend \$1,800 a month, essentially every penny I have after the basics, to pay off what I owe. I live like a pauper to pay for the privilege of surviving cancer.

People have asked me why I don't just declare medical bankruptcy and wash my hands of the debt. But bankruptcy to me has always seemed like a cop-out. And I don't cop-out on my commitments. I have made recovering from cancer my mission for the last five years. Now, my mission is to get out of debt. I think it will take me about seven years to pay off this debt, the same time it would take to restore my credit if I were to declare bankruptcy.

I'm fortunate that my current employer offers comprehensive health insurance, because as a cancer survivor I'm completely uninsurable in the individual market. If I went back on the open market and tried to buy myself health insurance, even the same crummy coverage I had before, they wouldn't cover me because I have a pre-existing condition.

The kind of health reforms in the House proposal would have kept me out of this devastating debt and the financial circumstances that I'm now in, despite my own best efforts. Limiting annual out-of-pocket costs and prohibiting junk policies will save other young people from facing the same circumstances I'm in now.

People like me, working to build our careers, we need a real choice for affordable, reliable coverage. Thank you.

For the record, I'd like to comment on a couple other provisions I understand are under debate.

First affordability is key. If Congress is going to require people to get insurance—and that is the only way that prohibiting pre-existing conditions makes economic sense—

then the policies have to be good and the costs affordable. The Senate Finance Committee bill fails in these areas. Basically ending help for deductibles and co-pays for people above 200% of poverty (about \$29,000 for a couple) and capping premium subsidies at 300% of poverty just doesn't work for people in a high cost area like San Francisco or many other cities—like the areas represented by Congresspersons Markey, DeGette, Doyle, Schakowsky, Green, and Sutton. I hope you stand by the House bill's benefit assistance levels.

Second, consumers need more help in selecting a good insurance policy. I want to thank Dr. Burgess of this Subcommittee for his amendment spelling out the details of consumers' rights to appeal a decision by a plan and to get an expedited decision. I hope the House can adopt a provision from the Senate HELP Committee bill, section 3101, that requires standard definitions of insurance and medical terms so that consumers can really compare 'apples-to-apples.' And that Section also requires the plans to offer scenarios of what it would cost to get treatment for certain common conditions—like breast cancer. Even though the different plans are supposed to be actuarially equivalent within certain tiers, the way plans meet that standard can provide enormously different levels of protection. Scenarios make it plain to consumers like me what kind of plan I am really buying into.

I urge you to consider an amendment that Consumers Union has been advocating. Require the administrator of the insurance Exchange to provide confidential, personalized estimates of the total annual cost of different plans. Just having the premium information is not enough. With today's electronics one could provide an estimate of a plan's total cost, based on a person's assessment of their health as good, fair, or poor. Once the Exchange program is up and running, more refined estimates could be provided based on your previous year's health history. Recognizing that estimates of future medical spending are imperfect, these estimates are still more useful than premiums alone. Consumers Union has hard data that shows that giving people estimates of their total annual costs in the Medicare Drug plan causes people to pick better plans for themselves and saves consumers about 1/7th of what they would spend if they picked a drug plan just on the basis of it being the lowest premium. These Medicare Drug savings also save taxpayers money because less subsidy money is needed. If this simple

disclosure of data saves tons of money in Medicare Part D, the same principle could save everyone money in health insurance. It is an idea worth considering if you are trying to lower costs and help consumers.

Mr. STUPAK. Mr. Null, if you would like to pull that mike up and hit the light, we would like to take your opening statement. Again, a longer one will be submitted for the record.

If you would, please. We look forward to your testimony.

STATEMENT OF DAVID NULL

Mr. NULL. Thank you. Good afternoon, Chairman Stupak. We appreciate the invitation here. It is quite an honor, and we thank the entire subcommittee for taking the time to hear our story.

Our story actually begins in 1999, when I became self-employed. We had a company. We employed 12 people, we had group insurance, and then 9/11 hit. And, like many Americans, that time hit us very difficult. Within about 6 months we had to drop our company-sponsored insurance, and I had to enter into the world of individual insurance.

In January 2005, we had been without insurance for about three months. We had a short lapse, and a quick trip to the ER for an \$800 liquid bandage for my daughter's chin was a costly but excellent reminder of the value of insurance, so we began looking for a policy.

Sherry and I spoke at length to an insurance agent at our dining room table, and I explained, I don't mind paying for the hospital or the doctor visits; it is the big catastrophic hospital visits that we need. I told him, quote-unquote, "I need coverage for the big, 'Oh, no'"; and he looked at me in the eye and told me that I am a very savvy shopper and that this was the policy for us. By the time, he said, that we factor in our negotiated rates and what the policy pays out, "You will hardly have to pay anything." The way he explained it, we felt like we were getting what we asked for, and we were relieved to be protected again.

Three months later, Tatum was seven. It was the first night of our family vacation and Tatum's touch of stomach flu seemed to worsen and so we headed home. Hours later, she slipped into a coma. Before the sun set the next day we were told she would require a liver transplant within days to save her life if they could keep her alive that long.

While Tatum was clinging to life in the ICU, the transplant department administrator came to me and said, We need to talk about insurance, and he walked me to a counsel room. As we walked, I thought to myself, I wonder what he wants to talk about; aren't I glad that we picked up this policy when we did.

We reached the counsel room, and he proceeded to explain that my insurance had capped out at \$25,000. That was basically the night before. From that point forward, Tatum no longer had any sort of insurance, and it was hospital policy to collect a \$200,000 deposit for them to proceed with the liver transplant.

I honestly couldn't believe this was happening. Could this be true? Surely it is a mistake, because this is the big "Oh, no" that I was buying protection from. Suddenly, not only were we facing the possible death of our child, but now the financial death of our family. How could this be happening to us? We have insurance for this.

A donor was located, and Tatum received her transplant with probably less than 48 hours less to live. Once she stabilized, the

hospital helped me apply for Medicaid, and we were narrowly approved. The coverage was retroactive, and they covered the entire transplant, well over \$500,000. Our so-called hospitalization policy covered less than one-tenth of that cost. Even with insurance, we were left with a balance we could never bear to pay back.

Tatum and our finances both had near-death experiences. Although we didn't know at the time what going on Medicaid was going to mean to our family, we were grateful for it. But our daughter had been on life support for a week, and now our finances were going to be going on life support for the next 2 years.

Post-transplant is very medically expensive. We never knew what each day would bring, but we knew we couldn't afford even 1 day without insurance. We began to look for insurance that would help cover post-transplant expenses so we could get off of Medicaid. Then I was told by insurance agents not to waste the time, paper, or ink filling out the applications with Tatum's name on it because they would refuse to even accept it. We now had nowhere to turn, and we were somehow now stuck on Medicaid.

It was simply that the insurance industry would not make a policy available to us in the individual market. So in order to keep receiving health care for Tatum, we had to voluntarily drop our income to near poverty to satisfy the Medicaid requirements. The allowed monthly income on Medicaid was a shocking \$1,630 for a family of four. This barely allowed us to cover our mortgage, most utilities, and some of our food bills. This meant that I would frequently had to pass on work, and it was even suggested that maybe Sherry and I should get a divorce for financial reasons. These were tough times, and we found ourselves in the red every month.

Interestingly, though, with Medicaid we never incurred any costs for health care. We actually owe nothing due to medical debt at this time. The cost of staying on Medicaid is on the back side, trying to survive on \$20,000 a year. We took tremendous debt on, eliminated our savings and retirement, and put our growth on hold trying to survive while she got the health care that she needed.

After 2 years, she began to reclaim her new life. There were now more good days than bad days, and so her mother returned to teaching and group health coverage, an entirely different insurance experience.

I found it interesting, when we transitioned to group coverage Tatum was accepted with open arms and without question. It would appear as though individual policies and group policies exist in completely different universes.

Her mother and I are thankful that Tatum's physical recovery is quicker than our finances. She is growing, thriving, and giving back. She regularly appears on behalf of Children's Medical Center, the Southwest Transplant Alliance, and her favorite charity, Make a Wish. Her life has been a joy and an inspiration to many. We would do it all again for her sake. And we are thankful Medicaid was there for us. We are thankful to be off of Medicaid.

We do hope our testimony illustrates how the hospitalization policy in question today was obviously worthless. We have learned that the language of policies can be confusing. In spite of both being college educated, we didn't understand at the time the

\$25,000 maximum for miscellaneous hospital expenses basically meant all hospital expenses.

Even today we find the wording still a little bit counterintuitive and misleading. But I asked for in very clear language, I thought, a policy that would protect us from the big “Oh, no,” and we ended up with a policy that would do no such thing.

While our testimony should be labeled “Grossly Underinsured,” we have since learned that even traditional million dollar policies, which would seem like a safe bet, are no challenge for long-term, life-threatening illnesses. I got the call on Tuesday that the hospital had added up Tatum’s cost at Children’s Medical Center, and as of right now her cost is \$1,284,335. And that does not include any of the doctors’ bills. They are billed separately.

But, most importantly, we have learned that being underinsured really is the same as being uninsured. They both lead to the same end.

Underinsurance certainly impacted our lives. God carried us through, and we trust that he will continue to do so, and we are glad. We have learned from this experience, and we are trying to move on.

It seems like the story ends here, but it is actually just the beginning for Tatum, as you already know. Underinsurance probably isn’t the biggest tragedy of our story, if you ask me. Her story encompasses other shortcomings that you need to do something about.

What continues to sadden her mother and I is this issue of black-listing because of her preexisting. Tatum is going to grow up, and one of these days she is going to need insurance. And we are lucky because Sherry’s dream has always been to teach, and that gives us access to group coverage and the benefits that come with that, but that may not necessarily be everybody’s dream; and I don’t think that is really fair, and I don’t really think that that is American.

I ask you to consider this. When Tatum was just 4, she went to New York City and stood transfixed on Lady Liberty. They told her then that Lady Liberty stands and invites the world to come to the land of opportunity where anyone can follow their dreams. And yet Tatum, a born-and-bred American citizen, might not be able to share in this dream through no fault of her own simply because the insurance industry has developed a system that won’t allow it.

Our Tatum has so much potential, but for now she doesn’t have full access to Lady Liberty’s promise. She can’t pursue little-girl dreams to be an artist or have a dress shop or restaurant or be self-employed in any fashion that requires individual coverage.

When she asks me what she should be when she grows up, I can’t tell her the same thing that you probably tell your kids. I can’t tell her she can be anything she wants; and you guys need to fix that for me. Do I tell her that the government before her today—a government for the people, by the people—refuses to take the steps to also protect her rights to life, liberty, and the pursuit of happiness? What do we tell her?

In closing, while my purpose today is to testify and answer your questions as an American citizen, I also come to pose just one question to the very distinguished committee as a father: Which of you

will commit yourself today to be able to look Tatum in the eye and tell her that you will be helping lead the way, and you will see to it that when she grows up she will have affordable access to adequate health care regardless of her occupation; and that today she too can start pursuing all of her Americans dreams?

We sincerely pray that God will bless you and guide you. And God bless America. Thank you.

And please be an organ donor.

Mr. STUPAK. Thank you.

[The prepared statement of Mr. Null follows:]

**United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
October 15, 2009**

Testimony of David Null

My name is David Null and my family's insurance story begins in 1999. My best friend and I finally came to realize what we considered the American dream; we started our own company together. Our baby, Tatum, was now two and my wonderful wife, Sherry, quit her job teaching so we could raise our family at home. We employed 12 and had group health coverage sponsored by the company. We were doing well, life was good. But like many Americans, 9/11/2001 hit our company hard. Contracts got cancelled, our business plummeted and we were forced to discontinue our group coverage within 6 months. That's when we had to switch to the individual policy market. Business was bad but we knew the value of insurance and didn't want to go without, although sometimes we did. Three times in 5 years we were unable to continue coverage without lapse because of decreased business in the 9/11 aftermath. We'd lose coverage for a few months and then we'd get a good contract and get a new policy.

January of 2005 I found myself shopping for health insurance again. We had been without insurance for about 3 months when our youngest daughter, Hannah, fell in the bathtub and split her chin. A quick trip to the ER for a liquid bandage cost us almost \$800. It served as an excellent but costly reminder for the need to be insured. So I began the search for another policy.

Sherry and I spoke at length to an insurance agent at our dining room table. I explained an event in detail to the agent when my mother had become deathly ill suddenly. Her intensive care had cost nearly \$200,000. I explained to the agent, "I don't mind paying for the doctor's visit for the head cold. We can handle that out of pocket. It's the big "Oh, no!" like what happened to my mother that I need to protect my family from financially. Something like that could bankrupt us." The agent told us, "You're a very savvy shopper and this is the policy for you. By the time you factor our negotiated rates and what the policy pays out, you'll hardly have to pay anything." The way he explained it, it sounded like we were getting what we asked for, protection from being bankrupted by the \$200,000 example I gave him. Our premiums were affordable at \$320 a month, about \$100 less than what we paid just before for insurance. I was under the impression my savings were due to not having significant office visit coverage like I asked. We felt relieved to be protected again.

March of 2005, just three months later. We started out for Sea World for Tatum's first spring break, she was seven. Tatum had been sick to her stomach a little but we left thinking she'd be better the next day. She was a quick healer and always the picture of health. We had been in the hotel only hours when she looked at us

with canary yellow eyes. We knew something was very wrong and immediately headed home to see the doctor the next morning. We didn't realize until we arrived home that Tatum's condition had deteriorated so much that her peaceful sleep in the truck was actually her slipping into a coma. We rushed her to the hospital and before the sunset that day we were told she would require a liver transplant within days to possibly save her life, if they can keep her alive that long.

Tatum laid in the ICU clinging to life. Her brain swelling from the poisons accumulating that her liver normally removes. The doctors told us she was the sickest kid in the hospital and they struggled constantly just to keep her alive. She had only days at best to live. In the midst of all this, the transplant department administrator came to me and said we needed to talk about insurance and walked me to a council room. As we walked I thought to myself, "Aren't I glad we picked up that policy when we did. Wonder what he wants to talk about". We sat down and he proceeded to explain that my insurance had a 25,000 max and Tatum had reached that after the first night. She had no more insurance from this point forward and its hospital policy to collect a \$200,000 deposit to proceed. I couldn't believe this was happening. Could this be true? Surely it's a mistake because this is the big oh no I was buying protection from. Now my precious child lies just down the hall struggling for her life. Suddenly, not only were we facing the possible death of our child but now the financial death of our family at the same time. How could this be happening to us when we have insurance for this?

Thankfully, the hospital CEO agreed to proceed without any guarantee of payment. Tatum's life is most important to the hospital and we're grateful for that humanity. Miraculously, within two days a donor had been located. A loving family, who lost their daughter Angela, graciously donated her liver to Tatum so she could keep living. Tatum received her transplant with probably less than 48 hours to live.

Once Tatum was stabilized, the hospital helped me apply for Medicaid and we were narrowly approved. The coverage was retro active so they covered the entire transplant. Tatum's bill for the first stay of 21 days approached \$600,000 and our so-called hospitalization policy only covered about 1/10th of that cost. Even with insurance, this left a balance we could never bear to payback, it would have bankrupted us. Our insurance had failed us. We were clearly relieved that Medicaid covered the entire cost. Tatum and our finances both had near death experiences. Although, we didn't know at the time what going on Medicaid was going to mean to our family. Our daughter had been on total life support for a week and now our finances would be going on life support for the next two years.

Post transplant is also medically expensive. Her blood labs were \$4,000- 6,000 a month. Her medicine over \$1,000. CT scans and liver biopsies were the norm. The first sign of rejection was cause for 3 days inpatient for IV treatment. Nine months post she developed a complication of the anti-rejection medicine and developed a cancerous like infection. That required 7 weeks in the hospital with IV

treatments daily. That treatment caused her to need another monthly IV treatment that was several thousand dollars for each bag. We never knew what the next day would bring but we knew for sure we can't afford even one day without insurance.

We began to look for insurance that would help cover her post transplant expenses so we could get off Medicaid. We thought Medicaid was there to help people who couldn't afford insurance or their medical bills. Then I was told by insurance agents to "not waste the time, paper or ink filling out an application with Tatum on it because they won't even accept it." We were learning Tatum was blacklisted from individual policies. Getting a corporate sales job for group coverage didn't seem like an option for me. I'd make too much during the waiting period for company insurance and we'd get dropped by Medicaid, leaving a gap we couldn't cover. Sherry is a teacher and schools do most their hiring just once a year. Additionally, our family was instructed by the hospital to self quarantine from public for infectious reasons. Teaching is a sure way to bring home a virus that could put Tatum's life at risk due to high immuno-suppression. We now had no where to turn. We were somehow stuck on Medicaid. Not because we couldn't afford insurance, we thought we had insurance when this started. It was simply that the insurance industry would not make a policy available to us in the individual market.

So, in order to keep receiving health care for Tatum we had to voluntarily drop our income to near poverty to satisfy Medicaid requirements. The allowed monthly income limit on Medicaid was a shocking \$1,613 a month for a family of 4. This barely allowed us to cover our mortgage, most utilities and some food bills. That's under \$20,000 a year. This meant I would frequently have to pass on work because I'd make too much for Medicaid. It was even suggested that we might fair better financially if we got a divorce.

Those were tough times and we found ourselves in the red every month. Many expenses went on credit waiting for a day when we could afford to make the money to pay it back. Interestingly, with Medicaid we never incurred any cost for her healthcare. We're very lucky; we actually have no debt related directly to medical bills. The high cost of staying on Medicaid is on the backside, trying to survive financially on less than \$20K a year. We took on tremendous debt, eliminated our savings and retirement and put our growth on hold trying to survive while she got the healthcare she needed. All because we didn't get the insurance coverage we specifically asked to have.

After two years Tatum began to reclaim her new normal life. Her immune system and new liver were getting along much better and she was on a bare minimum of immuno-suppression. There were now more good days than bad so her mother could return to teaching, group health coverage and an entirely different insurance experience.

I found it interesting when we transitioned to group coverage; Tatum was accepted with open arms and without question. They wouldn't give us the individual application and yet on the group application, all we had to do different was check a couple 'yes' boxes and write 'liver transplant' in a blank. Next thing we knew we had insurance cards in hand. The insurance cost deducted from Sherry's paycheck is actually reasonable and identical to other co-teachers. Our rates have remained that way for three years now. Under group coverage we're treated like we don't have a preexisting. It would appear individual policies and group policies exist in completely different universes.

Her mother and I are thankful Tatum's physical recovery is quicker than our finances. She's growing, thriving and giving back. She regularly appears on behalf of Children's Medical Center, the Southwest Transplant Alliance and is active in supporting her favorite charity, Make-A-Wish. Her life has been a joy and inspiration to many. We'd do it again for her sake. We're thankful Medicaid was there for us to provide the protection that nobody else would. We're equally thankful to be off Medicaid.

We do hope our testimony illustrates for you how the Hospitalization and Surgical policy in question here today was obviously worthless at actually protecting anyone from financial disaster with its ridiculously low maximum caps. Through all this, we've learned the languages of policies and agents can be confusing. In spite of both being college educated, we didn't recognize or understand at the time that \$25,000 maximum for "Misc Hospital Expenses" meant the total of the medical bill. We thought it literally meant misc hospital expenses. Even today we still find the wording a little counter-intuitive and misleading.

While policy language can be confusing, we asked in very simple terms, for a policy that would protect us from the big "Oh, no!" We ended up with a policy that would do no such thing. We trusted the agent was matching our needs to his product. He was not. His policy was saving us only 25% compared to our last policy but the \$25,000 cap was 1/40th the coverage (\$1million). No college degree is needed to see that's not a good deal. Obviously not a policy with the consumer in mind.

While our testimony should be labeled "**Grossly** Under-insured", we've since learned that even traditional \$1 million policies are sometimes no challenge for long-term life threatening illnesses. Maybe 10 years ago it was sufficient. Today it's very possible that \$1 million will still leave you under-insured. They estimate that transplants, nationally, average somewhere in the ¾ million dollar range, plus post transplant expenses. Had we started our experience with a million dollar policy, we'd be close to maxing it out now, if not already. If that ever happens, my wife will be forced to move to another school district with a different insurance provider or I must give up self-employment and take a corporate job. Only time will tell.

Most importantly, we've learned that being under-insured really is the same as being uninsured. They both lead to the same end. Unfortunately, we've learned that if your American dream is to be self-employed, the insurance companies can make it your nightmare. Under-insurance certainly impacted our lives. God has carried us through and we trust He will continue to do so, and we're glad. We've certainly learned from this experience and are trying to move on.

It would seem like the story ends here but it's actually just the beginning for Tatum. Under-insurance isn't the biggest tragedy of our story if you ask me. Tatum's story encompasses another shortcoming of the health care system that you need to do something about so people like Tatum can be truly free. Without health care reform from Capitol Hill there will be more challenges for a grown up Tatum and those like her.

What will continue to sadden Sherry and me is the issue of blacklisting on the individual market, for life. That carries a lot of ramification behind it that most of us never consider. We're lucky because Sherry's dream has always been to teach and with that career choice we have access to group coverage. But that's not every bodies dream. Does this mean Tatum and those like her, will be required to dream of corporate work for group coverage or marry into it. What if they get laid off? Small companies will certainly find reason to not hire her, or her husband, if they find out she's transplanted because it will torpedo their insurance rates. Will Tatum and her husband be forced into the Medicaid trap too, not because of finances but because of policy unavailability? Her career options to access affordable health care in the future are tremendously effected simply because the industry has designed it. Is that really fair? Is that American?

Consider this. When Tatum was four, she and her mother went to New York City. Tatum visited Ellis Island and stood transfixed on Lady Liberty, our American symbol of freedom and beacon to the world. Tatum even got herself a Lady Liberty costume. She was told Lady Liberty stands and invites the world to come to the land of opportunity, where anyone can follow their dreams. And yet Tatum, a born and bred American citizen, might not get to share in this dream through no fault of her own. Simply because the insurance industry has developed a system that won't allow it. Our Tatum has so much potential, but for now, she doesn't have full access to Lady Liberty's promise to pursue her dreams. She can't pursue little girl dreams to be an artist, or have a dress shop, a restaurant or self-employed in any fashion that requires individual coverage.

When she asks me what she should be when she grows up, I can't tell her the same thing you probably told your kids. Right now I can't tell her she can be anything she wants and you need to fix that. Do I tell her Lady Liberty does not stand for her too because the insurance industry has made it so with under-insurance and preexistings? Do I tell her the government before her today, a government for the people, by the people, refuses to take the steps to also protect her rights to life, liberty and the pursuit of happiness?

What **do** we tell her? Tomorrow our family plans to see with our very own eyes our Declaration, Constitution and Bill of Rights. A true privilege and honor as an American. These documents were bought and upheld with the blood of men for all of us. What do we tell about her place in those? What **do** we tell her?

In closing, while my purpose today is to testify and answer your questions as an American citizen, I also come to pose just one question to the very distinguished committee as a father. Which of you, will commit yourself today to be able to look Tatum in the eyes and tell her, that you will be helping lead the way and you will see to it that when she grows up she'll have affordable access to adequate healthcare, regardless of her occupation, and that today she too can start pursuing all her American Dreams?

We sincerely pray that God bless you and guide you. And God bless America.
Thank you.

David Null
October 15, 2009

Mr. STUPAK. Mr. Wilkes, your testimony, please.

STATEMENT OF NATHAN WILKES

Mr. WILKES. Mr. Chairman and members of the subcommittee, my name is Nathan Wilkes. Thank you for the opportunity to talk to you today about the difficulty my family has had in maintaining health insurance due to the high cost of the treatment for my son, Thomas, the treatment he needs to live a healthy and productive life.

Although we have always been insured, always insured by group coverage, our family has come up against the issue of lifetime caps—not once, but twice before he was 4 years old. I have been able to maintain insurance coverage, but it has been a constant struggle and a worry for me. I am going to tell you a little bit about what we have had to deal with and how I have dealt with it, and ask your help in immediately eliminating the practice of lifetime caps as part of health legislation.

My son, Thomas, was born in 2003 and diagnosed with severe hemophilia, a genetic blood-clotting disorder, treatment for which means he has to get replacement clotting factor on a regular basis. It is easily manageable if he can get it, but it is very costly and very expensive to treat. If he does have a bleed, it has to be treated quickly or else irreversible damage or death could occur. Bleeding into the joints, bleeding into the head or brain or abdomen could cause significant long-term damage.

On the day Thomas was diagnosed, a local hematologist came to us to help us with what we were facing. Her first question was, do you have good insurance? I said, Absolutely. I work for a company who made it a mission that we had the best, gold-plated, Cadillac—whatever you want to call it—plan we could have; and they had struggled to maintain that.

In 2004, he began—we had to start treating him. The cost of the treatment that year was roughly half a million dollars. The result of that was that in 2005 the insurance company forced us to accept a high-deductible plan, where we had been on a PPO that had covered everything before. They had shopped around all the other insurance companies, all of whom refused to cover my company that I worked for previously because of the high cost of claims.

In 2005 and 2006, claims rose to about three-quarters of a million dollars a year. These were treatments that were necessary for my son's well-being, and today, he is a very healthy and productive 6-year-old.

But one of the things they tacked on was a \$1 million lifetime cap. When they did so, my wife cried for days. I worked with my HR director and the broker that they worked with to try to get around it, get an exclusion, get rid of it, do whatever it meant. But it couldn't be undone. We knew the hourglass had been turned over; it was running out on us. We knew we had maybe a year, maybe a little more before we had to find some other solution. We discovered that we had choices. We had six choices, and I have documented them here in the testimony. And as I go through them, I think you will understand that we really didn't have any choices at all.

I could have quit my job and gone to work for a larger company, somebody with a larger pool where I could hide in the shadows or hopefully lurk and not let them know that my son has a serious illness, or face possible termination.

I could go to work for the government, but frankly, it doesn't pay enough.

I could have my wife go to work. She had already made the decision to stay home to take care of our son, who had a chronic illness. That would mean putting kids into day care, and we just couldn't afford that, either, and that was just shifting the problem to another company.

We tried to turn to Medicaid. Now, Colorado is a difficult State to get on Medicaid, and we earn too much money. We didn't want to impoverish ourselves and go down that road. We had already been racking up significant medical debt as a result of this.

Several social workers told us we could get divorced. Just get a paper divorce, then the kids could qualify for Medicaid under my wife if she didn't work. But that would both put my wife at risk, because it turns out she is a carrier as well, and we didn't want to do that; that just wasn't in our family values.

We could put Thomas on the State high-risk pool. That too has a \$1 million cap. That is something that once he did cap out in 2007, we put him in the high-risk pool; he lasted on that a year. That was the second million dollar cap. That is known as insurance of last resort, but it didn't last for us.

And finally, the option was to start my own business, quit my job, take a pay cut, try to get myself—since you can only get insured as an individual if you are healthy and have no issues, or by the government if you are Medicare-eligible, or impoverished and have a disability for Medicaid, or you have to get insured through an employer. I decided to become an employer.

The struggle that we faced—all the while we were insured there were years where we were paying roughly \$25,000 a year in premiums and deductibles and out-of-pocket and ancillary medical expenses. This hardship left us fighting to keep up with bills, forced us to rely on credit and home equity to stay afloat. The more credit we used, the worse our credit rating got. The worse our credit rating got, the more we ended up paying for everything as our interest rates climbed. Harassing collections agencies began calling us. We struggled to get providers paid for everything from the day he was born.

It took us over a year to set up our own business, so in May 2008, when my son nearly exhausted his \$1 million cap on CoverColorado, I would be able to pull him into our own company. I had to quit my job even though my employer tried to do everything they could to keep me on board. They were fine with paying the rising premiums. Other companies weren't willing to take me on as that kind of employee, but they did everything they could to work with me. Ultimately, I had to quit my job and take a pay cut and start this business.

Now we are covered by another high-deductible health plan, a \$6 million cap this time. Another hourglass. There has a little more sand in there this time, but it won't be long before we run out of that as well.

This thing about where we were now is one single event. We are hanging by a thread—death, injury, anything that stops the income through my business, or a serious illness that puts him in the hospital for a significant length of time means we are out.

I have included with my testimony and chart that shows the year-over-year changes to our premiums which I think you will find pretty interesting. When we started the claims, our premiums, our cost of care, went up 35 percent the next year.

The other point I want to make very quickly is the impact of the high cost of his care was not just felt by my family, but everyone I worked with. There were only 150 employees with the firm at the time, but moving into the high-deductible plan meant that everybody was now paying for medical care out of their own pocket.

Just a couple of quick examples: I had a coworker who got his leg cut, didn't have the money to go to the ER to cover it, so had a friend stitch up his leg on the kitchen table. Minor case.

Another case, a coworker, a young coworker, his wife was pregnant, had to have a C-section. And because of the deductible at the time, they were faced with putting over \$9,000 on their credit cards just to deliver the baby.

So you have heard today maintaining health insurance has been a struggle, but it has allowed me to provide my son with the life-saving treatment that he needs. He is 6 and very healthy. But without reforming the existing private insurance system in this country, this struggle will continue for me and many more.

It is critically important to me that the individuals and families that face health care costs due to chronic conditions see reform happen. I am pleased to see that several discriminatory practices such as preexisting conditions and annual lifetime caps are part of the plan, but I am concerned that for those of us currently insured that these changes won't take effect until 2013 or even later. Some of the plans we see have grandfathered in the caps, or they don't take effect until 2018.

I tell people that, in the individual market, rescissions are how insurance companies weed out the sick. What happened to us, we have always been in the group market. High-deductible health plans and caps have been how they have weeded us out and how they weeded other out people in the group market; and that has to stop and that has to change.

Our country needs health insurance reform. My family needs health insurance reform. And my family is thankful for the congressional efforts to eliminate lifetime caps on benefits and health reform. Thank you.

Mr. STUPAK. Thank you.

[The prepared statement of Mr. Wilkes follows:]

Testimony of Nathan Wilkes
Hearing on "Insured But Not Covered: The Problem Of Underinsurance"
House Energy and Commerce Committee
Subcommittee on Oversight and Investigations
October 15, 2009
2123 Rayburn House Office Building

Mr. Chairman and Members of the Subcommittee, my name is Nathan Wilkes and I am from Englewood, Colorado. Thank you for the opportunity to talk to you today about the difficulty my family has had in maintaining health insurance due to the high cost of the treatment my son, Thomas, needs to live a healthy life. Our family has come up against lifetime limits or caps in our insurance policies more than once and this occurred before Thomas was 4 years old. I have been able to maintain insurance coverage, but it has been a struggle and a constant worry for my family and me. Today, I would like to tell you a little bit about how I managed to deal with lifetime caps, which I believe is an insurance practice that discriminates against individuals with high cost chronic conditions, like my son. I would also like to ask you for your help in immediately eliminating this practice in all health insurance policies as part of the health reform legislation that is being considered by Congress.

My son Thomas was born in 2003 and was diagnosed with severe hemophilia A the day after he was born. Hemophilia is a genetic blood-clotting disorder that prevents his body from creating clots when he sustains injury. Contrary to general belief, the risks to bleeding are not from superficial cuts, but rather internal bleeding – such as bleeding into joints which causes pain, swelling, and joint damage (arthritis) and bleeding into the brain which can cause neurological damage or could be fatal. Thomas's bleeds must be treated quickly and aggressively to prevent irreversible long-term damage and painful disability.

Fortunately, we discovered that we lived close to one of the leading Hemophilia Treatment Centers in the country. The Mountain States Regional Hemophilia and Thrombosis Center provides a comprehensive disease management program for people living with hemophilia. This high standard of care is essential to Thomas living a healthy and productive life. Thomas was prescribed a treatment known as factor replacement therapy or clotting factor. These treatments are very effective, but very expensive. As a newborn, we would only need to treat him when he had a bleed, but the cost each time he was treated was at least \$1,000.

On the day Thomas was born, our local hematologist came by to help us comprehend what we were facing. Her first question to us was: Do you have good insurance? At the time, I was working in the telecommunications industry and my company, Virtela Communications, offered excellent health insurance.

In 2004, when Thomas was 7 months old, he developed an inhibitor to his clotting factor replacement therapy. An inhibitor meant that his body developed an immunological response to the life-saving factor treatments that normally allowed his blood to clot if he had an injury. This meant two things: 1) we had to start immune tolerance therapy – giving Thomas regular doses of Factor VIII and 2) if Thomas did have a bleed, we had to use a more expensive treatment therapy to stop the bleed. As a result, claims for 2004 were very high, approximately \$500,000.

In 2005 and 2006, Thomas's treatment increased, costing around \$750,000 per year. During this period the premiums for my company's insurance policy with United Healthcare increased and when my company sought to renew its policy in 2006, we

were only offered a more expensive and more restrictive policy with a \$1 million lifetime cap. In late 2005, when the lifetime cap was announced for 2006, working with my company's HR director and the insurance broker, we tried to see if there was anything we could do to get it removed, get a waiver, or find another way to work around it. Despite my employer's best efforts, there was nothing that could be done.

The introduction of the cap for the 2006 plan-year started a timer that couldn't be reversed. I recognized that when, not if, we hit the cap, I would have to make critical decisions related to my work, my family and lifestyle. To go without insurance for even a few months would put us into a "pre-existing condition" category due to my son's hemophilia and our access to insurance would be severely compromised.

I knew I would have to find some way to maintain private insurance coverage. Over the next few months we considered our options:

- 1) Quit my job and work for a larger company or the government with a larger risk pool, where my claims would not be noticed as quickly.
- 2) Have my wife go to work and shift our children to her new employer's plan. We felt that this would only shift the problem temporarily and we would then need to put our three children into childcare which was costly and something we did not want to do.
- 3) Turn to Medicaid for Thomas. By all accounts, Colorado is one of the most difficult states in which to get on to Medicaid. Since we "earn too much money," the only option would be through a waiver program. We did start this process, but his qualification was not certain and the waitlist at the time was around five years. A wait of five days would be a problem for us – five years was out of the question.
- 4) Get divorced and have my wife – earning no income – qualify for Medicaid. A social worker told us that others have done this in order to provide health insurance for their children. While this would be a "paper divorce," it was not an option we would consider.
- 5) Put Thomas on our state's high risk pool, CoverColorado, which has a \$1 million cap. At the current rate of claims, this would have been a short-term fix, where we would likely hit the cap in 6-18 months.
- 6) Start my own consulting business as an employer of two, thus falling into the small group insurance category and being able to select from all small-group plans thanks to guarantee-issue requirements.

In April 2007, Thomas, who was almost 4 years old, hit the \$1 million lifetime cap of our employer-based insurance policy with United Healthcare. Our only option was to enroll him in the state high risk pool, CoverColorado. We worked with CoverColorado for months in preparation, but they couldn't accept him until he officially reached the cap. To make sure that we would not have a gap in coverage we tried to track our cap on a

daily basis. Although we were in constant contact with United Healthcare they could never accurately tell us exactly how close we were to reaching the cap – even in the final few days of being covered. In the end, the inability of United Healthcare to help coordinate our claims left us with significant out-of-pocket expenses.

For the next year, Thomas was covered under CoverColorado and the rest of our family had separate coverage. During this time, we were paying over \$25,000 per year in premiums, deductibles, and other out-of-pocket expenses for insurance and medical care. We were paying two sets of premiums and deductibles – one to CoverColorado for Thomas and another for the employer-based coverage for the rest of the family. This hardship on our family left us fighting to keep up with bills and forced us to rely on credit and home equity to stay afloat. The more credit we used, the worse our credit ratings got. The worse our credit ratings got, the more we ended up paying for everything as our interest rates climbed. Harassing collections agencies began calling as we struggled to get providers paid.

We spent over a year setting up our own business so that in May 2008, when my son had nearly exhausted CoverColorado's \$1 million lifetime cap, we would be able to pull him into our new company's group coverage. I had to quit my job, even though my employer tried everything they could to find another solution to our health insurance needs that would enable me to stay on as an employee. In addition to considerable accumulated medical debt prior to this juncture, quitting a good-paying job, taking a pay cut, and starting a business also took their toll, but I could not fail.

Our family is now covered by a high deductible health plan with a \$6 million cap, premiums of roughly \$10,000 per year, and an annual deductible of \$6,000. It is only a matter of a few years before we reach the end of that road and have to change course once again. However, one single significant event between now and then could destroy our currently tenuous security. Injury, death, loss of work contract income, or even reversal of the 2008 state law that instituted modified community rating in Colorado (preventing significant rate-up due to health status) would have a disastrous effect for us.

Attached to my written testimony is a chart that shows the insurance premiums and benefits from my previous employer since 2002. After my son's high dollar claims started in 2004, a significant change in coverage for 2005 occurred, with the cost of coverage rising approximately 35%. When this occurred my previous employer tried to find another insurer to cover the company, but to no avail. United Healthcare was required to continue to sell the company insurance, but in order to keep the basic premiums down for employees, my company offered us a high deductible health plan with a small investment in our health savings accounts to help us afford the coverage.

After my son came off of my employer's health plan in April 2007, benefits improved and the premium actually decreased in 2008. According to my former employer, in 2009 not only did cost-sharing improve again, but they were also able to once again offer a PPO plan and not just the high deductible plan. Also, premiums had decreased by 25% in the two years since my son was no longer covered under the plan.

The point I want to make here is that the impact of the high cost of Thomas' care was not just felt by my family, but by everyone I worked with. There were only 150 employees in the firm. Moving to the high deductible health plan had a huge impact on my co-workers. Families without funded health savings accounts put off going to the doctor for both preventive and acute care because they couldn't afford it. One co-worker had a friend sew up a laceration on his kitchen table because he couldn't pay for an ER visit. A young man, who had just started with the firm, had to put over \$9000 onto credit cards in order to pay for the delivery of his child by C-section. All of these changes must be remembered in the context of the faltering economy over the past few years, which made these changes particularly difficult for my co-workers and their families.

As you have heard today, maintaining health insurance has been a struggle for our family, but it has allowed me to provide my son with the lifesaving treatment he needs. Thomas is now 6 and very healthy, but without reforming the existing private insurance system in this country this struggle will continue for me. Health reform is critically important to me and the many other individuals and families that face high health care costs due to chronic conditions. I am pleased to see that the health reform legislation being considered would eliminate several discriminatory insurance practices such as pre-existing condition exclusions and annual and lifetime caps, but I am concerned that for those of us currently insured these changes will not take effect in existing plans until 2018. This is simply too long for my family to wait.

HR 3200 eliminates lifetime caps in the new qualified health benefit plans offered through the Exchange or through new employer-based plans as of 2013, but existing group plans are exempt from this requirement until 2018. As the Committee working directly on this bill, I ask you to not delay and immediately eliminate lifetime caps in existing insurance plans. The National Hemophilia Foundation, along with 30 other organizations representing individuals with chronic diseases and high cost conditions is seeking this change, which is similar to the provision in HR 3200 that prohibits insurance policy rescissions immediately. Both rescissions and lifetime caps are insurance company practices that penalize people who submit high-cost claims. Rescissions may have a more immediate impact since they occur following the submission of claims, but the end result is the same: a person with a serious medical condition loses insurance coverage.

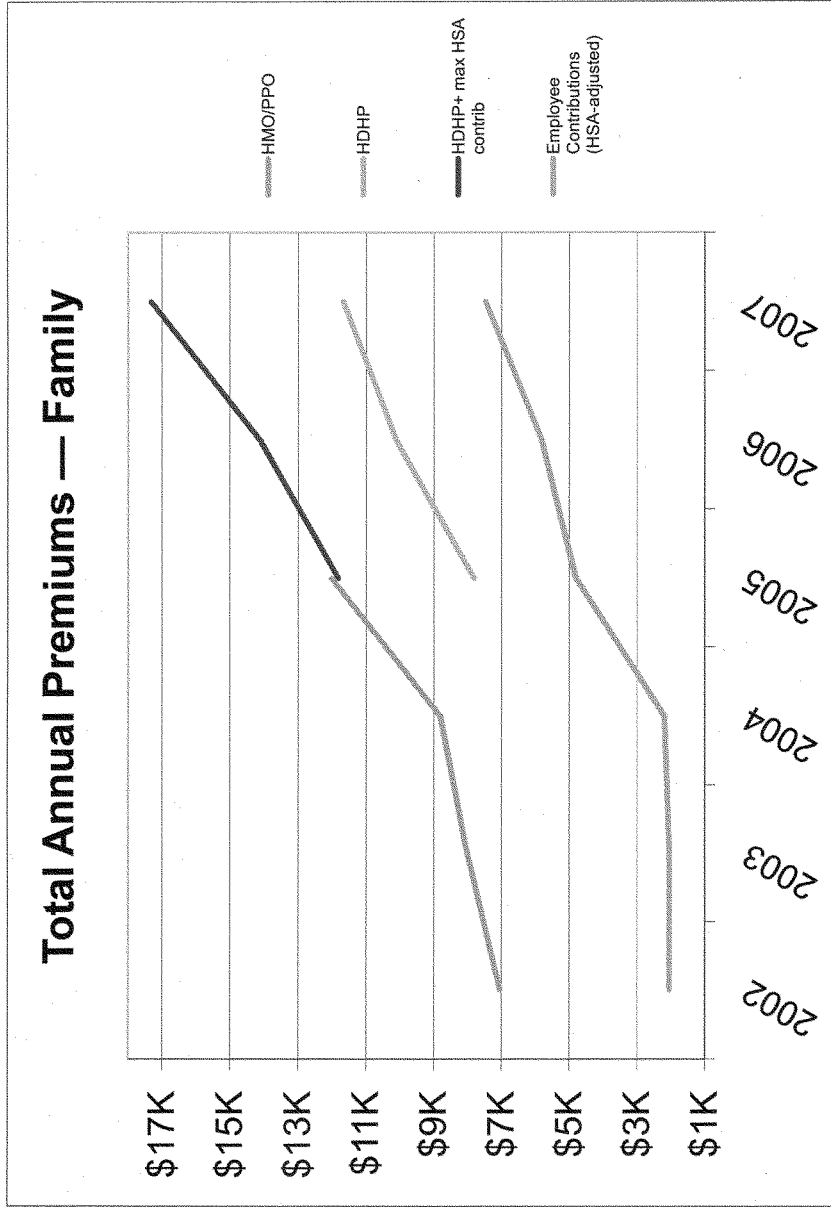
I would like to submit for the record a letter sent to Chairman Waxman requesting the immediate elimination of lifetime caps in HR 3200 and a study by PricewaterhouseCoopers that estimates a savings to both Medicaid and Medicare if lifetime caps are eliminated.

Our country needs health insurance reform. My family needs health insurance reform, which would bring a future without annual or lifetime caps on benefits. My family is thankful for the Congressional efforts to eliminate lifetime caps on benefits in health reform.

Thank you.

Timeline of significant events	
April 2000	Employee #9 at Virtela (original lead engineer).
August 7, 2003	Thomas is born.
August 10, 2003	Thomas and mother discharged from hospital (spending 1 day in NICU for observation).
September 2003	Receive bill for \$50,000 since NICU inside the in-network hospital is actually an "out-of-network" subcontractor.
April 2004	Regular high-cost medical claims as ITT/prophylactic therapy begins
January 2005	~35% increase in cost of insurance and shift to HDHP
January 2006	\$1M lifetime cap instituted
December 2006	Though near cap, UHC cannot give accurate figures on our proximity to cap.
March 2007	Spoke in favor of CO HB1355 (state bill for modified community rating for small group health insurance plans).
First week of April 2007	Thomas capped out of UHC plan, no longer covered by UHC.
April 6, 2007	Policy start date exception granted; Thomas begins Cover Colorado (state high-risk pool)
April 2007	Receive bill for \$80,000 due to medical claims that exceeded the cap, but before Thomas could be covered by CoverColorado.
April 2007	Begin incorporation, bylaws, meeting with lawyer & CPA (re: starting consulting business)
January 1, 2008	CO HB1355 enacted. Insurers cannot rate small groups up due to health status or claims history.
May 2008	Begin payroll (insurer needs to see 3 payroll runs before starting health insurance plan)
July 2008	Quit job at Virtela so can work for consulting business full time for insurance benefits for family
July 1, 2008	Thomas (and rest of family) covered under new small group plan at RAF 1.0. CoverColorado claims were over \$900,000 (\$1M permanent cap).

Other dates of interest	
December 2006	After numerous conflicting reports about our proximity to cap (5 calls on same day = 5 wildly different answers), requested printed summary list from UHC of all claims.
October 2008	Finally received printed summary list from UHC of all claims through December 2006 (22 months after request).



Mr. STUPAK. And thank you all for your testimony.

As many members have said in their opening statements, you really help us put a face on what is going on in America with health care—those folks who are unfortunate enough to have medical problems we do not anticipate, and even when we have insurance, we cannot afford to deviate from the norm.

I am going to ask the chairman, Mr. Waxman, if he would like to go first. I know you have some meetings. And if you would like to begin questioning, we will have questioning for 5 minutes.

Mr. WAXMAN. Thank you very much, Mr. Chairman. I appreciate your courtesy to me.

I want to say to all of you, what happened to you is wrong. It is wrong in this country that people should be forced into bankruptcy, that Tatum should face a future where she may not get insurance under the way things operate now, that bankruptcy becomes the only way to wash your hands of these debts. And you all had insurance.

Tatum, I am going to assure you that if we enact the legislation that President Obama is supporting, your future will be very bright. It is not going to be hindered by your inability to get insurance, yours or anybody else's, in this country.

Insurance should be that we spread the costs over a broad population, and then those who need the care will have it available to them. But the insurance companies look at it differently; they want to avoid having to pay money, so they don't want to cover people who might be a risk. They exclude you if you have a preexisting condition. They put lifetime caps. They have annual limits on the out-of-pocket costs—annual limits on the costs that they will pay. There are so many things they do to avoid living up to what you expected you bought when you paid for your insurance coverage.

Now, Ms. Howard, you thought you were buying insurance coverage that would protect you. You knew it was going to require that you would have to pay a lot of money up front; but then, after that, if it was a huge amount, you would be covered. Isn't that what your thinking was?

Ms. HOWARD. That is what I thought. But that was wrong.

Mr. WAXMAN. Well, your policy said that if your costs exceeded \$5,000, then the insurance company would pay for all of it. Isn't that right?

Ms. HOWARD. It did say that.

Mr. WAXMAN. So what happened with you was you spent far more than \$5,000, because under your Anthem policy, every time you got a treatment, they didn't count that toward your out-of-pocket limits for the \$5,000. They disqualified costs of out-of-network treatments and the portion you paid for prescription drugs. Isn't that the situation?

Ms. HOWARD. Yes. And that amounted to roughly \$10,000 per year for each of those years.

Mr. WAXMAN. \$10,000 each year for the—

Ms. HOWARD. Each of those years while I was under active treatment.

Mr. WAXMAN. So even though you exceeded the \$5,000, they didn't step up to pay the rest. They just said what you paid doesn't

count toward the \$5,000, and kept on—it is almost like a goal they kept on moving away further and further from you.

When you tried to stay within network, because they said you have to stay within network—if you go out of network, they are not going to count those costs—how difficult was it to find somebody within their network?

Ms. HOWARD. There were some services that were not available in San Francisco.

Mr. WAXMAN. So you would have to go somewhere else other than San Francisco.

Ms. HOWARD. Yes.

Mr. WAXMAN. San Francisco is a pretty big city. So I would assume that you are talking about hundreds and hundreds of miles to get the care.

Ms. HOWARD. I made the choice to get the care that I needed regardless of cost. And that is why I feel like I am alive today.

Mr. WAXMAN. And each time you had a prescription filled, you had to pay a coinsurance fee of 30 percent of the cost; is that right?

Ms. HOWARD. Yes.

Mr. WAXMAN. And how much out of pocket did you actually spend while you had insurance coverage?

Ms. HOWARD. It was over \$40,000 between 2004 and 2008.

Mr. WAXMAN. So for the years you were protected, presumably, for expenses no more than \$5,000, you ended up spending \$40,000 over that time?

Mr. Wilkes, your policy had a cap on out-of-pocket expenses as well, but they also had various limitations and exclusions.

Can you estimate the total out-of-pocket costs that your insurance did not cover?

Mr. WILKES. In the 6 years total that we have had, direct and indirect costs, I would say, well over \$50,000, if not \$100,000.

There were some claims that—at the very beginning and at the very end that they said they either did not cover because it was out of network or did not cover because it exceeded the cap; and those two individual claims were \$50,000 and \$80,000 each.

Mr. WAXMAN. Well, we started the hearing today—we had opening statements, and some of my colleagues on the side of the aisle who opposed health insurance reform said, We don't want one size to fit all, we want competition in the system.

Well, there is no competition when one insurance company can sell you a plan that doesn't pay over a certain amount, if it doesn't pay within the cap or it is not a one-size—in other words, what they are saying is competition—is competition to exclude payments.

And what we need is legislation that would ban the lifetime and annual caps, would have no limits on out-of-pocket costs, no more discriminatory insurance practices. And what we would like is a defined benefit package, so then you can shop around between different insurance claims; and you will know that you are buying a plan that will cover your needs. And you are going to choose between them, based on the price or based on the quality, but not based on what they will cover and what they will not cover when you find out that you really need that coverage to pay for your medical expenses.

I hope we will get that bill passed. And I thank the chairman for allowing me to proceed with these questions.

Mr. STUPAK. Thank you, Mr. Chairman.

Mr. Walden for questions, please.

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

I just want to make clear that there are many of us this side of the aisle who have also supported health care reform and insurance reform during my days in the Oregon legislature and here in Congress, and I will continue to. And I support dealing with the preexisting condition issue, dealing with the caps issue, dealing with the competition issue. I think insurance should be available across State lines.

I was on a hospital board for 5 years in a small community, and we looked at the uncompensated care we wrote off every month and dealt with the regulators and dealt with the companies and dealt with everybody involved.

I was a small employer, like you were, where we had 15 employees. We had virtually no option on where to go for insurance—maybe one, two companies. And I never could throw the dart high enough on the budget board each year to figure out what my premium increases were going to be. So I am sympathetic.

And you heard my own personal story as a parent.

Ms. Howard, I am curious, doesn't the State of California regulate the insurance policies like the one that you have or had? You don't still have that?

Ms. HOWARD. Fortunately, I don't have that policy anymore.

Mr. WALDEN. But would that policy have fallen under the regulatory scheme of the State of California?

Ms. HOWARD. Well, when I realized that expenses were mounting in a way that I had not foreseen, I called and I said, How is this possible? And they pointed to my signature on the contract and said, You signed up for this.

Mr. WALDEN. And so what good is the regulatory scheme in the State of California then to make sure that—don't they determine anything to do with the policies?

Ms. HOWARD. At the time that I was facing all of this, I was so ill that I had no strength to learn all of those things, and it is really only in retrospect that I have attempted to piece together the story.

Anthem, in fact, refused to hand over my records to me. I understand that they handed them over to the subcommittee, but—

Mr. WALDEN. They wouldn't give you your own records?

Ms. HOWARD. No. Because I don't have that policy any longer.

Mr. WALDEN. That is amazing.

Ms. HOWARD. I don't know what they could have to hide.

Mr. WALDEN. But I assume we subpoenaed them or requested them?

Mr. STUPAK. Requested them, and we have them: And she has access to them.

Ms. HOWARD. Maybe I could look at them.

Mr. STUPAK. Yes, you can. Right after, come on up and we will give you a complete copy.

Mr. WALDEN. These are the sorts of reforms that there needs to be a change here. There is no doubt about it. I am sorry for what you have gone through.

And I guess that is one of the things. You know, we hear that we have to have this regulatory scheme State by State; and yet I hear your story and think, well, that didn't exactly protect you as a consumer.

And I am sure that—I don't know. When we shop for health insurance, trying to read through those policies and figure out what is covered and what is not is a challenge. I leave that up to my wife, and she makes pretty good decisions on that front, but it is still a challenge.

And yet I want to make sure that you aren't tied to a job or have to go broke in order to have insurance for your kids. And while I am not convinced the bill before us, the one passed out of here, is the best way to achieve that, I do believe there are ways to get there.

And so I don't have any further questions, and I know we are going to have votes in another 15 minutes, so I yield back the balance of my time.

Mr. STUPAK. Thanks. And I have got to compliment you, because you have helped us get Ms. Howard's records.

But the hearing we are having Tuesday on small businesses, that has been adjourned a couple times because even though the small businesses have agreed that we can look at their insurance policies, the insurance companies have refused to give us the records because of the HIPAA requirements. And you and your side have been most helpful in having that hearing Tuesday.

We finally got some records, but it is a hassle. Whether you are the patient or the policy holder yourself, they do not want to give up those records.

Mr. WALDEN. Maybe we can have an oversight hearing on HIPAA, too. There are lots of issues associated with that law.

Mr. STUPAK. I will take my turn for questions.

The stories we have heard here from this panel are heart-breaking, but unfortunately, are not unique. If I could go to slide No. 1 there, The Commonwealth Fund health survey provides some remarkable data, if you take a look at—right here. This slide comes, as I said, from The Commonwealth Fund report. We will hear from Ms. Collins next.

I would like to highlight the comment labeled Underinsured and Used Up All Savings, like this panel. According to the report, there were 25.2 million underinsured Americans in 2007. This table shows 46 percent of the underinsured burned through their savings in order to pay for medical bills. That is 11.6 million Americans with health insurance who still spent all of their savings on medical expenses.

The table also notes—and you can see the arrows there—that 33 percent of those underinsured took on credit card debt as a result of medical bills. That is another 8.3 million people relying on credit cards, often with high interest rates, to cover medical expenses just leads to greater financial burden.

I guess—as the chart shows, I think we are just all—the under-insured are just one step away of being uninsured, in financial ruin.

Mr. Wilkes, let me ask you this. In your testimony, you state your family relied on credit card and home equity to stay afloat. Is that correct?

Mr. WILKES. That is correct.

Mr. STUPAK. Roughly, how much medical debt did you finance through credit, whether home or credit cards?

Mr. WILKES. It was spread over several years. I am not sure. I even had to cash in a life insurance policy, spend down our savings—got no savings left. So many bills. I mean, we literally get stacks and stacks of statements and bills from the hospital, from the insurance company, from everybody. So it is impossible to keep track.

Just to tell you how impossible it is to keep track, even the insurance companies couldn't track.

Mr. STUPAK. Right. You were telling me you requested one time, it is in your testimony, one of those nice charts you made.

Mr. WILKES. In 2006, when we were near the cap, we said tell us where we are. Give us a line item list of the bills. We got that 22 months later, a year and a half after.

Mr. STUPAK. So what would have happened if you would have gone over that waiting for this information, to see if you are near that million-dollar cap, you go over the million-dollar cap, not knowing.

If it takes them 22 months after requesting to give you the information, all that would have been out of your pocket then?

Mr. WILKES. Like I said, we had \$80,000 over the cap that we were responsible for. Had we waited another week or two, it would have been well over a quarter million dollars.

Mr. STUPAK. Could I put up the chart by Mr. Wilkes? Because I want you to try to explain this one. You had it to your testimony.

I had a little trouble. I am in July, 2002 there. The green line on the bottom. It is about—just your total annual premium, right?

Mr. WILKES. The green line on the bottom is basically employee contributions. Just the portion—not the premiums that—

Mr. STUPAK. The employer paid?

Mr. WILKES. The minor portion of the premium that comes out of your paycheck.

Mr. STUPAK. The blue one there that starts at \$7,000 in 2002, is that employee and employer contribution?

Mr. WILKES. Yes, that is basically the full premium.

Mr. STUPAK. And then—so over 5 years you went from \$7,000 to over \$17,000, the employee and employer contributions, if you follow that top line?

Mr. WILKES. When we were under the high-deductible plan, it was basically a \$12,000-a-year premium. By the time we left, it was \$10,000 out of pocket on top of that.

So you are—it was well over \$22,000. And that includes—you know, plus funding the HSA that we had for those of us that could afford it.

Mr. STUPAK. So it was basically \$17,000 for a premium, but you had a \$10,000 deductible, first, you had to meet?

Mr. WILKES. Right.

There is another chart there, \$6,000 deductible, \$10,000 out of pocket with some coinsurance. The numbers get a little funny, but ultimately we had to lose a lot of money out of our pocket.

Mr. STUPAK. So with that coverage, even with the \$10,000 deductible, you indicated some of your fellow employees, who shared that pain with you, financial pain, had to pay for a C-section for the birth of a child, sewed up a leg on a kitchen table—

Mr. WILKES. Everybody in the company now—we were the bomb that went off, but they were all casualties, all around us. They were all paying this \$12,000 premium per family. But every time they had to go take their kid in to the doctor or go to the hospital, then they were paying 100 percent because they hadn't even come close to their deductible yet.

Mr. STUPAK. Well, I know you mentioned—and Mr. Null also mentioned—that one way to get around it is to file divorce, have one spouse get no income, go on Medicaid to pay for these expenses. I am pleased to see neither one of you chose that route, but I am sure financially you look at it, it makes you think at least once or twice. Fair to say?

Mr. Null, let me ask you this. You had to reduce your annual income you said to, what, \$16,013—

Mr. NULL. That is correct.

Mr. STUPAK [continuing]. In order to qualify? Or you had to be below \$20,000.

Mr. NULL. You had to maintain below that level; it is 16,014. You can handle it yourself.

Mr. STUPAK. So at—16,013 is the magic number. I am sure you had to divest your assets, get rid of a savings account if you had anything left by then.

Mr. NULL. Absolutely. They do a complete asset search, and you have to liquidate all of that.

Mr. STUPAK. How long were you on Medicaid then to pay for Tatum?

Mr. NULL. We were on Medicaid for about 2 years.

Mr. STUPAK. I think you said you had to avoid work or did not take on work because you were afraid to go over that cap?

Mr. NULL. That is correct.

Mr. STUPAK. What would have happened? You would be without the insurance?

Mr. NULL. Yes. They would drop us effective immediately.

Mr. STUPAK. During this time, did you look for other insurance companies to see if you could get off Medicaid and try to get some coverage for Tatum?

Mr. NULL. Yes, sir, we did; and no insurance companies would write us because of the preexisting. They, quote-unquote, said they would not even accept our policy for review, or request or accept our application for review.

Mr. STUPAK. So it was only when you went from a private individual plan to a group plan you were able to get insurance for Tatum?

Mr. NULL. Correct.

Mr. STUPAK. You indicated Tatum is blacklisted from insurance. Can you explain that a little further?

Mr. NULL. It is because of her preexisting. As I mentioned, we could not find any insurance companies that would accept our application with Tatum's name on it.

Mr. STUPAK. What if you—I guess if you didn't put your name on it, when a claim was submitted—if you didn't put Tatum's name on it, when a claim was submitted it would be rejected because she is not covered underneath the policy, right? There is no way to get around it.

Mr. NULL. There is no way around it. No, sir.

Mr. STUPAK. Ms. Howard, we all want to compliment you for the struggles you have been through, but still trying to pay it and to not file for bankruptcy. I think you said you didn't want to go down that road. Could you just explain a little bit?

Ms. HOWARD. Oh, I didn't want to go bankrupt.

Mr. STUPAK. Why didn't you want to go through bankruptcy? That was one way to clean your debt, right?

You are single. You could clear off your debt. In 7 years, you could probably get your credit reestablished.

Ms. HOWARD. I figure in the next 7 years I might be able to pay this off. I would like to be able to say that I have stood up on my own throughout all of this.

Mr. STUPAK. Well, I think you have got the respect of everybody on this committee for trying to do what is right. Not that the 62 percent of the Americans who play by the rules, had insurance—78 percent of those 62 percent had insurance, but they had to file because they just couldn't do it.

So we compliment you for trying.

Mr. Gingrey, questions, please.

Dr. GINGREY. Mr. Chairman, thank you.

First of all, I certainly want to thank all of you for sharing your stories and the courage that you have exhibited in trying to deal with the very difficult situation that all three of you have experienced. And I wanted to direct my first comments to Ms. Howard.

Again, I want to commend you on the steadfastness with which you have taken responsibility for your own medical debt. Could you please comment on how that has affected you personally?

And, specifically, did you ever consider Medicaid? You may have mentioned that, but if you don't mind talking about that again. And were you able to obtain medical care from any other group or organization? Was there anybody out there to help you other than just that insurance policy that you had?

Ms. HOWARD. Yes. For part of 2005, I qualified for a State of California MediCal program, specifically for low-income breast cancer patients. They offered me some help, but in the long term it was just a drop in the bucket.

I am lucky that now, through my employer, I am covered by excellent group coverage. But I know that if I were back on the individual market, no one would cover me.

Dr. GINGREY. In California, Ms. Howard—I know in the State of Georgia, my State, and unfortunately, it is underfunded, but they have something called State Aid for cancer patients, low-income cancer patients.

Did you indicate that they have something similar to that in California?

Ms. HOWARD. They do. Specifically it is for breast cancer and for which I qualified, but the outcome was really minimal. I was grateful for the aid at the time, but it was really insufficient, given the extent of my debt.

Dr. GINGREY. It was a minimal help; some help, but minimal.

How about the providers in the State of California, the physicians? Did you run into any difficulty with regard to them accepting State aid for cancer reimbursement for their services?

Ms. HOWARD. You know, it is all somewhat of a blur, looking back on 5 years ago. But I fortunately had an excellent oncologist and group that was caring for me that—they just said, Hey, we will figure this out together.

What we really figured out is that I have owed them a lot of money for a long time, and I am still paying on it.

Dr. GINGREY. God bless you.

Mr. Wilkes, I wanted to ask you, too. The chairman of the committee, Mr. Waxman, commented in his remarks that many on this side of the aisle don't feel that we need to have health insurance reform. And maybe my opening remarks led him to believe that, that maybe I personally didn't feel that we should have or needed to have health insurance reform or health care reform.

But, clearly, I personally believe that we need health insurance reform, and I think most members on this side of the aisle believe that—firmly believe it. Your testimony today certainly well supports the need for reform of the health insurance industry. We just believe we can do that without—we use the expression sometimes—throwing the baby out with the bathwater.

And Mr. Walden mentioned a number of things that we are supportive of in regard to reforming the health insurance industry and some of the egregious things that you have described, like rescission of coverage after the fact and denying the ability for people with preexisting conditions to get coverage. Maybe they can get it, but if it is five times standard rates, then they essentially can't get it.

So, Mr. Wilkes, I wanted to ask you in particular. I think you had mentioned that you were under group coverage for a time, and then when you had to get into the individual or small group market, because of the preexisting condition of your son with hemophilia, it was just virtually impossible.

And I want to ask you your opinion of a suggestion that I made in regard to reform to say that anybody that, say, a young healthy person like yourself with a young family, lots of expenses, and you are working and you really can hardly afford to get on the company's group policy. But you do it anyway. And you do it, you make that sacrifice every month and you pinch pennies, and maybe for 15 years or maybe 2 or 3 years even, you have done that and then all of a sudden something like this happens.

Don't you think that a company, an insurance company should be obligated because you have had this credible coverage, if something happens to you after the fact through no fault of your own—or one of your family members—that they should continue to cover you and your family at those essentially standard rates for until you are eligible for Medicare, or maybe even for the rest of your life? Because you have bought into that system and they have

made a nice profit probably on covering you until you finally did have those claims.

Tell us what you are thinking about that.

Mr. WILKES. That speaks to a point I talked to other people about. Because of the way the group market works, insurance functions best as a large pool. And the way we have divided—the employers are all these little, tiny pools, so depending on the size of your company, if one person gets sick, it could be very damaging to the company.

That is what happened to my previous employer. We had the high cost; they paid the price. So what you are talking about then speaks to community rating.

We were blessed. In Colorado, in 2008, the State enacted a law creating modified community rating. We are one of a handful of States that does that for the small-group market now. That is the only reason that I can afford small-group coverage today is because we have modified community rating in the State of Colorado.

And I just want to speak very briefly to something Mr. Walden said about selling insurance across State lines.

The way I see it, we are talking about underinsurance today. I think that is a very bad idea, because that invites underinsurance. The average number of things that are required to be covered in the State—there are about 45 or so things that have to be covered under insurance plans. In Colorado we have 51—things like chiropractors, certain types of nurses, colorectal cancer screening, breast cancer screening—whereas over in Idaho they only have about 16 of these things that have to be covered by their plans.

And I think if you invite selling across State lines that way, then the same—the United Health Care in Colorado will now have the United Health Care in Idaho come try to sell a low-cost plan in Colorado that doesn't cover those things. And then you run—you create more of the problems that we are having with finding that, Oh, the breast cancer is not covered anymore, or the liver cancer is not covered anymore.

So it is just—I hope that answers.

Dr. GINGREY. Mr. Wilkes, thank you.

Mr. Null, I don't have time. Maybe in a second round. But, again, thank you so much. And your daughter looks great and healthy, and thank God for that. I appreciate you.

Mr. STUPAK. Mr. Dingell for questions, please.

Mr. DINGELL. Thank you, Mr. Chairman. Again, to the panel, thank you for your presence and your help.

First question here is, some premises that are interesting. What is striking about each of your stories is that in medical emergencies, that your insurance policies had shortcomings which have limited your career options.

Mr. Null, in your testimony you mentioned that you had to lower your income in order to qualify for Medicaid. I understand that because you are a small business owner, that decision affected your business. I gather it related to having to turn away business to reduce your income so that you could qualify for Medicaid. Is that statement true?

Mr. NULL. Yes, it is.

Mr. DINGELL. Tell us a little bit more about it, if you please.

Mr. NULL. Well, the limit was \$1,613. And because I am self-employed, I am the salesman for the company, I am the collector, so I know exactly how much I am going to make. If I knew I was going to make too much, in order to be able to requalify for Medicaid, we would have to turn business away and I would be unable to take on that business because I knew I would make too much for the Medicaid limits.

Mr. DINGELL. Thank you.

Now, Mr. Wilkes, you told us how you had to leave a company that you liked to work for in order to get better coverage for your son. What would you like to tell us about that, please, sir?

Mr. WILKES. Well, they didn't want me to go. I was basically employee No. 9, the lead engineer of the company that we started in 2000. The company survived the dot-com bust. The company then was stuck facing these rising premiums, and they kept me around. For over a year, while we were dealing with this. I literally walked the halls of the company, felt like I had a big giant target on my back.

I am very close to other members of the hemophilic community. I hear horror stories every time I talk to these people about how they started a great job—they were doing well, they were performing, they were the top salesperson—and as soon as somebody in the company found out that they had a kid with hemophilia with the high cost of illnesses, they were terminated or let go, or their job was no longer needed.

So I felt I had that target on my back. I felt I had that target on my back for over a year.

When it came time to leave—I have to go; I don't have insurance unless I do this—they didn't want me—they didn't want me to go. They worked with me. They did everything they could, and I feel blessed that—a guardian angel looking over me and my family, that they were able to do that. But I know that is not the case for a lot of companies and a lot of people across this country.

Mr. DINGELL. Now, I gather that you on the panel have all had to shop around for insurance policies in order to meet your needs. Did you find that to be an easy process?

And did you have an easy time of comparing your policies or, rather, your choices amongst policies so that you could come up with the best choice for you and your family? Did you find it easy to know what the benefits would be, what the restrictions and the constraints were, what would be the costs, and what would be the duration of the policy and the other circumstances, including pre-existing conditions and questions of that kind?

Would you want to start, Mr. Null?

Mr. NULL. We found shopping for insurance to be very confusing. In fact, in Texas it requires a licensed agent in order to even be able to come talk to you about policies, it is so confusing.

My wife and I, we are both college educated. We believe that we are able to make good decisions. But being able to look at these policies and tell the difference—for example, this policy that we were on when Tatum had her illness, this policy was only 25 percent less than the policy I had been on previously with traditional caps in it that would have done our family much more service. It

was only 25 percent less, and yet the cap was 1/40th of a comparable policy.

No, we did not recognize anything along those lines when we were shopping for that policy. Had we seen something like that, that would have raised red flags; and we probably would have recognized that policy for being the worthless piece of trash it was.

Mr. DINGELL. Mr. Wilkes, do you want to make a comment on that?

Mr. WILKES. Yes.

Our family had been dealing with this issue about 5 years by the time it came time for us to actually shop for a plan. The policies themselves were very difficult to comprehend. The one thing that was really in my favor is that I was able to find an insurance broker who had cancer herself and really believed that the private insurance market has no business even existing in this country, and knew all the ins and outs and knew what to look for. I had her in my favor, who was being an advocate for our family.

And I also took the plans—in Colorado there are like 20-some different insurance companies that you can pick. We went to our hemophilia treatment center and said, Which of these companies is least likely to deny care, is least likely to give you any problems, is least likely to cause us problems when we go to the hospital? And out of those, there were only two that they said they have the least problems with and they can work with, that pay bills on a regular basis.

So, in the end, we had two insurance companies out of the many that offered that were really an option for us. And beyond that, then we had to work with our insurance broker, who had fought the fight that we fought before and knew what we were dealing with.

Mr. DINGELL. Thank you.

Ms. Howard, do you have any comments on the last question?

Ms. HOWARD. I do.

I feel like there is a real need to provide consumers with assistance in making sense of these plans, to give us an apples-to-apples comparison.

You know, like Mr. Null, I now have a master's degree, and I couldn't make sense of that policy. I really feel like it behooves the subcommittee to write into the bill that we just have to understand what we are signing up for: what would the cost be, what would the coverage be for unfortunate but common conditions like my own, like breast cancer or other common conditions, what would the financial ramifications be for an individual or family.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy.

Members of the panel, thank you for your very fine testimony.

Mr. STUPAK. Mr. Welch for questions, please. We have two votes. Let's try to get through some more questions before we have to vote.

Mr. WELCH. I just want to, I think, express myself what I think all of us feel, and that is, you guys are amazing. To have gone through what you have gone through, to be going through what you are going through with the medical anxiety and then—getting that news, and then learning that you actually didn't have insurance. And at a time when you need to have total concentration on your

health, your child, your partner, to find that you are in constant warfare with the insurance companies is just astonishing.

And what I am amazed at is that you all seem to be very nice, normal people, and it hasn't worn you down into smithereens. Now, you may be fooling us, but I don't think so. However you managed to have that strength—a lot of folks don't have it and really shouldn't have to have it.

And, if anything, I think what you have given us are very vivid examples, irrefutable, that if you are going to have insurance, it ought to be real coverage. You shouldn't have to be somebody with extraordinary personal emotional reserves to wade through it, willing to make extraordinary sacrifices in the long term to get through it.

And what you are describing really is a business model where insurance companies make their money by denying coverage or writing policies with obscure loopholes that make it impossible for people to get the coverage they need when they need it; and it is our responsibility here to change that.

And I think there really is some desire to have insurance reform, but the bottom line, I think the insurance company reform, if it is going to be across State lines, has to be with some consumer protection so that if you buy a policy from Kansas or California or Vermont, when that diagnosis comes and you need the care, one of your worries is not whether you have got the coverage.

So you have done just a tremendous service for us here, and I think all of us really admire just the personal strength that each of you has displayed. Because I think you are—but we don't want others to have to go through what you have done. That is really the goal here.

So thank you so much for coming and being so helpful.

Mr. STUPAK. The confusion you see on policies—this committee has been doing 2 years on private insurance. We have the same situation with Medicare Advantage. People signed up, they had no idea what they are signing up for; and that is one of the things we are trying to work on with health care reform.

Mrs. Christensen for questions, please. We still have 9 minutes before we have to vote.

Mrs. CHRISTENSEN. Thank you. I will just ask one.

Another troubling aspect of the underinsurance, besides the medical debt, is that it encourages policyholders to put off care in order to cut costs.

And Commonwealth has done some work on that: People don't pay for home heating or food or rent—all of that is needed to really sustain your health—and then those with chronic diseases don't take proper care of their health.

So I wonder—and I guess I would ask each of you about your experiences and have you—for example, Mr. Wilkes, did you ever avoid taking time to see the doctor because you knew he was near his cap?

Mr. WILKES. Absolutely. You know, not only did we have coworkers that were putting off primary and acute care, but, as we were facing the looming specter of the cap coming up, there were times when Thomas would complain about an injured joint. And the normal procedure would be treat it right away. That is standard. Treat

it right away. And if it is a bleed, the factor will take care of it. But we were facing this cap, and every single dose was precious to us. I mean, we are talking about a thousand dollars or more a dose at the time or even \$10,000 or more for full treatment. So we would wait and see.

At least three or four different times during that year, he would complain about something in his joint hurting, and we didn't know if it was his leg falling asleep or what, so we would wait. Rather than do the standard care of treat first, then check it out, we would wait a few hours, we would wait overnight. And, invariably, it would actually turn worse, and it would cost us, you know, \$80,000.

Mrs. CHRISTENSEN. And probably damage the joint in the process.

Mr. WILKES. Yes. And for 3 months, there was a period for 3 months, he had an ankle bleed, where he was confined to a wheelchair the whole time.

Mrs. CHRISTENSEN. Thank you.

Ms. Howard, did you ever skip any of your treatments?

Ms. HOWARD. I did not. I, without regard for expense, went forward. And, as I said before, if I don't die, I will just figure out how to pay for this later. But it has come at tremendous cost to my family and to my personal finances and has also affected how I choose to live my life—where I work, where I live, how I live.

Mrs. CHRISTENSEN. Mr. Null, did you ever?

Mr. NULL. No, ma'am, we never let that be a consideration.

Mrs. CHRISTENSEN. I, too, appreciate your coming forward. I think your personal histories are very important testimony to what we are trying to achieve. And we have great admiration for your strength, your courage, and your perseverance.

Thank you, Mr. Chairman.

Mr. STUPAK. Thanks, Mrs. Christensen.

Mr. Burgess for questions. There is 5 minutes before we have to vote, so we will have to keep it at 5.

Dr. BURGESS. OK. I can walk faster than 50 older Members, so maybe I will make it.

Mr. STUPAK. For other members, we will come back.

Dr. BURGESS. Ms. Howard, let me just ask you. And I probably won't take the full 5 minutes, but I did want to come back and visit with you. You know, we heard Mr. Welch talk about how confusing insurance policies can be. And they can be; no question about that.

I don't know if any of you have taken the time to read through the legislation that this committee passed on July 31st. It is pretty confusing, as well. And, for many people, it has been hard to discern will their lives be, in fact, better or more complicated if this bill passes.

But you referenced in your testimony having at least paid attention to one amendment that was passed, dealing with internal and external review. And I want to commend you for your ability to sort through a large number of words and dig up pieces of what almost would seem to be miniscule events.

To me, that was very important, to get that included. Obviously, I was concerned about the development of a public option plan without internal and external review being available.

Would that have helped you in your situation?

Ms. HOWARD. Absolutely.

I had previously had a group policy with the same provider that was excellent. And so, when it came time for me to buy a private policy, I went back to them willingly and said, "What do you have to offer for me? I have been a great customer of yours for several years." And had I been able to compare the disparity in coverage between a private and a group plan—how if I had been through this same illness and recovery under a group plan, I would not be in the financial circumstances that I am now.

So if I could have seen that apples-to-apples comparison and been told, "Hey, kid, if you get cancer, this is what it is really going to cost you," I might have made a different choice. But I don't know that there would have been really anything better for me out there.

Dr. BURGESS. And, of course, this gets to the larger point. When a larger corporation is negotiating for insurance coverage and prices, they bring a certain amount of clout to the table. I had a policy in the individual market at one point in my life, and you are correct, you are negotiating as a single individual. If they will even talk to you, you feel grateful, because you got the audience with the insurance company.

But there are many of us who believe that if we would permit more aggregation of consumers—it doesn't always have to be working for the same company; it might be members of the same church or alumni association or people who work in dentist offices or physicians offices.

I was always stuck with having to provide—not stuck, but faced with having to provide a competitive insurance policy for 50 employees. And, yes, while that is better than finding for just one individual, still, you are a pretty restricted purchaser in that. And we don't seem to be sensitive to the fact that, if we would allow aggregation of much larger groups with some sort of similarity in their business models, that we would give people more purchasing clout.

Now, interestingly, you have chosen to work out a payment schedule, and while it is one that seems aggressive, I was a practicing physician for years and certainly can recall, as long as a patient was making an honest effort to pay off the bill, that was all that our office would do as far as collection. Now, the hospital being owned by a big corporation—on national TV we won't mention any names, but their initials were—well, we won't even say their initials because they know who they were—they were less likely to work with the patient.

But as far as the individual physician's office—and oftentimes I could go to bat with hospital administration and say, look, you can put these folks to a collection agency and you will get 30 percent of what you otherwise would have gotten if you are willing to wait whatever length of time it is where they can pay this out.

And I just commend you for doing that and for thinking through that. Again, your payment schedule is aggressive. I never had a patient who paid me that promptly. But I don't think people are aware that this is available to them.

And I got to tell you, Mr. Chairman, I practiced for 25 years, and I can remember probably getting two bankruptcy discharges in my practice. And not that I pushed this person into bankruptcy, but,

as a creditor, I had to be notified that the debt was discharged and I could make no further—if I was doing anything to effect collection, that I would have to cease and desist. It just was an infrequent occurrence in the years that I was practicing. And then I set here listening to opening statements on this committee, and it seems like it is rampant.

One last final thought, Mr. Null. Did you talk to the Texas Department of Insurance, the commissioner of State commercial insurance, about the problems you had?

Mr. NULL. No, I did not.

Mr. STUPAK. OK. I have to cut you off. You are over time. And Mr. Doyle wants to get a question or two in before we have to go. Time has expired on the vote for Ms. Schakowsky and us.

But, Mr. Doyle, go ahead.

Mr. DOYLE. Thanks. And I will try to be quick, Mr. Chairman.

First of all, to the witnesses, thank you so much. It is a tremendous help to us for Americans to put a face on this, and we appreciate you doing this.

Mr. Null, I wanted to put your policy up on the screen. I have been reading your policy that you bought from United. I am licensed in all lines of insurance; I have been for 30 years. I have to tell you, as a licensed insurance agent, I was having a hard time understanding your policy.

When you look up there and it shows you that surgical—part four, surgical, 100 percent, I mean, how did you read that when you first bought that policy? Did you read that to mean that they were going to cover 100 percent of surgery?

Mr. NULL. Yes, in Texas, that is what that means; 100 percent is 100 percent.

Mr. DOYLE. And then you have to go a couple pages further into this, and then there is another schedule like this that lists different procedures and what they will pay for the procedures.

Did you have any idea what any of these procedures actually cost?

Mr. NULL. No, I had no idea. I had never seen a medical bill before in my life prior to this experience.

Mr. DOYLE. Mr. Chairman, this is one of the things, when we look at insurance reform, when we talk about transparency, that we have to get back to consumers to help them out. If it says you will pay \$5,000 for a procedure and the procedure costs \$25,000, then would you have bought the policy?

Mr. NULL. Well, no. That wouldn't seem like 100 percent to me. I mean, that wouldn't make sense.

Mr. DOYLE. Exactly. And this is the problem. People buy insurance policies all the time that have these schedules. Your daughter's surgery wasn't even on this schedule, is that correct?

Mr. NULL. It is not on there. I can't find it.

Mr. DOYLE. So there would be no way for you to—you just assumed it said 100 percent of surgery and so it was going to pay.

Mr. NULL. Unless listed otherwise, yes.

Mr. DOYLE. Yes. I mean, the need for health insurance reform is just so obvious. And the thought of companies selling across lines and nobody watching how these policies are written would be a national nightmare.

But we need transparency. People need to know what procedures cost and what their insurance companies are going to pay in plain language that you don't have to be an insurance agent or an attorney to understand. And, as an insurance agent, I still don't understand your policy.

So I see what you have gone through, and I am sorry that you went through it. And we are going to try to fix it.

Mr. NULL. Thank you. That makes me feel better.

Mr. STUPAK. Thank you, Mr. Doyle.

Tatum, did you want to say anything to this group? We are going to go do some votes and come back. But did you want to say anything to this committee?

Miss TATUM NULL. I just wanted to say that, knowing what is going on right now, I do want to be able to live my American dream, and right now I am not able to. So hopefully you can fix that.

Mr. STUPAK. I hope we can, too, for everybody.

Ms. Schakowsky, do you want to say something quick before we leave?

Ms. SCHAKOWSKY. Yes, if I could just thank them so much.

I know you have been here for a long time. We have a couple of votes, so I am going to waive my questions, but just say that you are emblematic of what could happen to anyone in our country. Everyone is one catastrophic illness away from the kinds of problems.

I would love to know who told you to get a divorce. I would also just be interested—and I am sure you spent endless hours of your precious time in the face of illness dealing with this. And we are going to address this issue. And I thank you for your contribution to that.

Thanks.

Mr. STUPAK. OK. We are going to stand in recess. I urge members to vote and come back. We have one more panel to go. I am going to excuse this panel. I am sure we all have more questions. We can follow up in writing.

But I know we have kept you all afternoon. We appreciate your being here. And thank you for sharing your story and putting a face on this.

We are in recess. I urge members come back immediately, get to panel number two.

[Recess.]

Mr. STUPAK. The hearing will now come back to order.

For the record, I talked to Mr. Walden. We were scheduled to be in tomorrow, but because some of the appropriation bills are stalled they have dismissed us for the night. So a number of Members are trying to catch airplanes with this weather, and they are already facing some delays, so a number of Members are going to leave.

I checked with Mr. Walden, the ranking member, and he said, "Give my regards to the next panel." He had to leave, but he was going to—he has asked us to continue with this hearing.

Members will be back early, even though we may be off Monday, members will be coming back early because we have another hearing on Tuesday on health insurance, private health insurance, especially how it affects small businesses.

So we are very pleased that our second panel can be here: Dr. Collins, Dr. Sara Collins, who is vice president of the Affordable Health Insurance Program of The Commonwealth Fund; and Dr. Stan Brock, who is director of the Remote Area Medical Volunteer Corps.

I would like to thank both of you for being here and being patient with us today.

It is the policy of this subcommittee to take all testimony under oath. Please be advised you have the right, under the rules of the House, to be advised by counsel during your testimony. Do you wish to be represented by counsel?

Both witnesses indicated they do not.

Therefore, I am going to ask you, please rise, raise your right hand, and take the oath.

[Witnesses sworn.]

Mr. STUPAK. Let the record reflect the witnesses replied in the affirmative. They are now under oath.

We would now like to hear a 5-minute opening statement from each of you.

Dr. Collins, if we may, we will start with you. If you would just turn on the mike there, a green light should go on, and pull it up there. And if you have a longer statement, that will be included in the hearing record. But you may begin. And thank you, again, for being here.

TESTIMONY OF SARA R. COLLINS, PH.D., VICE PRESIDENT FOR THE AFFORDABLE HEALTH INSURANCE PROGRAM, THE COMMONWEALTH FUND; STAN BROCK, DIRECTOR, REMOTE AREA MEDICAL VOLUNTEER CORPS

TESTIMONY OF SARA R. COLLINS

Ms. COLLINS. Thank you, Mr. Chairman, for this invitation to testify on the growing number of people who are underinsured.

The soaring cost of health care, along with the economic recession and stagnant wages, are leaving many working families without insurance or with medical expenses that consume a very large share of their income. 46.3 million people lacked health insurance in 2008. This is up from 45.7 million in 2007.

Among people who do have health insurance, The Commonwealth Fund estimates that, in 2007, 25 million working-age adults had such high out-of-pocket costs relative to their income that they were effectively underinsured, an increase from 16 million in 2003.

As the extraordinary testimonies of the first panel underscore, both these trends have had serious financial and health consequences for U.S. families. This committee and the other key health committees in the House and the Senate are to be commended for pursuing health reform that will help families secure access to affordable and comprehensive health insurance.

The combination of rapidly rising health care costs, very slow growth or no growth in real family incomes, and greater cost-sharing in health plans are contributing to the growth in underinsured adults. Based on analysis of The Commonwealth Fund's biennial health insurance survey, between 2003 and 2007 the share of

underinsured adults climbed from 9 percent to 14 percent of the under-65 population.

We defined underinsured adults as those who spent 10 percent or more of their income on out-of-pocket health costs, excluding premiums; spent 5 percent or more of their income if their incomes were under 200 percent of poverty; or had deductibles that amounted to 5 percent or more of their incomes.

Adults with low incomes are the most likely to be underinsured. Almost one-quarter of adults with incomes under 200 percent of poverty were underinsured in 2007. This is up from 19 percent in 2003. But the problem of cost exposure is moving up the income scale. The share of adults with incomes of 200 percent of poverty or more who are underinsured nearly tripled over the time period, growing from 4 percent to 11 percent. The most rapid growth occurred among adults earning between \$40,000 and \$60,000.

Underinsurance is associated with health plans that cover fewer health benefits. More than one-quarter of underinsured adults reported a deductible of a thousand dollars or higher, compared to 8 percent of adults who are not underinsured. Forty-eight percent reported that their health plan placed limits on the total dollar amount that their plan would pay for health care each year. Nineteen percent reported that their health plans limited the number of times per year they could see their physicians.

Underinsurance is also associated with reports of health plan problems. Forty-four percent of underinsured adults in our survey reported that they had had expensive medical bills for services that were not covered by insurance. Thirty-eight percent of underinsured adults reported that their doctor had charged them a higher price than their insurance plan would pay and they had to pay the difference.

Adults with health plans purchased in the individual insurance market are more likely to be underinsured. Thirty percent of adults who had purchased a plan on the individual market were underinsured, compared to about 17 percent of adults who were in employer-based health plans.

Underinsured adults report not getting needed health care because of cost at rates that are nearly as high as people who are without insurance coverage altogether. Sixty percent of underinsured adults in our survey reported at least one cost-related problem getting care.

Underinsured adults also report high rates of medical bill problems. Three of five underinsured adults reported a problem paying medical bills or had accrued medical debt over time. This is more than double the rate of those who had adequate insurance all year. Nearly half of adults who are underinsured reported that they are paying off medical debt over time.

Several provisions in the "America's Health Choices Act," or H.R. 3200, would reduce the number of people who are underinsured. The bill replaces the individual insurance market with a regulated insurance exchange. The new market regulations would extend to all health plans. Guaranteed issue and community rating would ensure that people could not be denied coverage, charged a higher price, or have a condition excluded from their coverage because of a preexisting condition.

Insurance carriers could not impose annual or lifetime limits on what their plans would pay and would be prohibited from the use of rescissions. The bill would establish a new minimum benefit standard, which would ensure that families do not become bankrupt because of medical costs, encourage the use of timely preventive services, and protect against catastrophic costs.

The premium subsidies in Medicaid expansion substantially improve the affordability of health insurance for people with incomes up to 400 percent of poverty. The cost-sharing credits will significantly reduce out-of-pocket expenses for people with incomes under 350 percent of poverty.

For people whose incomes exceed the income threshold for subsidies, premium costs will likely decline from current levels due to a decrease in administrative costs from restrictions on underwriting and reduced marketing and because of savings achieved through reduced provider payments and profits if a public option is included in the exchange.

Reducing out-of-pocket costs will also require national reforms aimed at improving the overall performance of the health system. The House bill includes key provisions for improving health system performance and lowering the rate of cost growth. These provisions will likely enhance the value obtained for health spending and set in motion reforms to slow the growth in health care costs over time.

Thank you.

[The prepared statement of Ms. Collins follows:]



THE GROWING PROBLEM OF UNDERINSURANCE IN THE UNITED STATES: WHAT IT MEANS FOR WORKING FAMILIES AND HOW HEALTH REFORM WILL HELP

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THE GROWING PROBLEM OF UNDERINSURANCE IN THE UNITED STATES: WHAT IT MEANS FOR WORKING FAMILIES AND HOW HEALTH REFORM WILL HELP

Sara R. Collins, Ph.D.

The Commonwealth Fund

Executive Summary

Thank you, Mr. Chairman, for this invitation to testify on the growing number of people in the United States who are underinsured. The soaring costs of health care, along with the economic recession and stagnant wages, are leaving many working families without insurance or with medical expenses that consume a large share of their incomes. In September the Census Bureau reported that 46.3 million people lacked health insurance in 2008, up from 45.7 million in 2007. Among people who do have health insurance, the Commonwealth Fund estimates that in 2007, 25 million working age adults had such high out of pocket costs relative to their income that they were effectively underinsured, an increase from 16 million in 2003. Both these trends have had serious financial and health consequences for U.S. families. An estimated 72 million adults under age 65, both with and without health insurance, reported problems paying their medical bills in 2007 and 80 million reported a time that they did not get needed health care because of cost. This Committee and the other key health Committees in the House and the Senate are to be commended for pursuing health reforms that will help families secure access to affordable and comprehensive health insurance.

The Growing Problem of Underinsurance

- According to an analysis by Cathy Schoen and colleagues of the Commonwealth Fund Biennial Health Insurance Survey between 2003 and 2007 the number of underinsured adults climbed from 16 million to 25 million, or from 9 percent to 14 percent of the 19-64 population. Underinsured adults were defined as those who spent 10 percent or more of their income on out-of-pocket health costs, excluding premiums; spent 5 percent or more of their income, if their incomes

were under 200 percent of poverty; or had deductibles that amounted to 5 percent or more of their income.

- Adults with low incomes are the most likely to be underinsured. Almost one-quarter of adults with incomes under 200 percent of poverty were underinsured in 2007, up from 19 percent in 2003.
- The problem of cost exposure is moving up the income scale. The share of adults with incomes of 200 percent of poverty or more who were underinsured nearly tripled over 2003-2007, climbing from 4 percent to 11 percent. The most rapid growth occurred among adults in households earning between \$40,000 and \$60,000.
- Reflecting higher rates of chronic illness and poor health, older adults ages 50-64 are the most likely of any age group to be underinsured. Between 2003 and 2007 the share of older adults who were underinsured increased by 60 percent, rising from 11 percent to 18 percent.
- Underinsurance is associated with health plans that cover fewer health care benefits. More than one-quarter (26%) of underinsured adults reported a deductible of \$1,000 or higher compared to 8 percent of insured adults who were not underinsured, 48 percent reported that their health plan placed limits on the total dollar amount their plan would pay for medical care each year compared to 36 percent of adults who were not underinsured; 19 percent reported that their health plans limited the number of times per year that they could see physicians, excluding mental health visits, compared to 11 percent of adults who were not underinsured.
- Underinsurance is also associated with reports of health plan problems. Forty-four percent of underinsured adults reported that they had had expensive medical bills for services that were not covered by insurance, twice the rate reported by adequately covered adults, 38% of underinsured adults reported that their doctor had charged them a higher price than their insurance plan would pay and they had to pay the difference compared to 25 percent of adequately insured adults, and 42 percent said that they had to contact their insurance company because

they had failed to pay a bill or denied payment, compared to 32 percent of adequately insured adults who reported a similar problem.

- Adults with plans purchased in the individual insurance market are more likely to be underinsured than those who have health benefits through their employer. In 2007, 30 percent of adults who had a health plan they purchased on the individual insurance market were underinsured, up from 17 percent in 2003. About 17 percent of adults in employer plans were underinsured in 2007, an increase from 10 percent in 2003.

Rising Health Care Costs, Slow Growth in Incomes, and Higher Cost Sharing Are Contributing to the Growth in Underinsured Adults

- In 2007, national health expenditures grew at a rate of 6.1 percent, faster than the overall rate of growth in the economy, with similar annual rates of growth projected through 2018. Steady annual increases in health care costs have placed upward pressure on the cost of health insurance: premiums grew at a rate of 5.5 percent in 2009, faster than wage growth and consumer price inflation. The average annual cost of family coverage in employer-based health plans, including employer and employee contributions, topped \$13,375 in 2009. A recent analysis by the Commonwealth Fund found that at current cost trends, average family premiums in employer plans will nearly double by 2020.
- Employers have tried to hold their premiums by increasing employee cost sharing. In-network deductibles for single coverage in PPO plans have more than tripled since 2000, rising from \$187 to \$634 in 2009. Among companies with fewer than 200 employees, deductibles have risen by nearly a factor of five, climbing to an average \$1,040 in 2009.
- Jon Gabel and Roland McDevitt found that the actuarial value, or the percentage of total health spending paid by insurance, declined in employer plans nationally between 2004 and 2007, falling from an average 81.4 percent to 80.1 percent, a statistically significant drop. Expected out of pocket spending for all medical services by adults enrolled in employer plans increased on average by 34 percent,

from \$545 to \$729. For the highest cost 1 percent of adults, expected out-of-pocket spending increased by 42 percent to \$8,703.

- Rising exposure to health care costs over the past decade has occurred at the same time that incomes for working families have grown very little.

Adults With Individual Insurance Market Coverage Face Higher Health Care Costs Than Those with Employer Health Benefits

- The individual insurance market is usually the sole option for people who do not have access to employer coverage and whose incomes are too high to qualify for Medicaid, but it has proven to be a sorely inadequate substitute. People who buy health insurance on their own must pay the full premium, and, in all but a handful of states, insurance carriers can underwrite prospective enrollees on the basis of health status, age, gender, and other characteristics that increase the potential for high claims costs in the future.
- A recent study by the Commonwealth Fund found that of adults who tried to purchase insurance in the individual market in the last three years, nearly three-quarters (73%) said they never bought a plan, either because they could not find a plan they could afford, they could not find a plan that met their needs, or they were turned down, charged a higher price or had a condition excluded from coverage because of a pre-existing health problem.
- People who do purchase health insurance in the individual market pay far more out-of-pocket for their premiums, face much higher deductibles, face more limits on what their plans will pay, and spend larger shares of their income on premiums and out-of-pocket costs than their counterparts with employer-based group coverage.
- Half (51%) of adults with individual market plans spent more than 10 percent of their income on premiums and out-of-pocket expenses in 2007 compared to 29 percent of adults in employer plans.

Underinsured Adults are Nearly as Likely as Uninsured Adults To Not Get Needed Health Care Because of Cost

- Underinsured adults report not getting needed care because of cost at rates that are nearly as high as those who are uninsured: 60 percent of underinsured adults in the Commonwealth Fund Survey reported at least one cost-related problem getting care in 2007, including not going to a doctor or clinic when sick; not filling a prescription; skipping a medical test, treatment, or follow-up visit recommended by a doctor; or did not see a specialist when a doctor or the respondent thought it was needed.
- Among adults with chronic health problems who regularly took prescription drugs, 46 percent of those who were underinsured reported skipping doses of medications or not filling prescriptions for their chronic conditions because of cost, compared to only 15 percent of adults with chronic conditions who had adequate health insurance. Adults with chronic health problems who were underinsured reported seeking care in an emergency room, staying overnight in the hospital, or both, for their condition at higher rates than did those with adequate health insurance.

Underinsured Adults Report High Rates of Medical Bill Problems

- Based on the Commonwealth Fund Biennial Health Insurance Survey, an estimated 72 million adults under age 65, both with and without health insurance, reported problems paying their medical bills in 2007, up from 58 million in 2005.
- Adults with gaps in health insurance coverage or those who were underinsured were most at risk of having problems with medical bills: in 2007 three of five reported any one medical bill problem or accrued medical debt, more than double the rate of those who had adequate insurance all year. Nearly half of adults who were underinsured reported that they were paying off medical debt over time.
- Among underinsured adults who reported medical bill problems 46 percent had used all their savings to pay for their medical bills; 33 percent took on credit card debt because of their bills, and 29 percent were unable to pay for food, heat, or rent.

America's Health Choices Act (H.R. 3200) and the Problem of Underinsurance

- The America's Health Choices Act (H.R. 3200) aims to provide near-universal health insurance coverage by building on the strongest aspects of the insurance system – large employer insurance and Medicaid and CHIP – and regulating and reorganizing the weakest part of the system – the individual and small group insurance markets – where so many individuals and small businesses are hurt by high premiums, high administrative costs, underwriting, and a lack of transparency in the content of benefit packages.
- The bill would go a long way towards reducing the problem of uninsurance in the United States. The Congressional Budget Office estimates that by 2019 the number of people without health insurance would fall to 17 million, from an estimated 54 million people, or about 97 percent of legal residents.
- Several provisions in the bill would also likely reduce the number of people who are underinsured and the numbers of people who accumulate medical debt each year.
 - The bill replaces the individual insurance market with a regulated insurance exchange operated at the federal level with a choice of both private and public health plans. The new market regulations would extend to all health plans sold in the United States. Guaranteed issue and adjusted community rating with 2:1 age bands would ensure that people in poor health or who are older could not be denied coverage, charged a higher price or have a condition excluded from coverage because of a pre-existing condition. Insurance carriers could not impose annual or lifetime limits on what plans would pay and would be prohibited from the use of rescissions.
 - The bill would establish a new minimum benefit standard with four tiers. Annual out-of-pocket spending in the essential benefits package is limited to \$5,000 for individuals and \$10,000 for families. Such standards will ensure that families do not become bankrupt because of medical costs, encourage the use of timely preventive services, and protect against

catastrophic costs and bankruptcy in the event of a serious accident or injury. Standardized benefits will also facilitate the ability of people to compare prices of similar health plans and provide incentives for insurers to compete on price.

- While keeping the benefit package constant, the bill defines three levels of cost-sharing tiers by actuarial value, or the average share of medical expenses covered by a health plan: 70 percent (basic), 85 percent (enhanced), and 95 percent (premium and premium plus, which also includes oral and vision care). Cost sharing could include a combination of deductibles, co-insurance and out-of-pocket limits. The average actuarial value in employer based plans is an estimated 80 percent and about 84-87 percent for the Blue Cross Blue Shield Standard Option in the Federal Employees Health Benefits Program.
- The premium subsidies and cost-sharing credits in H.R. 3200 will substantially improve the affordability and protection of health plans offered through the new exchange. The premium subsidies cap spending on premiums at no more than 1.5 percent of income for those earning 133 percent of poverty or \$29,327 for a family of four and rise to no more than 12 percent of income for those with incomes at 400 percent of poverty, or about \$88,200 for a family of four in 2009. People earning less than 133 percent of poverty are eligible for Medicaid.
- The cost-sharing credits will significantly reduce out-of-pocket expenses for people with incomes under 350 percent of poverty, raising the actuarial value of the basic plan to 97 percent for those with incomes of 133% of poverty and sliding down to 72 percent for those with incomes at 350% poverty.
- For people whose incomes exceed the income thresholds for subsidies, premium costs will likely decline from current levels because of a decrease in administrative costs due to restrictions on underwriting and reduced marketing and because of savings achieved through reduced

provider payments and profits if a public option is included in the exchange.

- In addition to insurance market regulations, benefit standards, and premium and cost sharing subsidies, a choice of a public plan in the insurance exchange, reducing out-of-pocket expenditures will also require national reforms aimed at improving the overall performance of the health system. The House bill includes key provisions for improving health system performance and lowering the rate of cost growth including investing in primary care; replacing the current Sustainable Growth Rate (SGR) formula for updating physician fees; adjusting for geographic variations; piloting programs for rapid-cycle testing of innovative payment methods, including medical homes, accountable care organizations, and bundled hospital payments; ensuring choice of private and public plans; containing costs, including reviewing premium increases in the exchange; and fostering quality improvement. These provisions, in combination with provisions of the American Recovery and Reinvestment Act of 2009, would enhance the value obtained for health spending and set in motion reforms to slow the growth in health care costs over the long term.

With working families in crisis from a combination of declining job, income, and health security, the time has never been more urgent for policymakers to find consensus and forge ahead on implementing solutions to the nation's worsening health insurance problem, while placing the health care system on a path to high performance.

Thank you.

THE GROWING PROBLEM OF UNDERINSURANCE IN THE UNITED STATES: WHAT IT MEANS FOR WORKING FAMILIES AND HOW HEALTH REFORM WILL HELP

Sara R. Collins, Ph.D.

The Commonwealth Fund

Thank you, Mr. Chairman, for this invitation to testify on the growing number of people in the United States who are underinsured. The soaring costs of health care, along with the economic recession and stagnant wages, are leaving many working families without insurance or with medical expenses that consume a large share of their incomes. In September the Census Bureau reported that 46.3 million people lacked health insurance in 2008, up from 45.7 million in 2007 (Figure 1).¹ Among people who do have health insurance, the Commonwealth Fund estimates that in 2007, 25 million working age adults had such high out of pocket costs relative to their income that they were effectively underinsured, an increase from 16 million in 2003 (Figure 2).² Both these trends have had serious financial and health consequences for U.S. families. An estimated 72 million adults under age 65, both with and without health insurance, reported problems paying their medical bills in 2007 and 80 million reported a time that they did not get needed health care because of cost.³ The relentless growth in health care costs combined with the severe downturn in the economy has almost certainly deepened the health insurance crisis facing families across the country. This Committee and the other key health committees in the House and the Senate are to be commended for pursuing health reforms that will help families secure access to affordable and comprehensive health insurance.

¹ C. DeNavas-Walt, B.D. Proctor, J.C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2008*, U.S. Census Bureau, Current Population Survey, September 2009.

² C. Schoen, S. R. Collins, J. L. Kriss, and M. M. Doty, How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007, *Health Affairs* Web Exclusive, June 10, 2008:w298–w309. Underinsured adults are insured all year and report spending 10 percent or more of their income (5 percent if their incomes are under 200 percent of poverty) on out-of-pocket health costs, excluding premiums; or having deductibles that amount to 5 percent or more of their income.

³ 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, August 2008).

The Growing Problem of Underinsurance

The combination of rising health care costs, greater exposure to health costs in insurance plans and stagnant income growth has led to an increasing number of adults who are underinsured. As reported in a 2008 *Health Affairs* article by Cathy Schoen and colleagues, between 2003 and 2007 the number of underinsured adults climbed from 16 million to 25 million, or from 9 percent to 14 percent of the 19-64 population (Figure 3).⁴ The authors based their estimates of underinsured adults on the 2003 and 2007 Commonwealth Fund Biennial Health Insurance Surveys, nationally representative, population-based telephone surveys conducted by Princeton Survey Research Associates International.⁵ The authors defined underinsured adults as those who spent 10 percent or more of their income on out-of-pocket health costs, excluding premiums; spent 5 percent or more of their income, if their incomes were under 200 percent of poverty; or had deductibles that amounted to 5 percent or more of their income. Aside from the deductible component, this measure reflects out-of-pocket costs that were actually incurred over the past year rather than the extent to which a person's health plans leaves them potentially exposed to high out of pocket costs. It is thus a conservative estimate of the number of working age adults who are underinsured.

Adults with low incomes are the most likely to be uninsured or underinsured. Almost one-quarter of adults with incomes under 200 percent of poverty were underinsured in 2007, up from 19 percent in 2003. When combined with the share of people in that income range who were without health insurance for at least part of the year, nearly three-quarters (72%) had inadequate health insurance coverage in 2007.

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): w298-w309.

⁵ The Commonwealth Fund Biennial Health Insurance Survey (2007), is a national telephone survey conducted June 6, 2007 through October 24, 2007, among a nationally representative sample of 3,501 adults ages 19 and older and living in the continental United States. The underinsured measure is based on the 2,616 respondents ages 19 to 64. The survey achieved a 45 percent response rate (calculated according to the standards of the American Association for Public Opinion Research) and has an overall margin of sampling error of ± 2 percent at the 95 percent confidence level. In 2003, the survey was conducted September 2003-January 2004 and included 3,293 adults ages 19 to 64 with a 50 percent response rate and an overall margin of sampling error of ± 2 percent at the 95 percent confidence level. Both surveys were conducted by Princeton Survey Research Associates International using the same methodology.

The problem of cost exposure, however, is not confined to lower income families, but has moved up the income scale over the last few years. The share of adults with incomes of 200 percent of poverty or more who were underinsured nearly tripled over the four-year period, climbing from 4 percent in 2003 to 11 percent in 2007. The most rapid growth in those underinsured in that income range occurred among adults in households earning between \$40,000 and \$60,000, rising from 5 percent in 2003 to 13 percent in 2007. There was even a doubling of the rate of underinsured among those earning between \$60,000 and \$90,000.

Reflecting higher rates of chronic illness and poor health, older adults ages 50-64 are the most likely of any age group to be underinsured. Between 2003 and 2007 the share of older adults who were underinsured increased by 60 percent, rising from 11 percent to 18 percent.⁶ Similarly, about 18 percent of adults of all adults under age 65 who are in fair or poor health or who have at least one of five chronic conditions were underinsured in 2007.

Underinsurance is associated with health plans that cover fewer health care costs. More than one-quarter (26%) of underinsured adults reported a deductible of \$1,000 or higher compared to 8 percent of insured adults who were not underinsured (Figure 4).⁷ Nearly 50 percent of underinsured adults reported that their health plan placed limits on the total dollar amount their plan would pay for medical care each year compared to 36 percent of adults who were not underinsured. Underinsured adults were also more likely to report that their health plans limited the number of times per year that they could see physicians, excluding mental health visits: 19 percent of underinsured adults compared to 11 percent of adults who were not underinsured. And underinsured adults were slightly but significantly less likely to have prescription drug coverage (91% vs. 94%) and substantially and significantly less likely to have dental coverage (59% vs. 78%) than those who were not underinsured.

Underinsurance is also associated with reports of health plan problems. In the Commonwealth Fund Biennial Health Insurance Survey, 44 percent of underinsured

⁶ 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): w298-w309.

⁷ 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): w298-w309.

adults reported that they had had expensive medical bills for services that were not covered by insurance, twice the rate reported by adequately covered adults (Figure 5). Nearly two in five (38%) underinsured adults reported that their doctor had charged them a higher price than their insurance plan would pay and they had to pay the difference compared to 25 percent of adequately insured adults, and 42 percent said that they had to contact their insurance company because they had failed to pay a bill or denied payment, compared to 32 percent of adequately insured adults who reported a similar problem.

While rates of underinsurance are climbing among all adults with private insurance, those with plans purchased in the individual insurance market are more likely to be underinsured than those who have health benefits through their employer. In 2007, 30 percent of adults who had a health plan they purchased on the individual insurance market were underinsured, up from 17 percent in 2003 (Figure 6). About 17 percent of adults in employer plans were underinsured in 2007, an increase from 10 percent in 2003.

Rising Health Care Costs, Slow Growth in Incomes, and Higher Cost Sharing Contributing to the Growth in Underinsured Adults

The growing number of people who are underinsured in the United States is the likely consequence of three factors: rapid annual growth in health care costs and premiums, little or no growth in real incomes, and increased cost sharing in health plans. In 2007, national health expenditures grew at a rate of 6.1 percent, faster than the overall rate of growth in the economy.⁸ Similar annual rates of growth are projected through 2018.⁹ Steady annual increases in health care costs have placed upward pressure on the cost of health insurance: premiums grew at a rate of 5.5 percent in 2009 compared to average wage growth of 3.1 percent and a decline in consumer price inflation of 0.7 percent (Figure 7). The average annual cost of family coverage in employer-based health plans, including employer and employee contributions, topped \$13,375 in 2009.¹⁰ A

⁸ M. Hartman, A. Martin, P. McDonnell, et al., "National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998," *Health Affairs*, Jan./Feb. 2009 28(1):246-261.

⁹ A. Sisko, C. Truffer, S. Smith, et al., "Health Spending Projections Through 2018: Recession Effects Add Uncertainty to the Outlook," *Health Affairs* Web Exclusive (Feb. 24, 2009):w346-w357.

¹⁰ G. Claxton, B. DiJulio, Heidi Whitmore, et al., "Job-Based Health Insurance: Costs Climb at a Moderate Pace," *Health Affairs* Web Exclusive (September 15, 2009):w1002-1012.

recent analysis by the Commonwealth Fund found that at current cost trends, average family premiums in employer plans will nearly double by 2020 (Figure 8).¹¹

Employers have tried to hold their premiums by increasing employee cost sharing. In-network deductibles for single coverage in PPO plans have more than tripled since 2000, rising from \$187 to \$634 in 2009 (Figure 9). Among small companies with fewer than 200 employees, deductibles have risen by nearly a factor of five, climbing to an average \$1,040 in 2009.¹² Indeed the share of workers in all companies who had a deductible of \$1,000 or more climbed from 18 percent in 2008 to 22 percent in 2009. Copayments, which are paid by 77 percent of covered workers, rose by a small but statistically significant margin in 2009, increasing from \$19 to \$20 for a primary care physician visit and from \$26 to \$28 for a specialist visit. About 14 percent of covered workers pay coinsurance with the average for physician visits about 18 percent.

Adults who have health plans with deductibles of more than \$1,000 spend substantial amounts on out-of-pocket costs compared to those with lower deductible plans. In the 2007 Commonwealth Fund Biennial Survey, among adults who had a deductible of \$1,000 or more, 46 percent spent between \$1,000 and \$5,000 on health care costs, not including premiums, and 24 percent spent \$5,000 or more (Figure 10). In contrast, among adults with deductibles of less than \$500, one-third (34%) spent between \$1,000 and \$5,000 out-of-pocket and only 9 percent spent \$5,000 or more.

In a simulation analysis of employer based health plans, Jon Gabel and Roland McDevitt found that the actuarial value, or the percentage of total health spending paid by insurance, declined in employer plans nationally between 2004 and 2007, falling from an average 81.4 percent to 80.1 percent, a statistically significant drop.¹³ Over that period, expected out of pocket spending for all medical services by adults enrolled in employer plans increased on average by 34 percent, from \$545 to \$729. For the highest cost 1 percent of adults, expected out-of-pocket spending increased by 42 percent to

¹¹ C. Schoen, J. L. Nicholson, and S. D. Rustgi, *Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes—State Health Insurance Premium Trends and the Potential of National Reform*, The Commonwealth Fund, August 2009.

¹² The Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits, 2000 and 2009 Annual Surveys*; G. Claxton, B. DiJulio, Heidi Whitmore, et al., "Job-Based Health Insurance: Costs Climb at a Moderate Pace," *Health Affairs Web Exclusive* (September 15, 2009):w1002-1012.

¹³ J.R. Gabel, R. McDevitt, R.Lore, et al., "Trends in Underinsurance and The Affordability of Employer Coverage, 2004-2007," *Health Affairs Web Exclusive*, June 2, 2009:w595-w606.

\$8,703. Actuarial values are higher among people with chronic health problems or who become severely ill and have greater health expenses since they exceed their deductibles and out-of-pocket maximums.¹⁴ Still, people in the worst health often pay the most out-of-pocket for their health care. For example, Gabel and McDevitt found that while insurance paid 90.6 percent of an average \$66,000 bill for breast cancer treatment among patients in the study, those patients were still left with out-of-pocket expenses of \$6,250, the highest in the study. The study illustrates that despite the fact that actuarial values have not changed significantly over time, rapid growth in underlying health care costs have dramatically increased cost exposure among Americans with employer coverage.

Rising exposure to health care costs over the past decade has occurred at the same time that incomes for working families have grown very little. Despite the fact that the economy expanded between 2001 and 2007, real median incomes rose from \$51,356 in 2001 to \$52,163 in 2007, an increase of just 1.6 percent.¹⁵ And according to the most recent Census data, those meager gains were completely wiped out last year: real median incomes declined by 3.6 percent in 2008 to \$50,303, lower than the level ten years ago.

The combined effect of more expensive health care, greater cost-sharing and stagnant incomes has led to increasing numbers of privately insured Americans who are spending large shares of their income on health care. According to the Commonwealth Fund Biennial Health Insurance Surveys, between 2001 and 2007 the share of privately insured adults under age 65 who spent 10 percent or more of their income on health care costs including premiums and out-of-pocket costs climbed from 20 percent to 31 percent (Figure 11).¹⁶ By 2007, three in five (60%) privately insured adults with incomes under 200 percent of poverty were spending 10 percent or more of their incomes on health care costs and premiums up from 2 in 5 (40%) in 2001. Among privately insured adults with

¹⁴ Among adults in the study with five chronic health conditions including asthma, breast cancer, diabetes, and chronic obstructive pulmonary disease, employer based plans paid on average 84 percent of their claims cost.

¹⁵ A. Sherman, R. Greenstein, D. Trisi, et al., *Poverty Rose, Median Income Declined, and Job-Based Health Insurance Continued to Weaken in 2008*, Center on Budget and Policy Priorities, September 10, 2009, <http://www.cbpp.org/cms/index.cfm?fa=view&id=2914>.

¹⁶ S.R. Collins, J.L. Kriss, M.M. Doty, 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) August 2008.

incomes of 200% of poverty or more, one-quarter (25%) were spending 10 percent or more of their income on health care, an increase from 13 percent in 2001.

Adults With Individual Insurance Market Coverage Face Higher Health Care Costs Than Those with Employer Health Benefits

Employer based health benefits are the prevailing source of health insurance in the U.S. More than 160 million people, or more than 60 percent of the under 65 population have health benefits through an employer. Nearly all employers with more than 200 employees offer their employees coverage.¹⁷ Employers contribute on average 73 percent of family premiums and 84 percent of single policies. According to Gabel and McDevitt, employer plans cover an average 80 percent of medical expenses.¹⁸

The individual insurance market is usually the sole option for people who do not have access to employer coverage and whose incomes are too high to qualify for Medicaid, but it has proven to be a sorely inadequate substitute. This is because people who buy health insurance on their own must pay the full premium, and, in all but a handful of states, insurance carriers can underwrite prospective enrollees on the basis of health status, age, gender, and other characteristics that increase the potential for high claims costs in the future. A recent study by the Commonwealth Fund found that of adults who tried to purchase insurance in the individual market in the last three years, nearly three-quarters (73%) said they never bought a plan, either because they could not find a plan they could afford, they could not find a plan that met their needs, or they were turned down, charged a higher price or had a condition excluded from coverage because of a preexisting health problems (Figure 12).¹⁹

People who do purchase health insurance in the individual market pay far more out-of-pocket for their premiums, face much higher deductibles, face more limits on what their plans will pay, and spend larger shares of their income on premiums and out-of-pocket costs than their counterparts with employer-based group coverage. The

¹⁷ G. Claxton, B. DiJulio, Heidi Whitmore, et al., "Job-Based Health Insurance: Costs Climb at a Moderate Pace," *Health Affairs* Web Exclusive (September 15, 2009):w1002-1012.

¹⁸ J.R. Gabel, R. McDevitt, R.Lore, et al., "Trends in Underinsurance and The Affordability of Employer Coverage, 2004-2007," *Health Affairs* Web Exclusive, June 2, 2009:w595-w606.

¹⁹ M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*, The Commonwealth Fund, July 2009.

Commonwealth Fund Biennial Health Insurance Survey found that in 2007, of adults with coverage through the individual market, nearly two-thirds spent 5 percent or more of their income on premiums, more than two times the share of adults in employer plans who spent that much (Figure 13). Nearly one-third of adults in individual market plans spent \$6,000 or more on premiums compared to just 6 percent of people in employer plans (Figure 14). Despite spending more on premiums, nearly 40 percent of adults with individual market plans had per person deductibles of \$1,000 or more compared to just 11 percent of adults in employer plans. In addition, people with individual market plans were much more likely than people in employer plans to report that their health plan limited the total amount of medical expenses it would cover (49% vs. 38%), that a doctor had charged them more than their health plans would pay as they had to pay the difference (39% vs. 28%), or that they had expensive medical bills that were not covered by their health plans (36% vs. 27%) (Figure 15). Adults with individual market plans were also less likely than those in employer plans to have prescription drug or dental coverage. Consequently, half (51%) of adults with individual market plans spent more than 10 percent of their income on premiums and out-of-pocket expenses in 2007 compared to 29 percent of adults in employer plans (Figure 16).

Underinsured Adults are Nearly as Likely as Uninsured Adults To Not Get Needed Health Care Because of Cost

The purpose of health insurance is to provide timely and affordable access to care and to protect against the costs of catastrophic illnesses and injuries. However, the rising costs of health insurance and inadequate health insurance are straining limited family budgets and leaving people less protected. The Commonwealth Fund Biennial Health Insurance Survey asked respondents if in the last year, because of cost, they did not go to a doctor or clinic when sick; had not filled a prescription; skipped a medical test, treatment, or follow-up visit recommended by a doctor; or did not see a specialist when a doctor or the respondent thought it was needed. In 2007, more than 70 percent of adults who were uninsured at the time of the survey or spent some time uninsured in the past

year cited cost-related problems accessing needed health care (Figure 17).²⁰ Underinsured adults reported not getting needed care at rates that were nearly as high as those who were uninsured: three in five underinsured adults reported at least one cost-related problem getting care in 2007.

There is considerable evidence that exposure to costs can have a negative effect on the ability of adults with chronic conditions to effectively manage their diseases. The Commonwealth Fund Biennial Health Insurance Survey asked respondents whether a doctor had told them they had any one of four chronic conditions: high blood pressure; heart disease; diabetes; or asthma, emphysema, or other lung disease.²¹ In 2007, among adults with chronic health problems who regularly took prescription drugs, 64 percent who lacked insurance and 46 percent of those who were underinsured reported skipping doses of medications or not filling prescriptions for their chronic conditions because of cost (Figure 18). In contrast, only 15 percent of adults with chronic conditions who were insured all year with adequate health insurance reported skimping on their medications. The survey also found that adults with chronic health problems who were uninsured or underinsured reported seeking care in an emergency room, staying overnight in the hospital, or both, for their condition at higher rates than did those with adequate health insurance.

Other studies highlight the risks of greater cost-sharing in health plans. A study by John Hsu and colleagues of Medicare beneficiaries found that people whose drug benefits were capped had lower drug utilization than those whose benefits were not capped; the consequences were poorer adherence to drug therapy and worse control of blood pressure, lipid levels, and glucose levels.²² Moreover, cost savings from the cap were offset by increases in the costs of hospitalization and emergency room use. Similarly, a study by Robyn Tamblyn and colleagues found that increased cost-sharing reduced the use of both essential and nonessential drugs among elderly and poor patients, and it increased the risk of adverse health events like hospitalizations and admissions to

²⁰ S.R. Collins, J.L. Kriss, M.M. Doty, 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) August 2008.

²¹ About 34 percent, or an estimated 59.7 million adults in the Commonwealth Fund Biennial Health Insurance Survey, 2007, reported at least one chronic health problem.

²² J. Hsu et al., "Unintended Consequences of Caps on Medicare Drug Benefits," *New England Journal of Medicine* 354, 22 (June 1, 2006):2349-2386.

the emergency room.²³ A review by Thomas Rice and K.Y. Matsuoka of more than 20 studies examining the impact of cost-sharing on health care use and the health status of people age 65 and older found that increases in cost-sharing nearly always reduced the health care use and/or the health status of this population.²⁴

Underinsured Adults Report High Rates of Medical Bill Problems

The growing problem of uninsurance and underinsurance has not only exacted a heavy toll on the health of U.S. families, it has also exacted a similarly heavy toll on their finances. The Commonwealth Fund Biennial Health Insurance Survey found more than two of five (41%) adults under age 65, or 72 million people, reported problems paying medical bills in 2007, an increase from 34 percent, or 58 million people, in 2005.²⁵ Problems with medical bills included experiencing difficulty or inability to pay bills, being contacted by a collection agency concerning outstanding medical bills, changing your life significantly in order to pay bills, or paying off medical debt over time. Adults with gaps in health insurance coverage or those who were underinsured were most at risk of having problems with medical bills: in 2007 three of five reported any one medical bill problem or accrued medical debt, more than double the rate of those who had adequate insurance all year (26%) (Figure 19). Indeed, adults who were underinsured had the highest rates of medical debt: nearly half reported that they were paying off medical debt over time.

In the face of mounting medical bills and debt, many adults make stark trade-offs in their spending and saving priorities. Among adults who reported any problems with medical bills or accumulated debt in 2007, nearly one of three (29%) said they had been unable to pay for basic necessities like food, heat, or rent because of medical bills; nearly two of five (39%) had used all their savings; one of three (30%) had taken on credit card

²³ R. Tamblyn et al., "Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Person," *JAMA* 285, no. 4 (2001): 421–429.

²⁴ T. Rice and K. Y. Matsuoka, "The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors," *Medical Care Research and Review* 16 (Dec. 2004): 415–452.

²⁵ S.R. Collins, J.L. Kriss, M.M. Doty, 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) August 2008; M.M. Doty, S.R. Collins, S.D. Rustgi, J.L. Kriss, *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by Families* (New York: The Commonwealth Fund) August 2008.

debt; and one-tenth (10%) had taken out a mortgage against their home (Figure 20). Rates of reported trade-offs were especially high among people who had spent any time uninsured or those underinsured. Nearly half of adults who had spent any time uninsured and reported medical bill problems had used all their savings to pay for their medical bills and two of five were unable to pay for food, heat, or rent. Underinsured adults made similar trade-offs: 46 percent said they had used all their savings, 33 percent took on credit card debt, and 29 percent were unable to pay for basic life necessities.

America's Health Choices Act (H.R. 3200) and the Problem of Underinsurance

The America's Health Choices Act (H.R. 3200) aims to provide near-universal health insurance coverage by building on the strongest aspects of the insurance system – large employer insurance and Medicaid and CHIP – and regulating and reorganizing the weakest part of the system – the individual and small group insurance markets – where so many small businesses and individuals are hurt by high premiums, high administrative costs, underwriting, and a lack of transparency in the content of benefit packages (Figure 21). The bill would establish new federal rules that require all insurance carriers selling policies in all markets to accept every individual and employer that applied for coverage (guaranteed issue) and prevents carriers from setting premiums based on health status (adjusted community rating). The bill would create a new health insurance exchange which is an organized marketplace managed and regulated by government in which eligible individuals and businesses can choose among health plans (private, public, or nonprofit co-operative plans) that meet the requirements of participation set by the exchange.²⁶ Premium subsidies would be available on a sliding scale to offset the costs of plans purchased through the exchange. A minimum standard benefit package with cost-sharing tiers would set a floor for plans offered through the exchange. Income eligibility for Medicaid and CHIP would be expanded up to 133 percent of poverty. Individuals would be required to have coverage, and large employers would be required to either offer coverage or contribute to the cost of their employees' insurance.

²⁶ P. B. Ginsburg, "Employment-Based Health Benefits Under Universal Coverage," *Health Affairs*, May/June 2008 27(3):675–85.

Reducing Uninsurance and Underinsurance

The bill would go a long way towards reducing the problem of uninsurance in the United States. The Congressional Budget Office estimates that by 2019 the number of people without health insurance would fall to 17 million, from an estimated 54 million people, or about 97 percent of legal residents (the bill does not cover illegal immigrants) (Figure 22).

Several provisions in the bill would also likely reduce the number of people who are underinsured and the numbers of people who accumulate medical debt each year. The bill replaces the individual insurance market with a regulated insurance exchange operated at the federal level with a choice of both private and public health plans. The new market regulations would extend to all health plans sold in the United States. Guaranteed issue and adjusted community rating with 2:1 age bands would insure that people in poor health or who are older could not be denied coverage, charged a higher price or have a condition excluded from coverage because of a pre-existing condition. Insurance carriers could not impose annual or lifetime limits on what plans would pay and would be prohibited from the use of rescissions except in cases where there is “clear and convincing evidence of fraud.” This set of consumer protections alone would be a vast improvement over the current situation in most states for people seeking coverage in the individual market.

In addition to new market regulations, the bill would establish a new minimum benefit standard with four tiers (Figure 23). Annual out-of-pocket spending in the essential benefits package is limited to \$5,000 for individuals and \$10,000 for families. Such standards will ensure that consumers have comprehensive health plans that both encourage the use of timely preventive services and protect against catastrophic costs in the event of a serious accident or injury. Standardized benefits will also facilitate the ability of consumers to compare prices of similar health plans and provide incentives for insurers to compete on price.²⁷ Uniform standards across markets will also prevent adverse selection into the exchange by people who are sicker, provide transparency of information for people purchasing coverage through the exchange, and ensure that the

²⁷ L.J. Blumberg and K. Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals* (Washington, D.C.: The Urban Institute) April 2009

cost of premium subsidies to the federal government doesn't vary by the type of benefit package offered. The requirement that employers provide at least the basic benefit package ensures equity and provides a benchmark for the enforcement of the employer requirement to offer coverage.

While keeping the benefit package constant, the bill defines four tiers by actuarial value, or the average share of medical expenses covered by a health plan: 70 percent (basic), 85 percent (enhanced), and 95 percent (premium and premium plus, which also includes oral and vision care). Cost sharing could include a combination of deductibles, coinsurance and out-of-pocket limits. For comparison, the average actuarial value in employer based plans is an estimated 80 percent and about 84-87 percent for the Blue Cross Blue Shield Standard Option in the Federal Employees Health Benefits Program.²⁸ In Medicare, a forthcoming Commonwealth Fund analysis by Gabel and McDevitt finds that actuarial value ranges from an estimated 64 percent for Medicare Parts A and B to 90 percent for Medicare Parts A,B,D, and a supplemental (Medigap) policy.²⁹

The bill importantly specifies a minimum standard benefit package even though cost sharing is allowed to vary. Allowing tiering by actuarial equivalence (i.e. defining benefit levels by the share of expenses covered by an insurance policy) can lead to substantial product differentiation with very different implications for enrollees of different health status and thus confusion during the enrollment process.³⁰ But variation just by cost sharing can also lead to a proliferation of plan options and different levels of protection from out of pocket costs even within the same cost sharing category, while presenting the possibility of selection into plans that would offer greater cost protection for people with health problems.³¹

²⁸ J.R. Gabel, R. McDevitt, R.Lore, et al., "Trends in Underinsurance and The Affordability of Employer Coverage, 2004-2007," *Health Affairs* Web Exclusive, June 2, 2009:w595-w606; J. Gabel, R. McDevitt, R. Lore, et al., *Comparing Medicare's Benefit Package with the Blue Cross Blue Shield Standard Option Federal Employees' Plan*, The Commonwealth Fund, forthcoming November 2009.

²⁹ J. Gabel, R. McDevitt, R. Lore, et al., *Comparing Medicare's Benefit Package with the Blue Cross Blue Shield Standard Option Federal Employees' Plan*, The Commonwealth Fund, forthcoming November 2009.

³⁰ American Academy of Actuaries, *Critical Issues in Health Reform: Actuarial Equivalence* (May 2009); N. Turnbull, Health Insurance Connectors: Lessons from Massachusetts, Presentation at the Alliance for Health Reform and Commonwealth Fund Briefing on Health Insurance Exchanges: See How They Run, May 11, 2009; Alliance for Health Reform and Commonwealth Fund Briefing on Health Insurance Exchanges: See How They Run, Transcript, May 11, 2009

³¹ American Academy of Actuaries, *Critical Issues in Health Reform: Actuarial Equivalence* (May 2009)

It is important to note that actuarial values are averages. Actuarial value, as well as out of pocket spending will vary by the medical expenses incurred by the policy holder and by the combination of deductibles, out of pocket maximums and co-insurance in the policy. While actuarial values of health plans will generally rise among people with chronic health problems as they exceed their deductibles and out-of-pocket maximums, the Gabel and McDevitt analysis shows that people in poor health often pay more out of pocket for their health care.³² The authors estimated the number of people in employer-based plans with incomes under 200 percent of poverty who could expect to spend 5 percent of more of their income on out-of-pocket expenses, excluding premiums. They found that about 20 percent would exceed the 5 percent threshold. But nearly all those with the highest medical claims costs (top 1% of the spending distribution) would spend more than 5 percent of their income on out-of-pocket costs, while no one in the bottom 50 percent of the spending distribution would exceed the threshold.³³ Similarly, more than 80 percent of people with incomes at 400 percent of the poverty level who were in the top 1 percent of the spending distribution would spend more than 10 percent of their income on out-of-pocket expenses, excluding premiums.

The premium subsidies and cost-sharing credits in H.R. 3200 will substantially improve the affordability and protection of health plans offered through the new exchange. The premium subsidies cap spending on premiums at no more than 1.5 percent of income for those earning 133 percent of poverty or \$29,327 for a family of four and rise to no more than 12 percent of income for those with incomes at 400 percent of poverty, or about \$88,200 for a family of four in 2009. People earning less than 133 percent of poverty are eligible for Medicaid. Using the Kaiser Health Reform Subsidy Calculator, annual premiums for single adults earning less than 400% of poverty would range from \$487 per year for those earning 150% of poverty to \$1,191 for people earning 200 percent of poverty to a high of about \$3,200 for those earning 300% of poverty (Figure 24).³⁴ People earning between 300-400 percent of poverty who are living in areas

³² J.R. Gabel, R. McDevitt, R.Lore, et al., "Trends in Underinsurance and The Affordability of Employer Coverage, 2004-2007," *Health Affairs* Web Exclusive, June 2, 2009:w595-w606.

³³ J.R. Gabel, R. McDevitt, R.Lore, et al., "Trends in Underinsurance and The Affordability of Employer Coverage, 2004-2007," *Health Affairs* Web Exclusive, June 2, 2009:w595-w606.

³⁴ Kaiser Health Reform Subsidy Calculator – Premium Assistance for Coverage in Exchanges/Gateways, Kaiser Family Foundation, <http://healthreform.kff.org/Subsidycalculator.aspx>

of the country with high medical costs and who are older, given the 2:1 age bands, would particularly benefit from the premium subsidies in that income range. For people exceeding the subsidy thresholds, premiums would be higher for older people and those living high cost areas.³⁵ For example, annual premiums for 60 year olds with incomes exceeding the subsidy thresholds could range from \$5,000 to about \$7,600 compared to \$2,500 to \$3,800 for 20 year olds who exceed the subsidy thresholds.

The cost-sharing credits will significantly reduce out-of-pocket expenses for people with incomes under 350 percent of poverty. Costs covered by the basic plan (or its actuarial value) would rise from 70 percent to 97 percent for those earning 133-150 percent of poverty, 93 percent for those earning 150-200 percent of poverty, 85 percent for those earning 200-250 percent of poverty, 78 percent for those earning 250-300 percent of poverty and 72 percent for those with incomes between 300-350 percent of poverty.

Reducing Health Care Costs and Premiums and the Importance of a Public Option

For people whose incomes exceed the income thresholds for subsidies, premium costs will likely decline from current levels because of a decrease in administrative costs due to restrictions on underwriting and reduced marketing and because of savings achieved through reduced provider payments and profits if a public option is included in the exchange. In addition, the House bill calls for a review of any health plan participating in the exchange whose premium increases exceed 150 percent of the medical inflation rate. Private insurance premiums more than doubled over the last decade, and they are projected to double again by 2020. If premiums had increased annually at even 150 percent of medical inflation from 1999 to 2008, family premiums would have been \$2,600 lower in 2008.³⁶ A Commonwealth Fund analysis finds that slowing premium growth by 1.0 percentage points annually would save \$2,571 in 2020

³⁵ L.J. Blumberg, M. Buettgens, B. Garrett, *Age Rating Under Comprehensive Health Reform: Implications for Coverage Costs, and Household Financial Burdens*, Urban Institute, October 2009.

³⁶ K. Davis, S. R. Collins, R. Nuzum, and C. Schoen, *On the Road to a High Performance Health System: Changing Course and Making History*, Invited Presentation, Forum on the Urgent Need for Health Care Reform, U.S. House of Representatives Steering and Policy Committee, September 15, 2009

family premiums; slowing it by 1.5 percentage points, as pledged by an industry coalition, would save \$3,759 for the average family in 2020.³⁷

The insurance exchange should allow consumers a choice of both private and public health plans for at least three reasons. First, public insurance plans operate with significantly lower administrative overhead than private plans and do not have profit margins imbedded in their premiums as private for-profit plans do. Administrative costs in the Medicare program, for example, are estimated to account for 2 to 5 percent of premiums compared to 25 to 40 percent of premiums in the individual insurance market.³⁸ This means that public plan premiums may be lower relative to private plans, providing an incentive for competing private plans to minimize costs. This would reduce the cost of premiums for people who do not qualify for premium subsidies and the cost of subsidies to the federal government and potentially help to lower the rate of overall cost growth in the health system.³⁹ Second, extensive consolidation in both insurance markets and hospital markets across the country has substantially reduced price competition in both markets.⁴⁰ There are only three states in the U.S. where the two largest health plans dominate less than 50 percent of the market. (Figure 25). If insurance companies are unable to negotiate lower rates with providers, the lack of competition in insurance markets means that carriers can pass on costs to employers and consumers in the form of higher premiums.

A public plan would enable the federal government to lower premium costs by setting provider rates for the public plan between Medicare and commercial rates. This ability of the public plan to set rates would stimulate competition in both provider and insurance markets. This would lower premiums and thus federal premium subsidies, and has the potential to lower overall health care cost inflation. Third, the public plan option

³⁷ C. Schoen, J. L. Nicholson, and S. D. Rustgi, *Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes—State Health Insurance Premium Trends and the Potential of National Reform*, The Commonwealth Fund, August 2009.

³⁸ McKinsey Global Institute, *Accounting for the Cost of U.S. Health Care: A New Look at Why Americans Spend More*, Dec. 2008.

³⁹ C. Schoen, K. Davis, S. Guterman, and K. Stremikis, *Fork in the Road: Alternative Paths to a High Performance Health System* (New York: The Commonwealth Fund, June 2009); S.R. Collins, R. Nuzum, S.D. Rustgi, et al., *How Health Reform can Lower the Costs of Insurance Administration* (New York: The Commonwealth Fund) July 2009.

⁴⁰ J. Holohan and L. Blumberg, *Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?* (Washington, D.C.: The Urban Institute) 2008.

within the exchange would enable the development and proliferation of innovative provider payment reforms that reward quality and efficiency beyond those efforts currently underway in the Medicare program. This dynamic could encourage similar innovations among carriers, and provide a competitive edge to integrated delivery systems that are already pursuing new models of patient-centered care coordination, disease management, and payment reform. CBO estimates that a public plan along the lines of that described in the House Ways and Means Committee bill would lower premiums by 10 percent, enrolling about 10 million people (Figure 26).

Health System Reforms

One of the major factors driving the increase in the number of people who are underinsured is the nation's rapid rate of growth in health care costs. In addition to insurance market regulations, benefit standards, premium and cost sharing subsidies, a choice of a public plan in the exchange, reducing out-of-pocket costs will also require national reforms aimed at improving the overall performance of the health system.

The House bill includes key provisions for improving health system performance and lowering the rate of cost growth including investing in primary care; replacing the current Sustainable Growth Rate (SGR) formula for updating physician fees; adjusting for geographic variations; piloting programs for rapid-cycle testing of innovative payment methods, including medical homes, accountable care organizations, and bundled hospital payments; ensuring choice of private and public plans; containing costs, including limiting premium increases in the exchange; and fostering quality improvement (Figure 27). The provisions would affect both the way we pay for care by giving providers an incentive to deliver high-value care, and the rate of increase in cost over time by requiring on-going productivity improvements. These provisions, in combination with provisions of the American Recovery and Reinvestment Act of 2009, would enhance the value obtained for health spending and set in motion reforms to slow the growth in health care costs over the long term.⁴¹ Specifically:

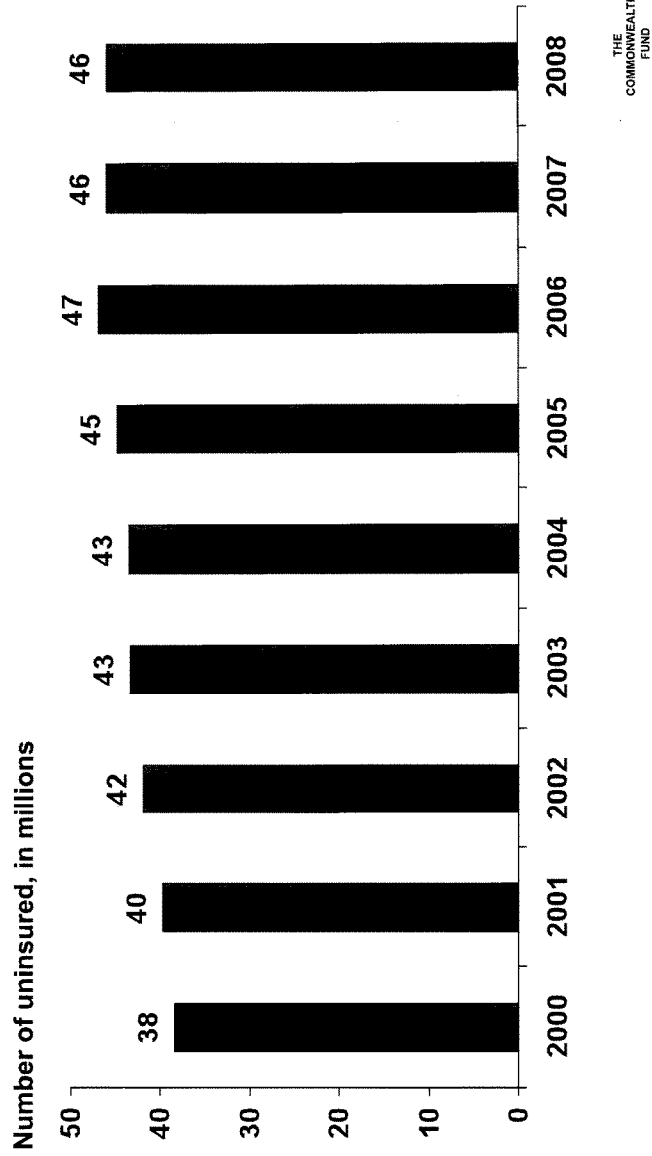
⁴¹ K. Davis, S. R. Collins, R. Nuzum, and C. Schoen, On the Road to a High Performance Health System: Changing Course and Making History, Invited Presentation, Forum on the Urgent Need for Health Care Reform, U.S. House of Representatives Steering and Policy Committee, September 15, 2009

- Investments in primary care, pilot programs to test new payment methods, and using the purchasing leverage of Medicare and a new public health insurance plan to slow health care spending growth would all help bend the health system cost curve over the long-run. Annual productivity improvements of one percentage point a year are assumed to be possible for providers to achieve, given the reductions in bad debt and charity care and given the opportunity to share in the savings gained from preventing avoidable hospitalizations and hospital readmissions, controlling chronic conditions, and eliminating ineffective and duplicative care.
- The House bill emphasizes the importance of prevention and wellness by eliminating any cost-sharing for preventive services in Medicare and increasing Medicare payments for key preventive services.
- Additional Medicare spending would come from resetting the SGR formula for updating physician fees—\$245 billion over the period 2010 to 2019 (including interactions with other provisions). Major new savings come from the productivity improvement requirement and other changes in provider payment updates (\$200 billion) and correcting Medicare Advantage payment rates (\$172 billion).
- The net effect would be \$448 billion of savings before the revision of the SGR formula, and \$219 billion after making this adjustment (Figure 28). Including the SGR payments in the baseline projection yields an 8.0 percent annual growth rate in federal health expenditures over the 2010–2019 period, up from 7.6 percent under current law. Applying the other net savings would bend the Medicare spending cost curve and reduce the annual growth rate to 7.3 percent.

With working families in crisis from a combination of declining job, income, and health security, the time has never been more urgent for policymakers to find consensus and forge ahead on implementing solutions to the nation's worsening health insurance problem, while placing the health care system on a path to high performance.

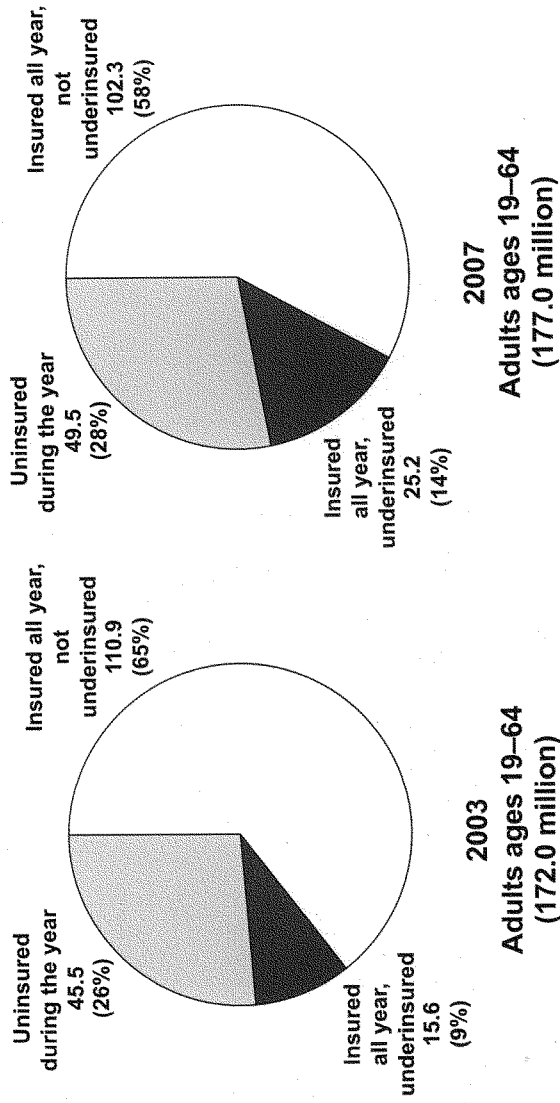
Thank you.

**Figure 1. 46 Million Uninsured in 2008;
Increase of 7.9 Million Since 2000**



Source: U.S. Census Bureau, March Current Population Survey, 2001–2009.

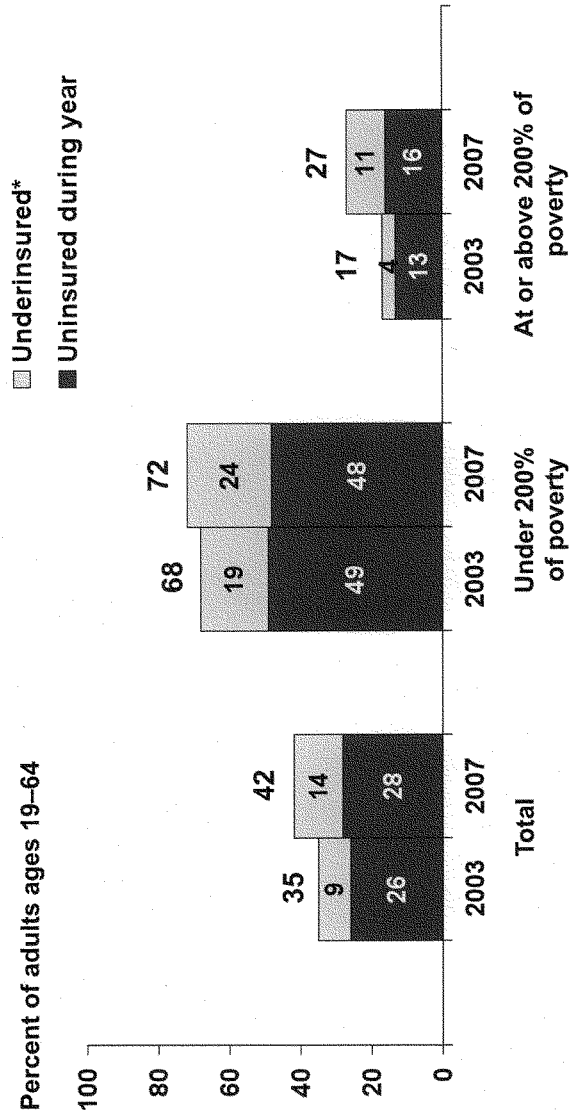
**Figure 2.25 Million Adults Underinsured in 2007,
Up from 16 Million in 2003**



*Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.
 Source: C. Schoen, S. R. Collins, J. L. Kriss, and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008. Data: Commonwealth Fund Biennial Health Insurance Surveys (2003 and 2007).

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Figure 3. Half of Adults with Low Incomes Lack Coverage During the Year; Another Quarter Are Underinsured



*Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.

Source: C. Schoen, S. R. Collins, J. L. Kriss, and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008. Data: Commonwealth Fund Biennial Health Insurance Surveys (2003 and 2007).

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Figure 4. Underinsured Adults are More Likely to Have Health Plans With Coverage Limits; Less Likely to Have Dental Coverage

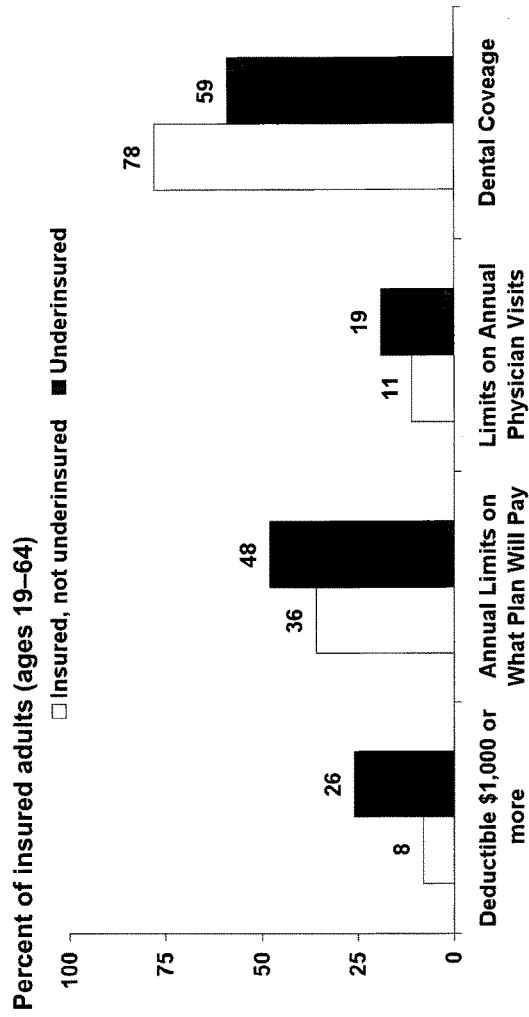
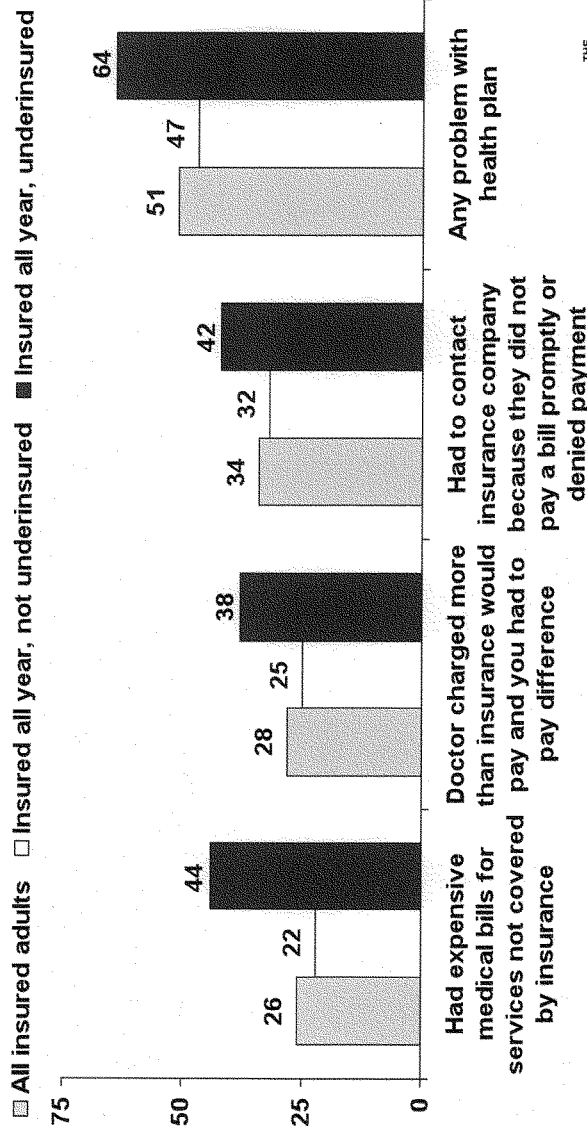


Figure 5. Underinsured Adults Report Higher Rates of Health Insurance Plan Problems than Adults with Adequate Insurance

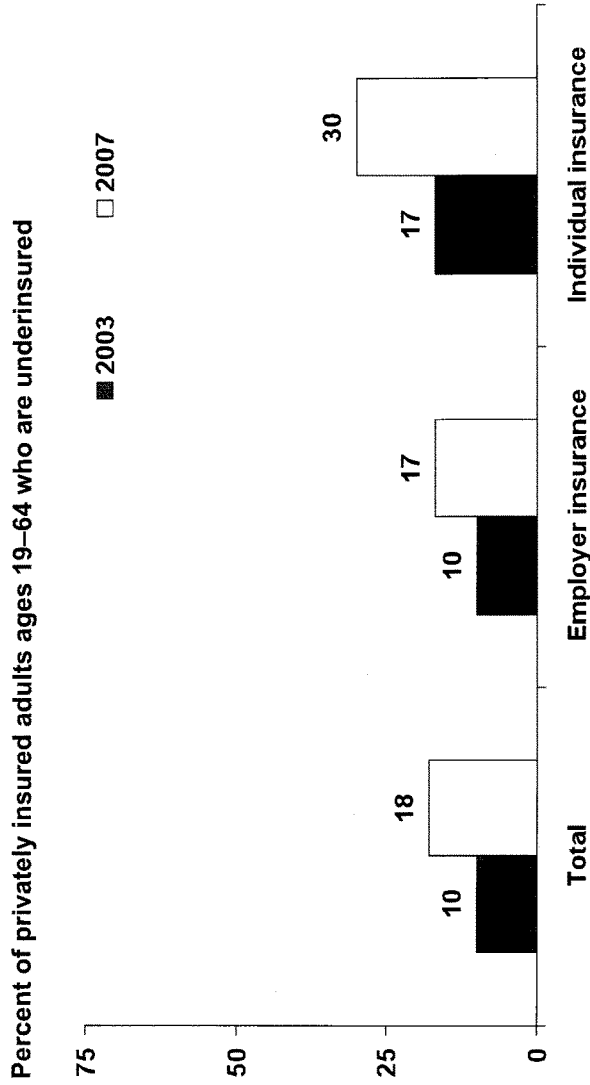
Percent of adults ages 19–64 who were insured all year and had problems with health insurance plan



Source: 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, The Commonwealth Fund, August 2008.

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Figure 6. Adults with Plans Purchased on the Individual Insurance Market Are More Likely to Underinsured Than Those with Employer Coverage



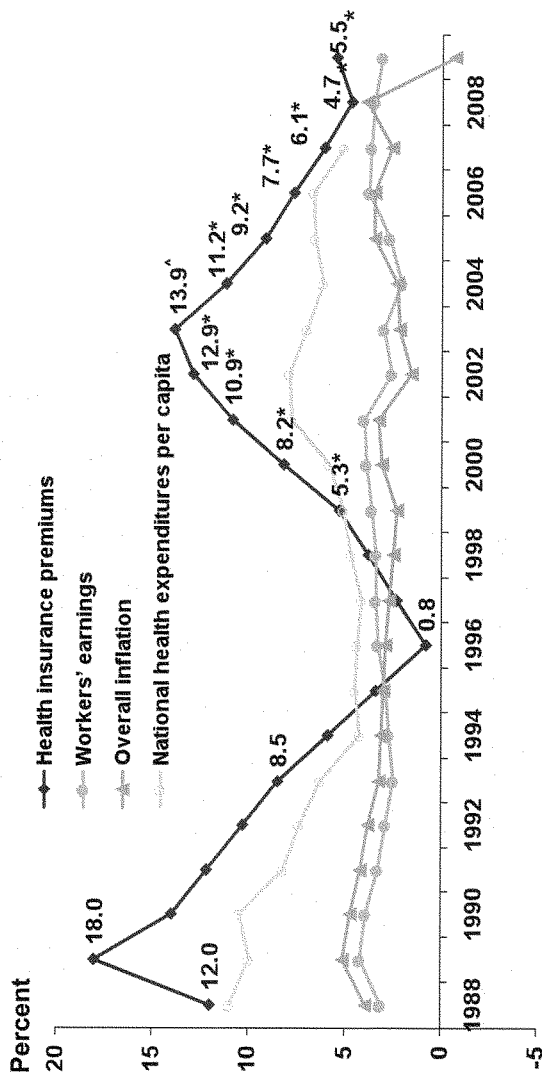
Notes: Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.

Adults continuously insured all year with employer-sponsored insurance or individual insurance.

Source: M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families, The Commonwealth Fund, July 2009.

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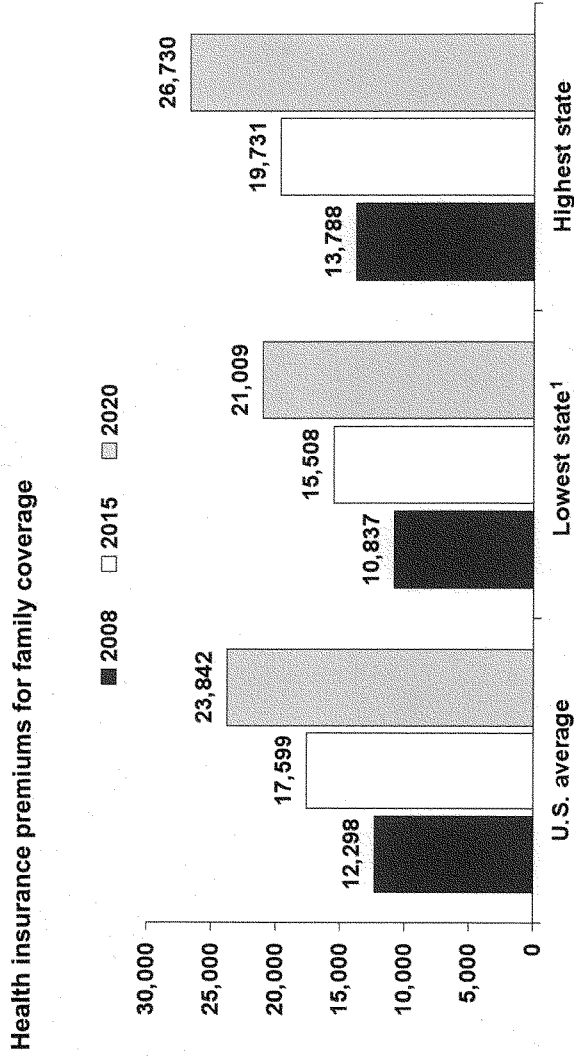
Figure 7. Increases in Health Insurance Premiums Compared with Other Indicators, 1988–2009



* Estimate is statistically different from the previous year shown at $p < 0.05$.
 ^ Estimate is statistically different from the previous year shown at $p < 0.1$.
 Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. Historical estimates of workers' earnings have been updated to reflect new industry classifications (NAICS).
 Source: Premiums: Henry J. Kaiser Family Foundation/Health Research and Educational Trust Survey of Employer-Sponsored Health Benefits, 1999–2007, and KPMG Survey of Employer-Sponsored Health Benefits, 1993 and 1996. Inflation: Bureau of Labor Statistics, Consumer Price Index (U.S. City Average of Annual Inflation, April to April), 1993–2009. Earnings: Bureau of Labor Statistics, seasonally adjusted data from the Current Employment Statistics Survey (April to April), 1993–2009. NHE: A. Cisko, C. Truffer, S. Smith, et al., "Health Spending Projections Through 2018: Recession Effects Add Uncertainty To The Outlook," *Health Affairs*, 28, no. 2 (2009): w346-w357.

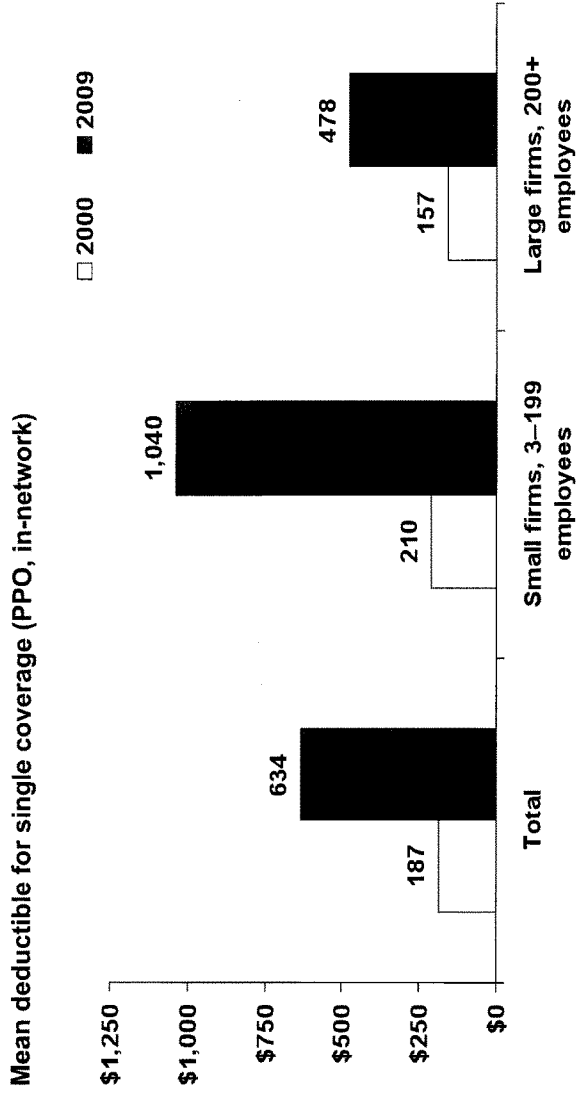
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Figure 8. Projected Premiums for Family Coverage, 2008, 2015, 2020



¹The lowest state is Idaho; highest state is Massachusetts.
 Data: 2008 premium data from Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2008 Medical Expenditure Panel Survey-Insurance Component; Premium estimates for 2015 and 2020 based on CMS, Office of the Actuary, National Health Statistics Group, national health expenditures per capita annual growth rate.
 Source: C. Schoen, J.L. Nicholson, S.D. Rustgi, *Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes, State-by-State Health Insurance Premium Projections With and Without National Reform* (New York: The Commonwealth Fund) August 2009.

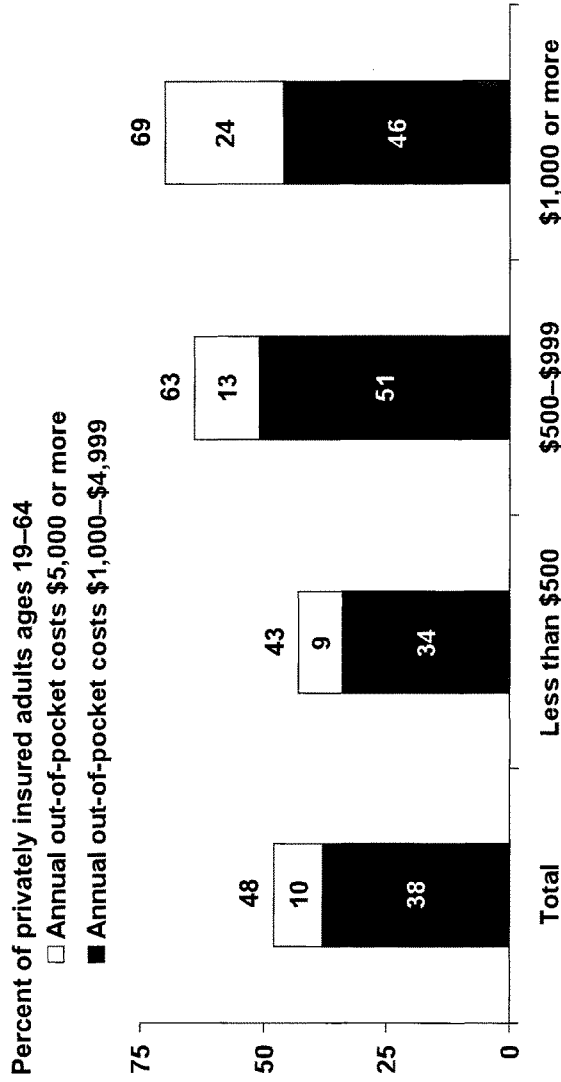
Figure 9. Deductibles Rise Sharply, Especially in Small Firms, 2000–2009



PPO = preferred provider organization. PPOs covered 57 percent of workers enrolled in an employer-sponsored health insurance plan in 2007.
 Source: The Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits*, 2000 and 2009 Annual Surveys.

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Figure 10. Adults with Higher Deductibles Are More Likely to Spend \$1,000 or More on Family Out-of-Pocket Expenses, 2007

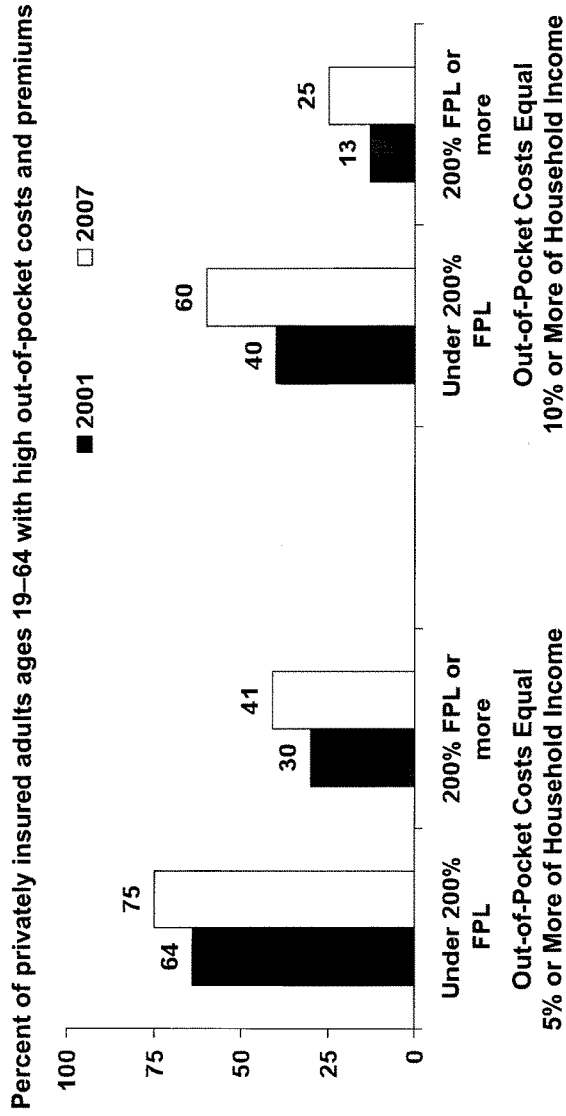


Annual Deductible

Notes: Family out-of-pocket expenses include out-of-pocket spending on medical care, prescription drugs, and dental and vision care. Does not include premium costs. Numbers may not sum because of rounding. Adults continuously insured all year with employer-sponsored insurance or individual insurance. Source: M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families, The Commonwealth Fund, July 2009.

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**Figure 11. Increasing Shares of Adults Across the Income Scale
Are Spending Large Amounts of Income
on Out-of-Pocket Costs and Premiums, 2001–2007**



Notes: Family out-of-pocket costs include all medical expenses, premiums, and prescription drug spending. Adults continuously insured all year with employer-sponsored insurance or individual insurance. FPL = Federal Poverty Level.
Source: M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families, The Commonwealth Fund, July 2009.

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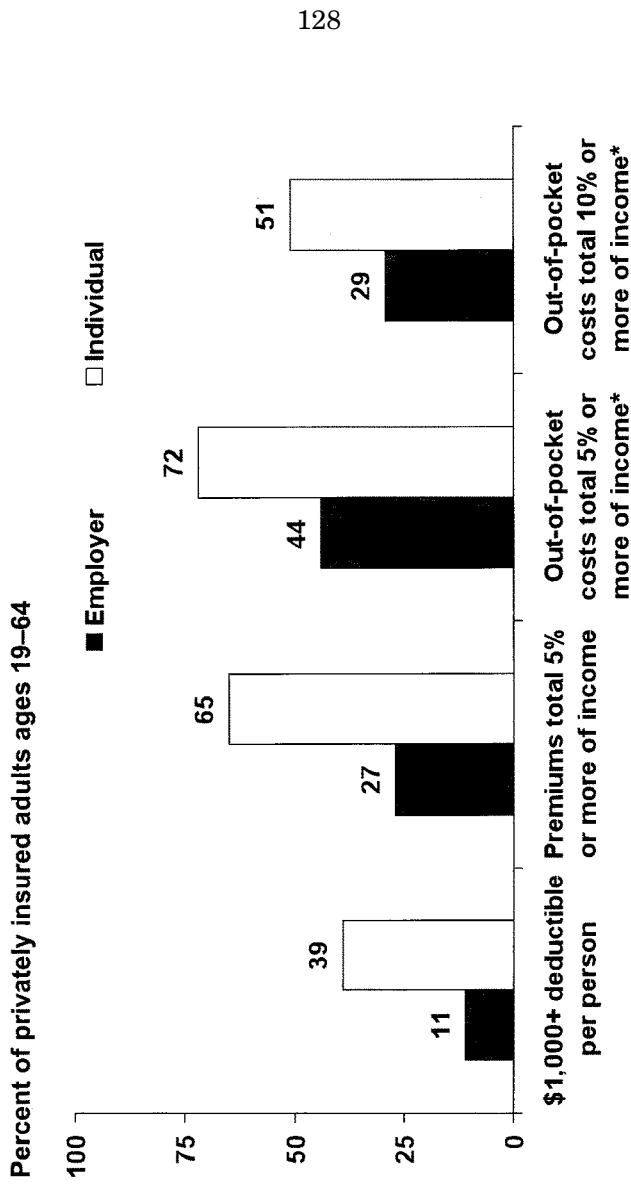
**Figure 12. The Individual Insurance Market
Is Not an Affordable Option for Many People**

Adults ages 19–64 with individual coverage or who tried to buy it in past three years who:	Total	Health problem	No health problem	<200% FPL*	200%+ FPL*
Found it very difficult or impossible to find coverage they needed	47%	60%	35%	52%	40%
Found it very difficult or impossible to find affordable coverage	57	70	45	63	53
Were turned down, charged a higher price, or excluded because of a preexisting condition	36	47	26	39	34
Never bought a plan	73	79	66	85	62

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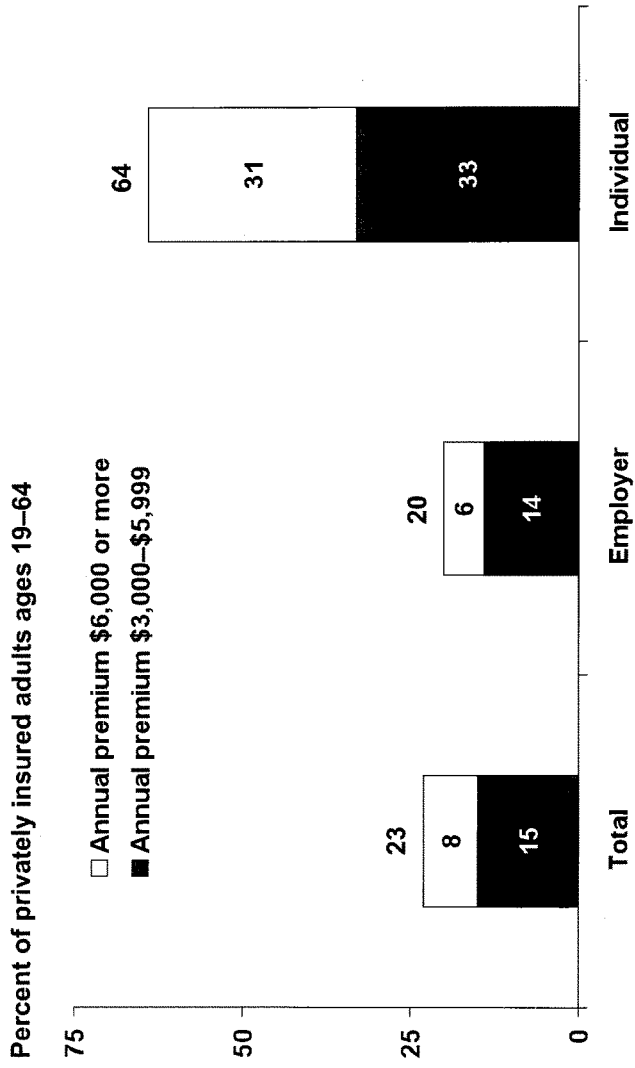
* FPL = federal poverty level.
Source: M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families, The Commonwealth Fund, July 2009.

Figure 13. Deductibles, Premium Costs, and Out-of-Pocket Spending Are Higher for Adults with Individual Insurance, 2007



* Out-of-pocket costs include all medical expenses, premiums, and prescription drug spending.
 Note: Adults continuously insured all year with employer-sponsored insurance or individual insurance.
 Source: M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families, The Commonwealth Fund, July 2009.

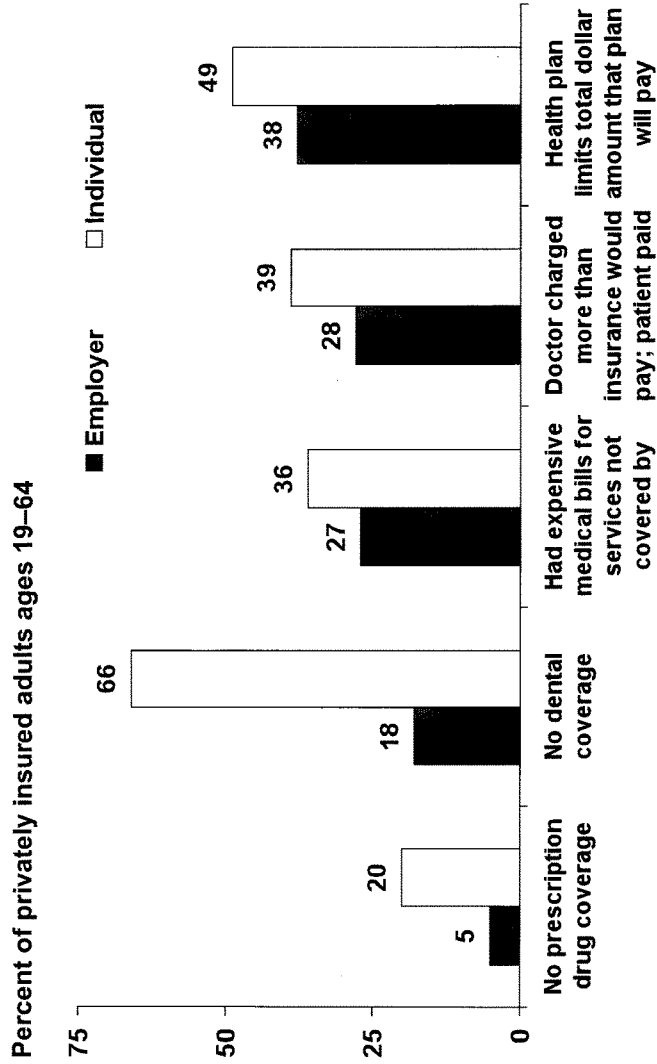
Figure 14. More than Three of Five Adults with Individual Market Coverage Have Annual Premium Costs of \$3,000 or More, 2007



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Note: Adults continuously insured all year with employer-sponsored insurance or individual insurance.
Source: Commonwealth Fund Biennial Health Insurance Survey (2007).

Figure 15. Individual Insurance Plans Are More Likely to Limit Benefits and Require Greater Cost-Sharing in 2007

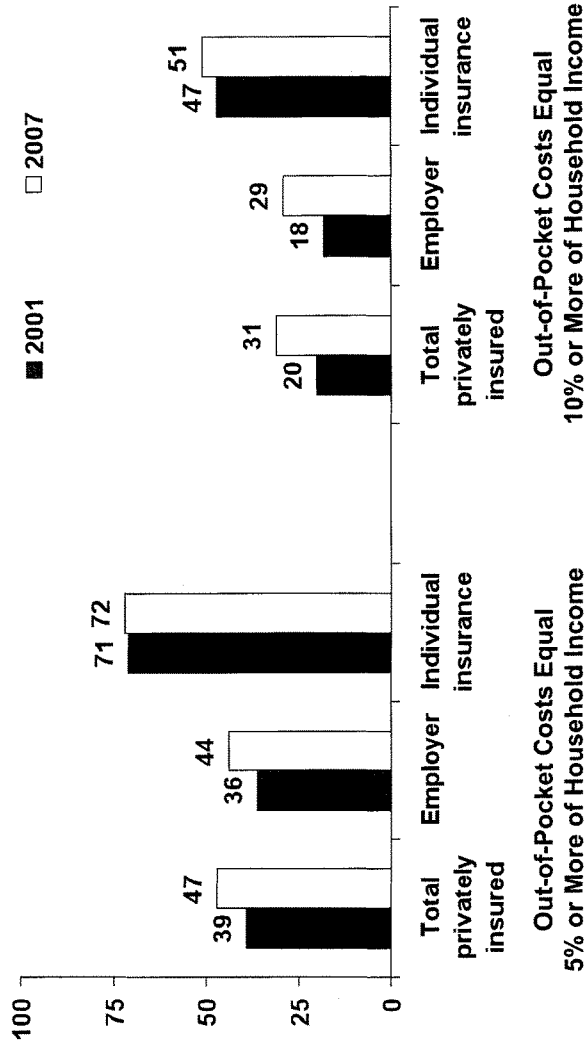


Note: Adults continuously insured all year with employer-sponsored insurance or individual insurance.
 Source: M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families, The Commonwealth Fund, July 2009.

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Figure 16. More Privately Insured Adults Are Spending Large Amounts of Income on Out-of-Pocket Costs and Premiums, 2001–2007

Percent of privately insured adults ages 19–64 with high out-of-pocket costs and premiums



Notes: Family out-of-pocket costs include all medical expenses, premiums, and prescription drug spending. Adults continuously insured all year with employer-sponsored insurance or individual insurance.
 Source: M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families, The Commonwealth Fund, July 2009.

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Figure 17. Uninsured and Underinsured Adults Report High Rates of Cost-Related Access Problems

Percent of adults ages 19–64 who had cost-related access problems in the past 12 months

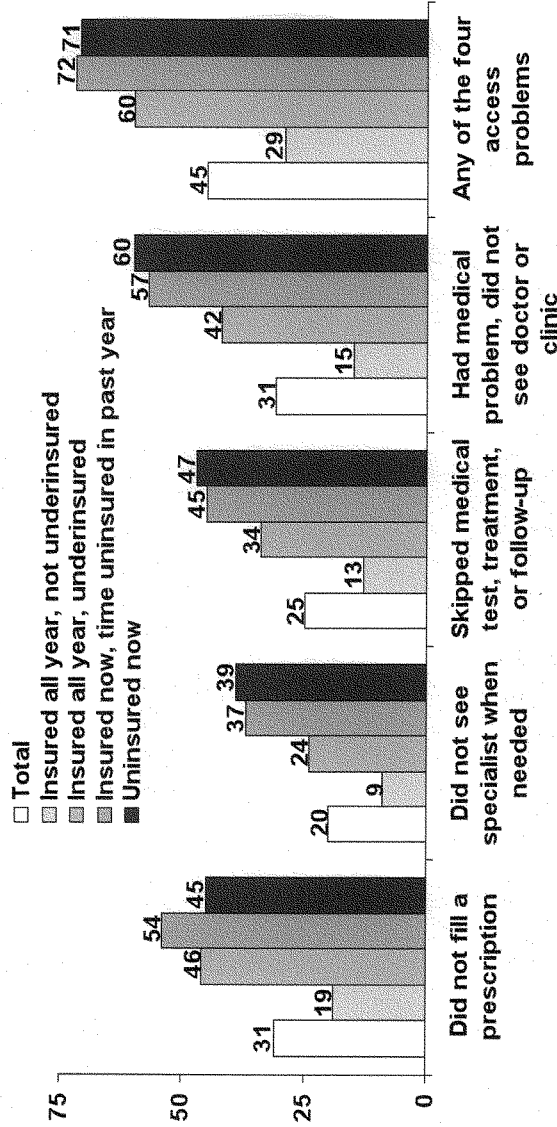
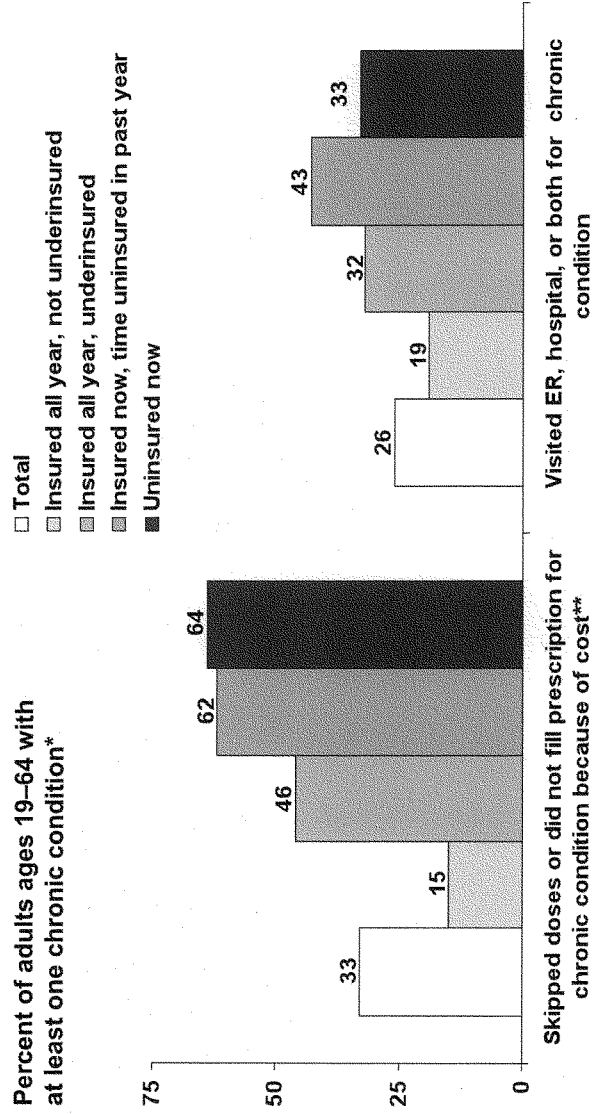


Figure 18. Uninsured and Underinsured Adults with Chronic Conditions Are More Likely to Visit the ER for Their Conditions



*Hypertension, high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease.

**Adults with at least one chronic condition who take prescription medications on a regular basis.

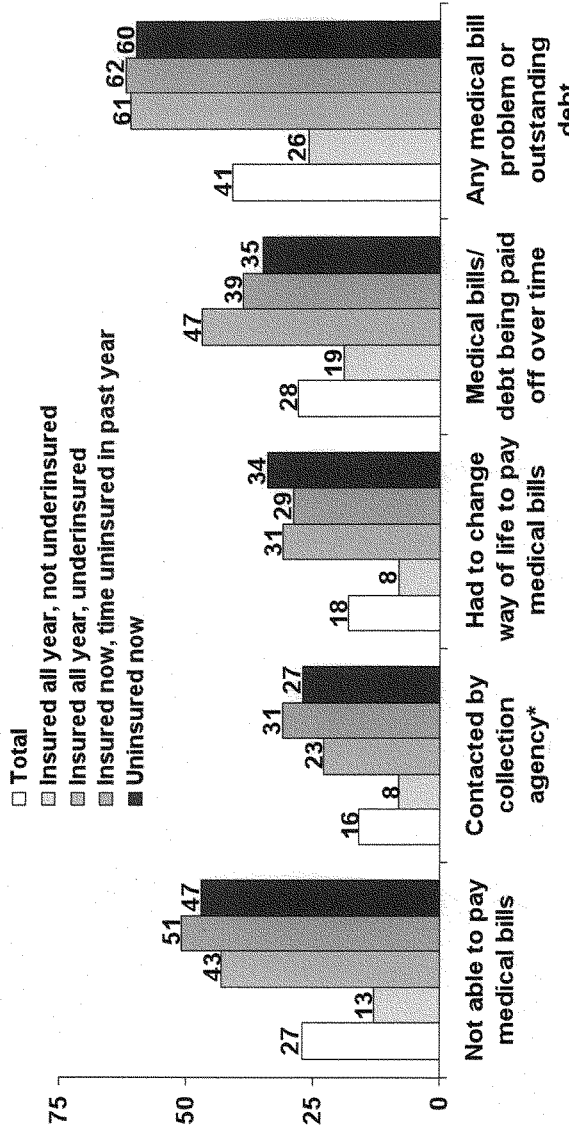
Source: S. R. Collins, J. L. Kriss, M. M. Doty, and S. D. Rusigi, Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance

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Surveys, 2001–2007, The Commonwealth Fund, August 2008.

Figure 19. Sixty Percent of Underinsured or Uninsured Adults Reported Medical Bill Problems or Debt

Percent of adults ages 19–64 with medical bill problems or accrued medical debt



*Includes only those individuals who had a bill sent to a collection agency when they were unable to pay it.
 Source: 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, The Commonwealth Fund, August 2008.

Figure 20. More Than One-Quarter of Adults Under Age 65 with Medical Bill Burdens and Debt Were Unable to Pay for Basic Necessities

Percent of adults reporting:	Insured All Year		Uninsured Anytime During Year	
	Total	No underinsured indicators	Insured now, time uninsured in past year	Uninsured now
Percent of adults ages 19–64 with medical bill problems or accrued medical debt				
Unable to pay for basic necessities (food, heat, or rent) because of medical bills	29%	16%	42%	40%
Used up all of savings	39	26	46	47
Took out a mortgage against your home or took out a loan	10	9	11	11
Took on credit card debt	30	28	34	26
Insured at time care was provided	61	80	82	24

Source: 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, The Commonwealth Fund, August 2008.

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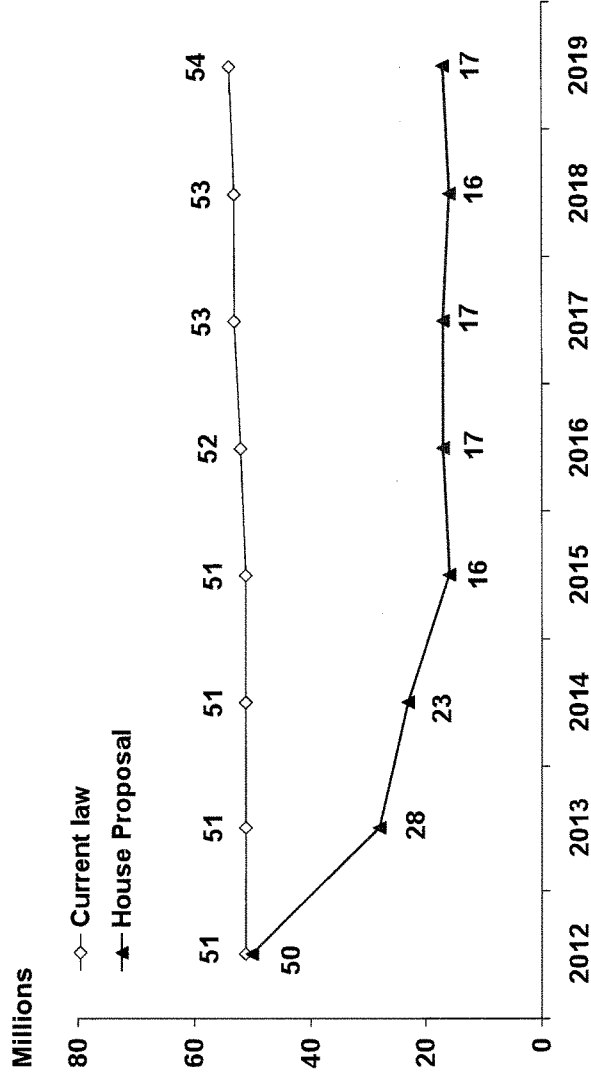
Figure 21. America's Health Choices Act (H.R. 3200) As Amended

Insurance Market Regulations	Guaranteed issue, adjusted community rating with 2:1 age bands; no annual or lifetime limits on benefits; prohibits rescissions; carriers meet medical loss standards
Individual mandate	Penalty 2.5% of difference between MAGI and GI up to average national premium;
Exchange	National or state
Plans offered	Private, public and co-op
Eligibility for exchange	Individuals and small businesses phase in <10-20+
Minimum benefit standard	Essential Health Benefits 70%-95% actuarial value, Four cost sharing tiers
Premium / cost-sharing assistance	Sliding scale 1.5%-12% of income 133%-400% FPL; cost-sharing credits 133%-350%FPL
Medicaid / CHIP expansion	Up to 133% FPL
Shared Responsibility / Employer Pay-or-play	Play or pay; amended firms >\$500,000 payroll, contribute 72.5%+ prem. contribution for ind/65%+ for families; sliding scale phased-in from 2% to 8% of payroll \$500k-\$750K; Small employer tax credit

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Source: Commonwealth Fund analysis of H.R. 3200.

**Figure 22. Trend in the Number of Uninsured, 2012–2020
Under Current Law and H.R. 3200**



Note: The uninsured includes unauthorized immigrants. With unauthorized immigrants excluded from the calculation, 97% of legal nonelderly residents are projected to have insurance under H.R. 3200.
Data: Estimates by The Congressional Budget Office.

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Figure 23. America's Health Choices Act (H.R. 3200) As Amended

An essential health benefits package, as specified by new Health Benefits Advisory Council, must provide comprehensive set of services, cover at least 70% of actuarial value, limit annual cost-sharing and not impose limits on benefits; All plans, including employers, must provide at least the basic package inside and outside the exchange

Minimum Benefit Package

Essential health benefits package at four cost-sharing tiers

- 1st tier (Basic) actuarial value: 70%
 - 2nd tier (Enhanced) actuarial value: 85%
 - 3rd tier (Premium) actuarial value: 95%
 - 4th tier (Premium-Plus) actuarial value: 95% plus oral health and vision care
- Annual out-of-pocket maximum \$5,000 for individuals, \$10,000 for families

Cost Sharing Tiers

Premium subsidy for purchase through exchange so contribution is limited to:

- 133-150% FPL: 1.5%-3.0% of income
- 150-200% FPL: 3.0-5.5% of income
- 200-250% FPL: 5.5-8.0% of income
- 250-300% FPL: 8.0-10.0% of income
- 300-350% FPL: 10.0-11.0% of income
- 350-400% FPL: 11.0-12.0% of income

Premium subsidy

(based on average premium of 3 lowest cost plans) If ESI coverage contribution is <12% of income, not eligible for subsidies

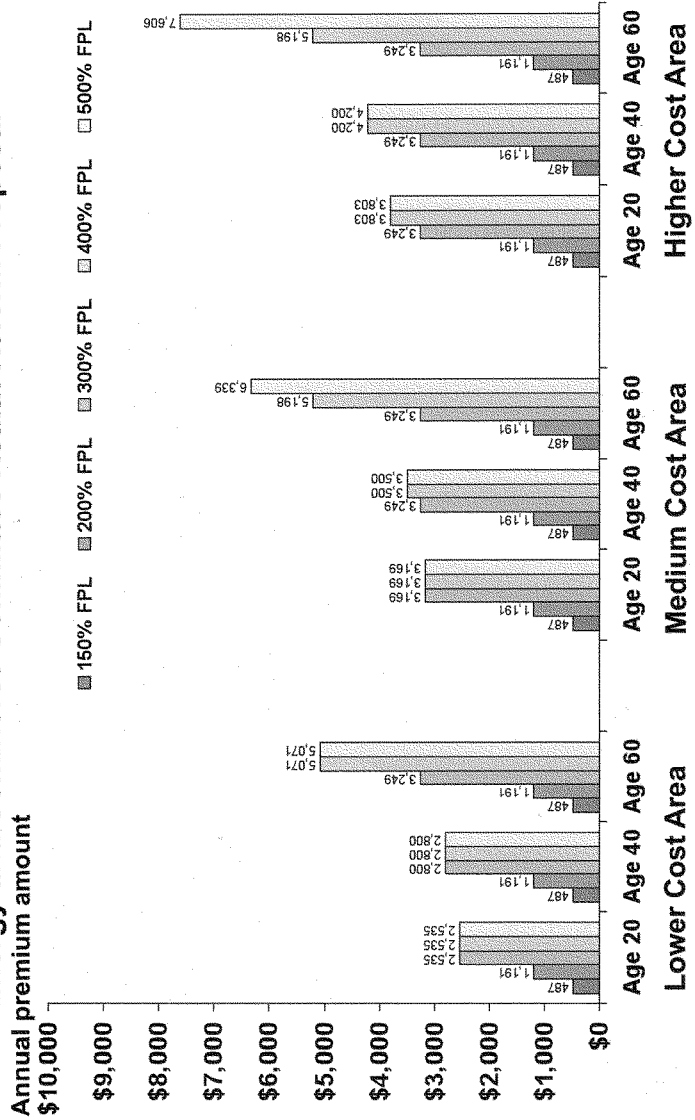
Cost sharing credits reduce limits on cost-sharing, thus increasing actuarial value of basic plan to:

- 133-150% FPL: 97%
- 150-200% FPL: 93%
- 200-250% FPL: 85%
- 250-300% FPL: 78%
- 300-350% FPL: 72%

Cost-sharing credits

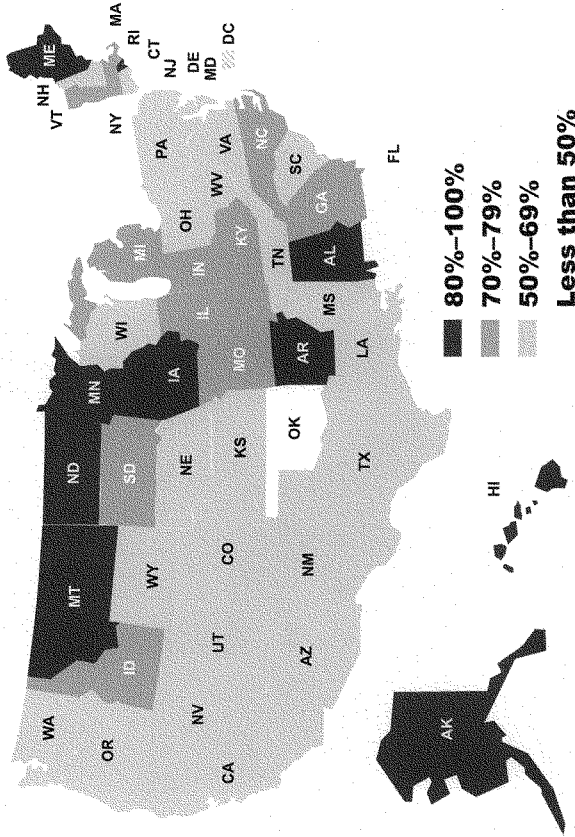
Source: Commonwealth Fund analysis of health reform proposals.

Figure 24. Annual Premium Amount Paid by Individuals Under House Energy and Commerce Committee Health Reform Proposal



FPL = Federal Poverty Level
 Note: Estimates are for single adults with no access to employer coverage.
 Source: Health Reform Subsidy Calculator – Premium Assistance for Coverage in Exchanges/Gateways, Kaiser Family Foundation, <http://healthreform.kff.org/SubsidyCalculator.aspx>, accessed 10/9/09.

Figure 25. Concentrated Insurance Markets: Market Share of Two Largest Health Plans, by State, 2006



Note: Market shares include combined HMO+PPO products. For MS and PA share = top 3 insurers 2002-2003.
 Source: American Medical Association, *Competition in health insurance: A comprehensive study of U.S. markets, 2008 update*; MS and PA from J. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs*, Nov/Dec 2004; ND from D. McCarthy et al., "The North Dakota Experience: Achieving High-Performance Health Care Through Rural Innovation and Cooperation," *The Commonwealth Fund*, May 2008.

Figure 26. Effect of HR 3200 on Insurance Coverage of People Under Age 65, 2015
(in millions)

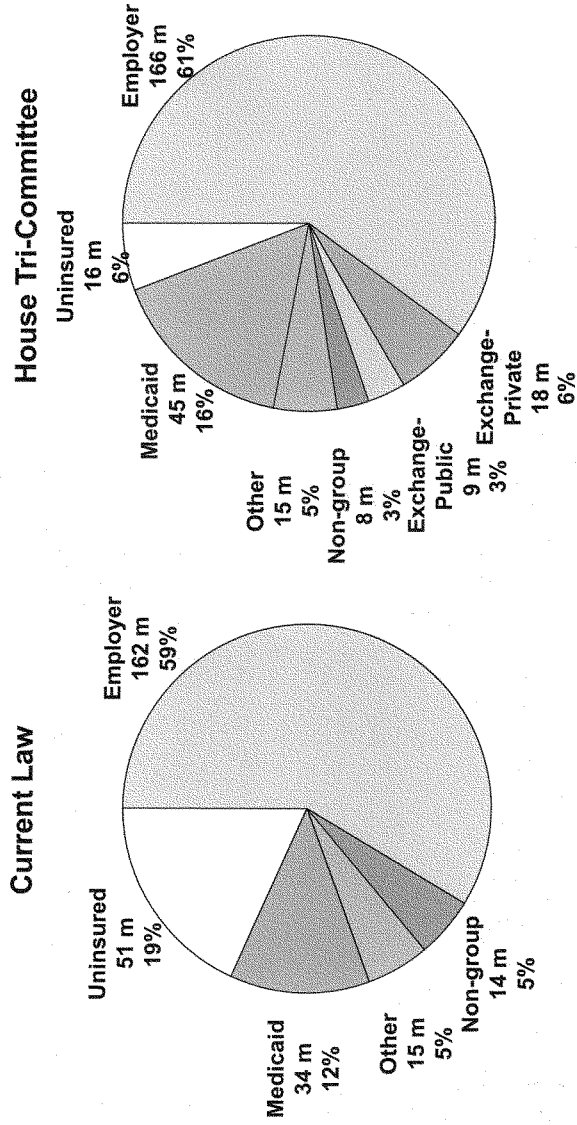


Figure 27. System Improvement Provisions of National Health Reform Proposals, 2009

H.R. 3200
as amended

Exchange Standards and Plans	National or state exchanges; private, public or co-op plans offered; Essential health benefits 70%-95% actuarial value, four tiers; insurers must meet specified medical loss ratio
Primary Care	Increase Medicare payments for PCPs by 5%; bring Medicaid PCPs up to Medicare level
Prevention and Wellness	Develop a national prevention and wellness strategy; remove cost-sharing for proven preventive services in Medicare; grants to support employer wellness programs
Innovative payment pilots: medical homes, accountable care organizations, bundled hospital and post-acute care	Adopt medical homes, ACOs, and bundled payments on large scale if pilot programs prove successful; Center for Payment Innovation
Productivity Improvements	Modify market basket updates to account for productivity improvements
Comparative Effectiveness	Establish Comparative Effectiveness Research within AHRQ
Quality Improvement	Establish the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices; develop national priorities for performance improvement and quality measures

Source: Commonwealth Fund analysis of health reform proposals.

Figure 28. Major Sources of Savings and Revenues Compared with Projected Spending, Net Cumulative Effect on Federal Deficit, 2010–2019
 Dollars in billions

	CBO estimate of H.R. 3200, as of 7.31.09
Total Net Impact on Federal Deficit, 2010-2019	\$239
Total Federal Cost of Coverage Expansion and Improvement	\$1,042
• Medicaid/CHIP outlays	438
• Exchange subsidies	773
• Payments by employers to exchanges	-45
• Small employer subsidies	53
• Payments by uninsured individuals	-29
• Play-or-pay payments by employers	-163
• Associated effects on taxes and outlays	15
Total Savings from Payment and System Reforms	-\$219
• Physician payment SGR reform	229
• Net improvements and savings	-448
Total Revenues	-\$583
• Excise tax on high premium insurance plans	0
• Surtax on wealthy individuals and families	-544
• Other revenues	-39

Source: The Congressional Budget Office Analysis of HR 3200, The Affordable Health Choices Act, July 17, 2009, <http://www.cbo.gov/ftpdocs/104xx/doc10467/07-17-09.pdf>. THE COMMONWEALTH FUND

Mr. STUPAK. Thank you.

Mr. Brock, your testimony please. If you will turn that light on, pull that mike up a little bit. And we look forward to your testimony. You may begin. Thank you.

TESTIMONY OF STAN BROCK

Mr. BROCK. Thank you. Thank you, Mr. Chairman, members.

In 1992, Remote Area Medical, a charity formed to provide free medical relief services overseas, began receiving requests for service here in the United States, including dental procedures, eye exams, free eyeglasses, and primary health.

Today, 64 percent of our work is in America, and we run about 30 expeditions per year and have completed 581. Some 45,000 volunteers have delivered \$40 million worth of free care in over 400,000 patient encounters and treatment to more than 64,000 animals. Our most sought-after services are dental and vision, with over 55,000 patients served in the U.S. in each specialty.

Demographics reveal that 94 percent of the patients are adults, with 83 percent between the ages of 21 and 64, reflecting a transition from childhood-covered programs to uninsured status prior to receiving Medicare. Sixteen percent of them visit a hospital emergency room in the event of sickness, undergoing extensive tests caused by the practice of defensive medicine, while dentists and eye doctors are unaffordable, leading to long lines of desperate Americans at RAM free clinics.

The greatest impediment the RAM programs face is regulation in 49 States preventing willing practitioners from crossing State lines to provide free care. Even during declared emergencies, reciprocity between States is a complex matter that current legislation under the "Uniform Emergency Volunteer Practitioners Act" cannot adequately address.

The sole exception is the "Volunteer Health Care Services Act" of Tennessee. Since 1995, a doctor can show up at a RAM event in Tennessee with license in hand, roll up their sleeves, and get to work. No bureaucratic application process, no fees, and no unnecessary background investigations.

In 1997, Representative John Duncan, Jr., introduced House Concurrent Resolution 69 in an effort to persuade States to adopt the Tennessee model. HCR 69 was referred to the Committee of Commerce. Despite endorsement by the American Medical Association in 1998, it gained no ground nationwide.

RAM attracts thousands of uninsured and underinsured patients and requires large numbers of doctors. Patient volume invariably exceeds the number of local providers willing or available to volunteer free services. This gap can only be filled by reinforcing our teams with volunteers licensed in other States.

There are more than 179,000 dentists in America and 800,000 physicians. They pass a nationally standardized competency test and graduate from a nationally accredited school. Many like to travel and will do so at their own expense to provide free care. Some do in other countries because volunteering outside of the U.S. is easier than overcoming bureaucratic hurdles to help those 47 million uninsured here in America. This demonstrates the need for all States to adopt the Tennessee model as proposed in HCR 69.

That need was recently emphasized at a Remote Area Medical event in Los Angeles. In 8 days, we treated 6,344 patients for a value of free care exceeding \$2.8 million. But those numbers could have been doubled. We had 100 dental chairs and 20 lanes of eye exam equipment, yet on some days we could only recruit 25 California-licensed dentists and five or six eye specialists. By comparison, in rural southwest Virginia, where laws were relaxed to allow the partial use of out-of-State doctors, RAM treated 2,715 patients in only 2 1/2 days, a patient number not attained in Los Angeles until the 4th day, while thousands of uninsured California residents were turned away.

RAM patient surveys indicate that some 46 percent carry no insurance, 23 percent are on Medicaid, and 18 percent on Medicare. Dental and vision insurance is carried by less than 1 percent.

Self-induced health issues wrought by the culture of poverty caused by fast foods, smoking, and lack of exercise are aggravated by the problem of access. Patients don't have access to the doctor. The doctor cannot cross State lines to have access to the patients. And the doctor does not have reasonable access to protection from lawsuits.

RAM data proves that allowing doctors to cross State lines dramatically increases service to the underserved. If the Tennessee statute was enacted by all 50 States or possibly at the Federal level, for example under the interstate commerce provisions of the Constitution, volunteers would respond en masse and serve millions of uninsured Americans at no cost to the government and no cost to the taxpayer.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Brock follows:]



1834 Beech Street • Knoxville, Tennessee 37920
(865) 579-1530 • Fax (865) 609-1876 • www.ramusa.org

October 9, 2009

Re: Testimony of Stan Brock, Remote Area Medical Volunteer Corps, for the
Committee on Energy and Commerce, Subcommittee on Oversight and Investigations
Hearing: "Insured but Not Covered: The Problem of Underinsurance,"
Scheduled for October 15, 2009, 1:30pm

In 1992, REMOTE AREA MEDICAL® (RAM), a charity formed to provide free
medical relief overseas, began receiving requests for services in the United States,
including dental procedures, eye exams, free eyeglasses, and primary health care. Today,
64% of our work is in America. We run about 30 expeditions per year and have
completed 581.

Some 45,000 volunteers have delivered \$40 million worth of free care in over 400,000
patient encounters and treatment to more than 64,000 animals.

***Remote Area Medical is a 501 (c) (3) charitable organization with no paid employees using
an airborne force of volunteers dedicated to serving mankind, providing free health care, veterinary services and
technical and educational assistance in remote and rural areas of the United States and around the world.***

Our most sought-after services are dental and vision with over 55,000 patients served in the U.S. in each specialty. Demographics reveal that 94% of the patients are adults, with 83% between ages 21 and 64, reflecting a transition from childhood-covered programs to uninsured status prior to receiving Medicare benefits. 16% of them visit a hospital emergency room in the event of sickness, undergoing extensive tests caused by the practice of defensive medicine, while dentists and eye doctors are unaffordable, leading to long lines of desperate Americans at RAM free clinics.

The greatest impediment RAM programs face is regulation in 49 states preventing willing practitioners from crossing state lines to provide free care. Even during declared emergencies reciprocity between states is a complex matter that current legislation under the Uniform Emergency Volunteer Practitioners Act (UEVHPA) cannot adequately address. The sole exception is the Volunteer Health Care Services Act of Tennessee. Since 1995 a doctor can show up at a RAM event in Tennessee with license in hand and get to work – no bureaucratic application process, no fees, and no unnecessary background investigations. In 1997, Representative John J. Duncan, Jr., introduced House Concurrent Resolution 69 in an effort to persuade states to adopt the Tennessee model. H.C.R. 69 was referred to the Committee of Commerce. Despite endorsement by the American Medical Association in 1998 it gained no ground nationwide.

RAM events attract thousands of uninsured and underinsured patients and require large numbers of doctors. Patient volume invariably exceeds the number of local providers willing or available to volunteer free services. This gap can only be filled by reinforcing

our teams with volunteers licensed in other states. There are more than 179,000 dentists in America and 800,000 physicians. They pass a nationally standardized competency test and graduate from a nationally accredited school. Many like to travel and will do so at their own expense to provide free care – some do so in other countries because volunteering outside of the U.S. is easier than overcoming bureaucratic hurdles to help those 47 million uninsured here in America.

This demonstrates the need for all states to adopt the Tennessee model as proposed in the failed H.C.R. 69 initiative. That need was recently emphasized at a REMOTE AREA MEDICAL® event in Los Angeles. In 8 days, RAM treated 6,344 patients for a value of free care exceeding \$2.8 million. But, those numbers could have been doubled. We had 100 dental chairs and 20 lanes of eye exam equipment, yet on some days, we could only recruit 25 California-licensed dentists and 5 or 6 eye specialists. By comparison, in rural southwest Virginia, where laws were relaxed to allow the partial use of out-of-state doctors, RAM treated 2,715 patients in only 2 ½ days, a patient number not attained in Los Angeles until the 4th day, while thousands of uninsured California residents were turned away.

RAM patient surveys indicate that some 46% carry no insurance, 23% are on Medicaid and 18% on Medicare. Dental and vision insurance is carried by less than 1%. Self-induced health issues wrought by the culture of poverty, caused by fast foods, smoking, and lack of exercise are aggravated by the problems of access: Patients don't have

access to the doctor; the doctor cannot cross state lines to have access to the patients; and the doctor does not have reasonable access to protection from lawsuits.

RAM data proves that allowing doctors to cross state lines dramatically increases service to the underserved. If the Tennessee statute was enacted by all 50 states, or possibly at the federal level (for example under the Interstate Commerce Provisions of the Constitution), volunteers would respond en masse, and serve millions of uninsured Americans at NO COST to the government or the taxpayer.

Mr. STUPAK. Thank you, Mr. Brock.

I will open up for questions now.

Ms. Schakowsky, would you like to go first? I know you have a pressing appointment.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. I really appreciate it.

First, let me just extend my thanks to The Commonwealth Fund for the incredible work that has been done to advance our knowledge about this whole area of health care and health care reform.

And, Mr. Brock, let me thank you for the Remote Area Medical foundation. And, for me, I guess what I would like to say about that, it has highlighted and really underscored a failure of the American health care system. Obviously, no discredit at all to you, because you are filling a gap.

But what I take away from that is that you should be doing this work in developing countries, in places where there is no capacity. But we are the United States of America. And I just feel ashamed when I see that people have to line up at 3 o'clock, at 4 o'clock in the morning, even people that have some kind of insurance.

My hope is that your organization will flourish and be able to serve people in truly remote areas around the world and that your work should be not only applauded but supported.

I wanted to talk, Dr. Collins, about the issue of health insurance market concentration. Today, because of mergers and acquisitions by large private health insurance companies, consumers in many parts of the country, I think most parts of the country, have few choices.

And I don't know if you have Figure 25 that has a map that shows the country and the concentration of private health insurance companies in the States. In eight States, you find just two private health insurance companies control 80 to 100 percent of the market. And in medium-blue States, the two leading companies have 70 to 79 percent of the market share. And in the majority of States, those that are shaded light blue, or lighter if you don't have color, two insurance companies control more than half the market.

As you said in your written testimony, there are only three States in which the two biggest private health insurance companies control less than half of the market. Is that right?

Ms. COLLINS. That is right.

Ms. SCHAKOWSKY. And what kind of effect, then, does this market concentration have on consumer premiums and out-of-pocket costs that American consumers face?

Ms. COLLINS. What it means is that insurance companies, if they are facing concentrated markets, concentrated provider markets, so there is not a lot of competition in provider markets either, and if they are not able to negotiate lower rates with providers, because of the lack of market competition in the insurance market, they can simply pass those costs off to consumers and employers.

And we are certainly seeing that now. It is probably contributing to the rapid increase in premiums and health care costs that we are seeing over time. So we really do need an increase in competition in the insurance market to counteract that dynamic.

Ms. SCHAKOWSKY. And how do you see H.R. 3200 affecting competition in the insurance industry? And what effect would this have, then, on underinsurance?

Ms. COLLINS. Well, 3200 includes a public plan option. So it means, in these markets, there would be a new option for people to choose from if they are buying through the health insurance exchange. It would mean, if the public plan was allowed to negotiate or to set provider payment rates, it would break up this dynamic that we are seeing where insurance companies just pass on their higher rates through to consumers and employers, inject some new price competition into those markets, likely lowering premium costs for everyone over time and contributing, really, to lower rates of growth in overall health care costs.

The other thing it would do is help spread innovation and payment reform, delivery system reform, having this presence of a public option.

So, really, introducing some needed price competition and also innovation on the payment and delivery systems reform side.

Ms. SCHAKOWSKY. Why don't more insurance companies try to enter these concentrated markets? What are the barriers, then, under our current system?

Ms. COLLINS. Well, many insurers are already contracting with current provider networks. So it is really difficult for an insurance company to come in and get those providers into their network. So that concentration in the market really does act as a barrier for other companies or insurance companies coming into the market.

Ms. SCHAKOWSKY. Thank you.

Thank you both.

Mr. STUPAK. Any further questions, Ms. Schakowsky?

Ms. SCHAKOWSKY. No.

Mr. STUPAK. OK. Mr. Green for questions, please.

Mr. GREEN. Thank you, Mr. Chairman.

During our first panel, we heard from our witnesses about problems with transparencies in insurance policies. And we took some time to look at the policy that David Null brought. He thought that it would protect him in a catastrophe. As it turned out, the policy didn't protect him as he expected it would.

I understand people should be responsible for reading their policies carefully, but all too often policies are confusing and loaded with technical jargon.

Dr. Collins, do you see a widespread problem with transparency in health insurance policies, or are consumers generally well-informed about their health plans?

Ms. COLLINS. I think the problem really does happen in individual and the small group markets, where people are really on their own when they are choosing plans. They are not often aware of what their plans cover. They may think that a lifetime limit of a million dollars is a lot until they get really sick and it really turns out not to be enough.

So it is a pervasive problem. I think minimum standard benefits and much increased transparency is really needed in both of these markets. The House bill really does do that with the minimum standard benefit packages just in this new environment of transparency that would be available through the exchange.

Mr. GREEN. In your view, what reforms would help ensure that consumers are informed better about their policies?

Ms. COLLINS. Well, I do think there needs to be much more regulation of the individual market. There needs to be, as Massachusetts has done, a way for people to look at what their policies have, to know that there is a minimum standard so that their policies won't fall below that standard, that there won't be limits on what their plans will pay. They will know what their deductibles are; they will know what their plans will pay.

And so, having that kind of standardization for this market, where people are on their own, is really important to counteract a lot of the testimony and experience that we saw on the first panel.

Mr. GREEN. And I know it was mentioned earlier, but one of the—it came out of this Oversight Committee over a number of years of hearings on transparency and hospital bills. And both Chairman Stupak and Ranking Member Barton and Congressman Burgess and I put an amendment on H.R. 3200. Most people don't think that that bill had the bipartisan effort in it, but a lot of the language in that bill actually came out of both sides of the aisle. It is just that we didn't get any votes in our committee on it.

But we did have a transparency amendment that would require hospitals to disclose the average prices for their common services. And would this help with transparency in insurance policies if we did something like that on a national basis for insurance policies?

Ms. COLLINS. I think having more transparency on the hospital pricing side—so, having both the Federal Government having those prices much more clear so that the cost is much closer to what prices are. Right now there is often no clarity on what the costs are for hospital procedures, what the prices are. So people who are uninsured, for example, are often charged far more than what insured patients would be under negotiated contracts.

So I think having that kind of transparency in pricing will be very useful to both Federal Government and also private insurers.

Mr. GREEN. OK. Thank you.

And I yield back my time.

Mr. STUPAK. Thank you, Mr. Green.

Mr. Dingell for questions.

Mr. DINGELL. Thank you, Mr. Chairman.

I would like to commend the panel for their very helpful testimony, and I have no questions.

Mr. STUPAK. I have a number of questions I would like to ask.

Mr. Brock, you indicated that legislation was introduced to help you to let doctors come and volunteer their time, dentists and all that, and that was introduced one time.

Has that been addressed yet? Do you still face that same problem today, where doctors cannot come to one of your operations in this country and volunteer their time?

Mr. BROCK. This is the most difficult problem that we face everywhere, except in the State of Tennessee where we have treated thousands and thousands of patients using predominantly practitioners from outside the State.

What we do, which is on a massive scale where we are dealing with thousands of people, it requires hundreds and hundreds of

doctors to do that. And it is just not possible, in most cases, in virtually every case, to recruit enough local providers.

Mr. STUPAK. So, like, when you mentioned Wise County, Virginia, you had to use doctors from Virginia, then.

Mr. BROCK. Yes. Now, Tennessee, to my knowledge, is the only State that has this across-the-board open-door policy. What you have in Virginia is an effort in that direction, which has not reached a point where it is really very, very workable. We can bring in people for no more than 3 days into Virginia, but it was a measure that was opposed by the dentists. So if we want to bring in dentists, we have to have them jump through a certain number of hoops.

Mr. STUPAK. I see.

Mr. BROCK. The most dramatic case in point, really, was just last month—well, August—in Los Angeles, where we treated 6,344 patients, but we had such an inadequate force of California-licensed doctors despite the fact that we petitioned to bring in volunteers from outside the State.

We had a hundred dental chairs set up, we had 20 lanes of eye exam equipment. And the best we could do with 25 very fine dentists, volunteers from California, and four or five very fine optometrists from California, and a dozen or so doctors. Meanwhile, we had given out 1,600 numbers. There were 1,600 people waiting on day 1. We had to turn all of them away except the 700 that we could do with the limited force.

Had we been allowed to bring in people from anywhere in the country who would have been more than willing to come—we had so many requests, and we had to say, “No, you are not allowed to come because we are going to a State that doesn’t allow it,” we could have treated 15,000 people instead of 6,344.

Mr. STUPAK. Let me ask you this. You also indicated that, whether it was in Tennessee or in Virginia, I understand you conducted some surveys to determine, among other things, what portion of your patients had health insurance.

What did you learn from these surveys regarding how many people had health insurance but were still seeking free health care provided by your fine organization?

Mr. BROCK. Well, it is all across the board, really. There are about 42 percent that do have insurance.

Mr. STUPAK. Some type of insurance.

Mr. BROCK. Of some type. The problem with—so this is not just treating people who are the unemployed and the homeless. We are getting people just like these wonderful folks that were in the first panel, people that have jobs, people that have reasonable incomes, but they have issues that are not covered on their insurance policy.

And, in many, many cases, it is a lack of dental coverage and a lack of vision coverage. And they simply cannot afford—or their deductible is too high.

So even though we may have a thousand people that come on a particular morning for treatment—and looking at the profile of these patients, you can see that they all have some pretty far-reaching medical problems: a large percentage of them smoking, a large percent of them with obesity problems. But they can take some of those problems to the emergency room when they run into

a problem, but they cannot take dentistry and they cannot take vision problems to the emergency room.

In fact, in our neighborhood, every emergency room has a sign up there: "If you are here because you have a bad tooth or you can't see properly, go and see Remote Area Medical, because we don't do that here."

So virtually a hundred percent of the patients that come to our clinic are there because they are in pain and need the dentist and they have vision problems and they need a pair of eyeglasses, even though they need to see the doctors, but they are preoccupied with dentistry and vision.

Mr. STUPAK. And that 42 percent that had some insurance, it made no difference whether you were in rural areas or urban areas; it was basically the same.

Mr. BROCK. It is very similar across the board, yes.

Mr. STUPAK. Well, thank you for the remarkable work you and your volunteers do and your staff that is with you here today. We appreciate your being here.

Dr. Collins, Mr. Brock said something very interesting, and he indicated that, you know, these are people who have insurance and policies. And you indicated that the most rapid growth of underinsured are people between \$40,000 and \$60,000, whose incomes are \$40,000 and \$60,000, based on your survey. Is that correct?

Ms. COLLINS. That is right.

Mr. STUPAK. See, like, in my district, my median household median is only \$38,000. So we would be struggling.

Your survey included 2007, right?

Ms. COLLINS. That is right.

Mr. STUPAK. So you would not have any statistics—because the economy really took a nosedive about August, September of 2008. I am sure your uninsured and underinsured figures would be much greater, would they not?

Ms. COLLINS. That is right. And it is also compounded by the fact that real median incomes actually dropped between 2007 and 2008. So there is that dynamic. As well, health care costs are rising at 6 percent a year. And we know more employers are cutting back on their benefits. People have lost their jobs, which means that they are either buying on the individual market or they are going uninsured. So those numbers have probably definitely worsened.

Mr. STUPAK. And most of your numbers are—when you talk about underinsured, those are basically people below 65, because at 65 most Americans have Medicare, right?

Mr. BROCK. That is right.

Mr. STUPAK. And, Mr. Brock, I think you said the same thing in your testimony, that the adults you see are 21 to 64 and not 65 or over. Is that basically because of Medicare coverage?

Mr. BROCK. Yes, right. Eighty-three percent are in the age group of 29 to 64, simply because after they pass that threshold out of childhood into adulthood they start letting these problems of dentistry and care go by the boards, and so that is the age group where they start to run into problems.

Mr. STUPAK. Sure.

Dr. Collins, if I can go back to you, you indicated that the problem of underinsured and uninsured, but really uninsured, comes

from a combination of rapid rise in health care cost, slow growth in family income, and a shift of the burden of cost that leaves the family or the policyholder to pay more for the health care cost.

And we have heard testimony and opening statements from members saying that premiums have risen 131 percent in the last decade, more than three times that of the average family wage increase.

So, Dr. Collins, what kinds of health care costs are families now being expected to absorb that they weren't 5, 10 years ago?

Ms. COLLINS. Well, we know from our survey that many more people are paying large shares of their income out of pocket, whether they are underinsured or insured, have adequate insurance. And that has moved dramatically up the income scale. So about 30 percent of people who are privately insured are paying more than 10 percent of their incomes on out-of-pocket costs and premiums.

So we are seeing rates among even middle-income families that we weren't seeing when we did this survey in 2001, for example. So those rates among middle-income families, median-income families are up where low-income families were in 2001. So it is really spreading up the income scale, this issue.

Mr. STUPAK. We have heard testimony today, and our last panel mentioned it, and we've talked about it, and I think we all have some idea, but could you explain a little bit more for me about health networks?

I know we had the map up there of the States, and most of them only have, like, two or three dominant providers. But Ms. Howard talked about health networks, I think Mr. Null did, and I think Mr. Wilkes did too, about they had to stay within their network.

What does that mean from an insurance perspective? Could you explain that?

Ms. COLLINS. What it means is—and it is also related to what you are responsible for paying out of pocket. So if your provider is in-network, you are likely to face lower costs. Likely your costs will be lower than they will be if you go out of network.

Now, what happens when you go out of network? You may understand that your insurance company pays a certain percentage of your costs, but not knowing, as that policy that was on the screen showed, not really knowing what the cost is. So just not going out of network because your insurance company doesn't cover out-of-network costs and being left with a big bill because of that.

This map really shows the massive concentration in the insurance industry right now. And it really has had an increasing pressure on overall health care cost growth, certainly on premiums. There just is a lack of competition in those markets.

Mr. STUPAK. So, like, my State of Michigan there, Blue Cross Blue Shield, it is our biggest carrier. So if I go outside of Blue Cross Blue Shield, then I have higher out-of-pocket or I may have to pay the whole amount because I am not in the Blue Cross Blue Shield network?

Ms. COLLINS. Right. So they will have some providers that are contracting with you that are in-network. If you are out of network, depending on your policy, your costs will be covered at some percent of the total cost.

But what is hard to know is what, even if they say they will cover this percent, it is hard to know what the total cost will be. And so, often, they will cover the share but you won't know what your margin of responsibility is until you get your bill.

Mr. STUPAK. Sure. And I live on a border community in the Upper Peninsula, and most of my medical care—in fact, we only have one doctor in my community—is in Wisconsin. So I am almost always out of network, just about. So, therefore, I pay more out of pocket with my policy.

For the record, I don't have the Federal employees health benefit package. I should, but it is a promise I made. I wouldn't take it until everybody had health care, so I don't have it. So I am doing myself, probably, a disservice.

But these are decisions that families are doing every day. And if you live on a border, like I do, it can be a lot different and greater. So the network is being within there.

And so, if you only have two of your large providers, if you are not one of those two, and they are probably not offering you a good plan, and you are out of network, it is going to cost you more money.

Ms. COLLINS. Probably, yes.

Mr. STUPAK. Let me ask you one more question. And you mentioned it in your testimony, about you learned about the types of treatments for medical care that underinsured individuals forego for financial reasons. And some of the other panels, like Mr. Wilkes, he didn't take his son when he thought maybe he should, because the cost could be as much as \$10,000. And I think your survey was showing the same thing. People were not filling a prescription, not seeing a specialist, skipping appointments.

Is that pretty common?

Ms. COLLINS. It is very common among people who are either uninsured or underinsured. The striking thing about our survey findings is that people who are underinsured have rates of avoiding necessary care because of the cost at rates that are nearly as high as people who are without insurance coverage altogether.

So it is a very real problem. We see it in our data. And it is a problem that has increased over time.

Mr. STUPAK. Has your organization been able to develop, or developed, any data which would show, if I am skipping my doctor's appointment or not getting the screening test, how much that is costing us in health care? Have you been able to put a financial value on these underinsured who are skipping payments, premiums—or not payments, excuse me—doctor offices, doctor visits, treatment, specialists? Can you put a value on that?

Ms. COLLINS. You know, we asked people about their chronic health conditions, and then we asked that group of patients, people in our survey who had a chronic health condition like heart disease, diabetes, asthma, whether they had ever skipped a prescription drug, tried to cut their pills in half in order to make their prescriptions last longer. And about 46 percent of people who had a chronic disease who were underinsured said "yes" to that question. Again, those rates are really high, almost as high as people who were uninsured.

And then we also asked this group whether they stayed overnight in a hospital or gone to an emergency room because of their health condition. And we found that about 32 percent of underinsured patients said “yes” to that question.

So you can expect that if people are skimping on their prescription drugs, they are probably having more serious health conditions. And there is a substantial amount of research in the literature that also underscores this finding.

Mr. STUPAK. We have the chart up there, and it is pretty interesting. Did not fill a prescription; did not see a specialist. The highest bars there are the underinsured or not insured, or not insured for part of time in the past year, those numbers.

I am sure, Mr. Brock, you see the same thing, because then they must turn to you for trying to get some care, especially since you said, in a basic health plan, dental and optical are probably not included. But you even see people who need basic coverage that are coming to you who have some sort of insurance. Is that true?

Mr. BROCK. Yes. In fact, large numbers of them are coming now that have insurance, but it doesn't cover those two specific areas.

We are getting people now that are coming hundreds and hundreds of miles, buying an airline ticket to come from Florida all the way up to Tennessee. We have had a request from a nongovernmental organization in Massachusetts wanting to bus people down from one of the richest States in the country to one of the poorest, to Tennessee, so that we could fix their teeth and make them eyeglasses.

So this is becoming even more common. Even though we are really not seeing any more patients in many areas than we have been seeing in the last 20-odd years, they are coming from a lot further away.

Mr. STUPAK. Well, all the great work your organization does—and you have some of your staff here with you today—and all the doctors and dentists and ophthalmologists and optometrists that have volunteered their time, how do you support your organization? Do you receive grant funding? Do you get donations? How do you support your organization.

Mr. BROCK. Well, our organization is largely supported by members of the public who send in those \$10 and \$15 donations. We do have some foundation support.

You know, up until early in 1998, the only people who knew what Remote Area Medical were doing were the poor, the people that came to our clinics. And then “60 Minutes” on CBS focused on us, and so this has caused a great increase in the interest in what we do and, I am glad to say, a certain increase in donations.

But we don't have any corporate support—I wish we did—of any magnitude, but we do have some foundation support. We do not take any government money. And, in fact, we would never apply or want any money from the government.

Mr. STUPAK. So if we passed health care, it would be a good idea if we, sort of, put you out of business, right?

Mr. BROCK. Oh, yes. It would be marvelous if we could go back to concentrating on places like Haiti and the Dominican Republic and India and Africa, which is what I formed this organization to do in the first place.

Mr. STUPAK. Did you imagine you would be coming to the United States and there would be such a great demand for your services here in this country, the richest country in the world?

Mr. BROCK. Well, you know, without digressing from that question very far, the sixth man to walk on the moon, astronaut Ed Mitchell, asked me basically the same question just several weeks ago. We had breakfast together.

I said, "Well, you know, where I grew up, we were 26 days on foot from the nearest doctor." This was in the Upper Amazon. And he said, "Well, gosh, I was on the moon, and I was only 3 days from the nearest doctor." I said, "Well, the people that we are treating right here in the United States might as well be on the moon or might as well be in the Upper Amazon, for the opportunity that they have to receive the care that they need in this country."

Mr. STUPAK. Well said. Well said.

Dr. Collins, anything you want to add?

Ms. COLLINS. No.

Mr. STUPAK. OK. That concludes all the questioning. I want to thank you for your patience and the witnesses for being here today and for your testimony. This panel will be dismissed. Thank you.

The committee rules provide that members have 10 days to submit additional questions for the record, and I am sure some members will submit some.

I ask unanimous consent that the contents of our document binder be entered into the record, provided the committee staff may redact any information that is business proprietary, relates to privacy concerns, or is law-enforcement-sensitive. Without objection, the documents will be entered in the record.

[The information follows:]



The Impact of Lifetime Limits

Prepared for

National Hemophilia Foundation on behalf of the:

Raise the Cap Coalition

(See full list of members inside)

March 2009

For additional information, contact Michael Thompson at (646) 471-0720 or Jack Rodgers at (202) 414-1646.



Lifetime Caps Coalition Members

Alpha-1 Advocacy Alliance
 Alpha-1 Association
 Alpha-1 Foundation
 American Autoimmune Related Diseases Association
 American Heart Association/American Stroke Association
 American Pain Foundation
 Autism Society of America
 Baxter Bioscience
 Brain Injury Association of America
 Breast Cancer Network of Strength
 Christopher and Dana Reeve Foundation
 Committee of Ten Thousand
 Cooley's Anemia Foundation
 Crohn's and Colitis Foundation of America
 CSL Behring
 Cystic Fibrosis Foundation
 Epilepsy Foundation
 Factor Foundation of America
 Factor Health Management
 Grifols, Inc
 Hemophilia Federation of America
 Hepatitis Foundation International
 Huntington's Disease Society of America
 Immune Deficiency Foundation
 Kids With Heart National Association for Children's Heart Disorders, Inc.
 Mended Little Hearts
 National Alopecia Areata Foundation
 National Gaucher Foundation
 National Health Council
 National Hemophilia Foundation
 National Marfan Foundation
 National Multiple Sclerosis Society
 National Organization for Rare Disorders
 National Patient Advocate Foundation
 Patient Services Incorporated
 Pediatric Stroke Network, Inc.
 Pulmonary Hypertension Association
 Scleroderma Foundation
 Sjögren's Syndrome Foundation



The Impact of Lifetime Limits

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Executive Summary

PricewaterhouseCoopers was engaged by the National Hemophilia Foundation on behalf of a coalition of advocacy organizations representing individual chronic diseases and disorders to conduct a study of lifetime limits under employer-sponsored medical plans. These include several high-cost conditions like hemophilia, Gaucher's disease, immune deficiencies, certain cancers and others where annual costs in the hundreds of thousands of dollars or more are not unusual. Specifically, the study examines the prevalence of lifetime limits, the number of people affected by them, and the costs of increasing, or removing, lifetime limits from health plans. The findings are based on public data, surveys of major insurers, and PwC actuarial modeling.

Prevalence of Lifetime Limits

- About 55 percent of individuals with employer provided health insurance are subject to lifetime limits, or 91 million people in 2009. The proportion of individuals with employer coverage, who have no lifetime limits increased substantially between 2000 and 2007.
- The most common lifetime limits are \$1 million or \$2 million. More than 20 percent of people covered by employer plans are subject to lifetime limits of \$1 million; another 32 percent are subject to limits of \$2 million or more.
- Employers that self-insure are more likely to have plans with lifetime limits.
- PwC estimates that in 2009 approximately 20,000 to 25,000 people are no longer covered by their employer-sponsored plans because of lifetime limits.

Cost of Removing Lifetime Limits

- Increasing lifetime limits from \$1 million to \$5 million would increase premiums, on average, by 0.6 percent to 0.8 percent (approximately \$3 per month for typical single plan, \$8 per month for family plan).
- Increasing lifetime limits from \$2 million to \$5 million would increase premiums, on average, by 0.25 percent to 0.35 percent (less than \$2 per month for typical single plan, \$4 per month for family plan).
- Extending the limits from \$5 million to \$10 million would increase premiums on average by less than 0.1 percent.

Illustrative Impact of Lifetime Limits in 2019

- If lifetime limits are not increased, the number of individuals who are no longer covered by their employer-sponsored plans because of lifetime limits will increase exponentially as healthcare costs continue to rise.
- According to the U.S. Department of Health and Human Services, healthcare costs per capita are projected to rise at about 6 percent annually, or about 80 percent over the next 10 years.
- At this rate of increase, PwC estimates approximately 300,000 people (0.3 percent of the people with lifetime limits) would be affected by lifetime limits in 2019 if current limits were not increased.

Medicaid Savings from Increasing Lifetime Limits to \$10 Million

- Many individuals who lose insurance coverage because of lifetime limits fall back on government programs, primarily Medicaid.
- If lifetime limits were increased to \$10 million, PwC estimates that Medicaid programs would save more than \$1 billion in 2010.



I. Background

PricewaterhouseCoopers was engaged by the National Hemophilia Foundation on behalf of a coalition of advocacy organizations representing individual chronic diseases and disorders to conduct a study of lifetime limits under employer-sponsored medical plans. Specifically, the study examines the prevalence of lifetime limits, the number of people who are affected by them, and the costs of increasing or removing lifetime limits from health plans.

Lifetime limits are provisions of many insurance plans that limit the total dollars in benefits that the insurance plan will pay out over the lifetime of an enrollee in the plan. For example, a health plan might specify that once \$1 million in benefits are paid out, the insurance plan no longer will pay for any claims for that enrollee. An individual may reach the limit in one year in the case of a catastrophic medical condition or an individual with chronic disease may reach the limit over five years by having \$200,000 in medical expenses each year. The latter situation is associated with diseases, such as hemophilia, which have high annual treatment costs.

People who have spending that exceed health plan limits have to find other ways to pay for medical costs, which involves a combination of paying more out of pocket, finding new public or private insurance sources (often through Medicaid) and curtailing medical care. Medicaid has income and asset limits so it may take months or years to "spend down" assets and become eligible for Medicaid. Some people are able to start over with new insurance plans as a result of job changes or insurance changes initiated by their employers. Some of these individuals qualify for Medicare after being disabled for two years.

The National Hemophilia Foundation, on behalf of a coalition of advocacy organizations representing individual chronic diseases and disorders, asked PricewaterhouseCoopers to estimate the following aspects of lifetime limits:

- Prevalence of lifetime limits including number of people whose health plans include them as well as how many people are affected by the limits;
- How the lifetime limits and the number of people affected by them have changed over time;
- The cost of removing lifetime limits in terms of increases in premium costs to employers; and,
- The savings to public programs, most specifically Medicaid if lifetime limits were removed.

There is currently no uniform industry source of data on lifetime maximum benefit plans and cost impact. The PricewaterhouseCoopers findings are based on public data, surveys of major insurers, and PwC actuarial modeling. The following summarizes our sources:

- PwC researched the public domain for surveys and reports on lifetime maximum distributions and cost. The overall estimates were based on the 2007 Kaiser Foundation Annual Survey Report on Employer Health Benefits.
- PwC performed a survey of several major national insurance carriers in which information was collected on:
 - lifetime maximum cost impact;
 - reinsurance issues;
 - distribution of current participant enrollees by lifetime maximums;
 - employer processes when transferring vendors;
 - current and historic trend patterns (e.g., amount maximums changed).

PwC developed an actuarial model utilizing a large national claim database to develop estimates of the frequency with which covered individuals hit lifetime maximums and costs associated with their plans.



II. Prevalence and Impact of Lifetime Limits

PricewaterhouseCoopers reviewed several sources of information available on the prevalence of lifetime limits in employer-sponsored health insurance plans. Based on our marketplace experience, review of other benefit surveys and interviews of several major insurance carriers, the most common lifetime maximum limits for companies with at least 20 employees are \$1 million, \$2 million and unlimited.

The table below, which is based on the 2007 Kaiser Family Foundation employer survey, summarizes enrollment by plan type.¹ An estimated 22 percent of people covered by employer plans are subject to lifetime limits of \$1 million; another 32 percent are subject to limits of \$2 million or more. Research by PricewaterhouseCoopers suggests that most lifetime limits that are under \$2 million are set at exactly \$1 million. A majority plans with limits of \$2 million or more are set at \$2 million.

Prevalence of Lifetime Limits	
Lifetime Limit	% of Individuals Enrolled
Less than \$1 million	1%
\$1 million - less than \$2 million	22%
\$2 million or greater	32%
Unlimited	45%

Source: Kaiser Family Foundation, 2007

Self-insured firms are more likely to have limits than firms that buy commercial insurance. Individual firms are not able to spread the costs of high-cost cases across as many lives as commercial insurers do. In terms of the number of people affected, PwC estimates that approximately 91 million people covered by employer plans are subject to lifetime limits. PwC estimates in 2009 that approximately 20,000 to 25,000 individuals reach their lifetime limits.

The number of people who exhaust lifetime limits will increase dramatically unless the limits are increased to keep up with the growth in medical costs. For example, by the year 2019, medical costs will be 80 percent higher than 2009, assuming healthcare costs increase 6 percent annually. Unless lifetime limits are increased, the number of individuals who will lose employer-provided benefits because of lifetime limits will increase exponentially. Assuming no change in the current lifetime limits take place, PwC estimates that approximately 300,000 people (0.3 percent of individuals with lifetime limits) will reach their lifetime limits in 2019.

III. Costs of Increasing Lifetime Limits

When lifetime limits are increased, the total health plan costs will increase based on an increase in the claims and reinsurance cost components. The administrative component will have a minimal increase. The reinsurance cost component will increase to reflect the greater financial assumed by the reinsurer as a result of any increase to the lifetime limit. Additionally, claims will increase as plan costs for ongoing claimants that are below the stoploss level increase.

¹ *Employer Health Benefits, 2007 Annual Survey*, Kaiser Family Foundation and Health Research and Education Trust, Washington, DC, 2007; available at <http://www.kff.org/insurance/7672>



PwC estimates that for 2009 the average monthly health premiums are approximately \$420 for single coverage and \$1,125 for family coverage.² Based on the size of an insurance carrier's book of business and the low overall frequency with which individuals reach lifetime limits, the cost of increasing the limits would be low (less than 1 percent of costs). As shown in the table below, PwC estimates that increasing lifetime limits from \$1 million to \$5 million would increase premiums by approximately 0.6 percent to 0.8 percent, or about \$3 per month for single coverage or \$8 for family coverage. The costs of increasing a \$2 million limit to \$5 million would increase costs by an estimated 0.25 percent to 0.35 percent, about \$1.50 for single coverage and \$3.50 for family coverage. Finally, increasing limits from \$5 million to \$10 million would increase cost by less than 0.1 percent, less than \$1 per month for either single or family coverage. Based on the current distribution of plans and their lifetime limits, we would estimate that the aggregate composite cost increase for all companies with lifetime limits would be 0.4 percent to 0.6 percent.

Premiums to Increase or Remove Lifetime Limits		
Lifetime Limit Change	% change	Monthly premium change
\$1 million to \$5 million	0.6 - 0.8%	\$3 (single)/\$8 (family)
\$2 million to \$5 million	0.25 - 0.35%	\$1.50 (single)/\$3.50 (family)
\$5 million to \$10 million	less than 0.1%	less than \$1 for single or family

Source: PricewaterhouseCoopers estimates

While the above cost increments represent average cost increases, the increases could be greater for any specific smaller self-insured or insured experience-rated employer who has ongoing high dollar chronic claimants in their covered population.

IV. Changes in Lifetime Limits, 1988-2007

All aspects of lifetime limits have changed during the past two decades. Not only have lifetime limits been increased as medical costs have risen but also the number of subject to lifetime limits has declined. The table below provides information from 1988 to 2007 showing that the percentage of people subject to lifetime limits in employer-sponsored plans has fallen from 79 percent in 1988 to 55 percent in 2007. During the same period the number of people subject to limits less than \$1 million has decreased from 34 percent to about 1 percent.

² The 2007 Kaiser survey indicated average monthly premiums of approximately \$373 for single and \$1,009 for family coverage. PwC added two years of medical trend (approximately 6% per year) to the 2007 Kaiser numbers.



Prevalence of Lifetime Limits, 1988-2007						
	2007	2004	2002	2000	1990	1988
Percent unlimited	45%	49%	33%	22%	22%	21%
Percent under \$1 million	1%	1%	4%	6%	22%	34%
Percent \$1 million or more	54%	50%	63%	72%	56%	44%
Value of \$1 million (2007 dollars)	\$1.0	\$1.2	\$1.3	\$1.6	\$2.8	\$3.6

Source: PricewaterhouseCoopers calculations based on data from employer surveys, 1988-2007

However, while lifetime limits have increased over the past two decades, the increases have not kept pace with increases in medical costs in all instances. If a 1988 lifetime limit of \$1 million is adjusted for the growth in healthcare costs (as shown in the last row of the table), the 2007 equivalent lifetime limit would be \$3.6 million. If we can consider that 65 percent had a lifetime limit of \$1 million or more in 1988, there would need to be at least 65 percent of the populations today with a lifetime limit of \$3.6 million or more for there to be no change. However, where lifetime limits exist today, only a low percentage of those limits are greater than \$2 million. Consequently, the data suggests that at the high end of the range, lifetime limits may actually affect more people today than in 1988.

Other data (not shown in the table) suggests that the percentage of people with lifetime limits below \$1 million (in 2007 dollars), has fallen over the past two decades. For example, in 1990, 7 percent of people with employer coverage were subject to lifetime limits less than \$250,000, which is equivalent to \$700,000 in 2007 dollars as compared to only 1 percent who were below the higher \$1,000,000 limit in 2007. It would appear that the percentage of people subject to particularly low lifetime limits has declined over the two decades.

The historical data on lifetime limits does not provide a clear answer as to the changes in impact of the limits over time. Clearly fewer people are subject to lifetime limits today as compared with two decades ago. However, a lifetime limit of \$1 million, which was the most common limit in 1988, is still quite common today.

V. Savings to Medicaid from Increasing Lifetime Limits

People whose spending exceeds a lifetime limit under their current insurance plan will seek other sources of coverage. Those who are financially well off may be able to pay for their care without assistance but most people will turn to other public and private sources. The most common source of care for those who meet income eligibility requirements is Medicaid.

For example, data from the U.S. Centers for Disease Control and Prevention (CDC) show that people with severe hemophilia are much more likely to have Medicaid coverage than is typical in the general U.S. population. The table below shows that about 14 percent of people in the U.S. have Medicaid coverage in a typical month. On average, 19 percent of people with hemophilia list Medicaid as their source of coverage. People with severe hemophilia are even more likely to have Medicaid coverage—29 percent compared to 18 percent of people with mild hemophilia.



Medicaid Coverage	
General US Population	14%
People with Hemophilia	
Mild	18%
Severe	29%

Source: PricewaterhouseCoopers calculations based on data from the CDC (<http://www2a.cdc.gov/ncbddd/htcweb/>)

PwC estimated the impact of lifetime limits on the total spending under Medicaid based on the lifetime limits in place today. Based on our finding that increasing lifetime limits to \$10 million would increase premiums by 0.5 percent, we estimate that spending within the lifetime limits in 2010 would be about \$2.1 billion. Using the conservative assumption that Medicaid, absent the increase in the limits, would replace 50 percent of those benefits, Medicaid savings from increasing the lifetime limits would be more than \$1 billion in 2010 dollars. Moreover, the amount would grow over time as medical costs rise. We estimate that Medicaid would save more than \$11 billion over the next 10 years.³

³ This estimate does not include spending above lifetime limits in firms with fewer than 20 employees. Small firms would likely be exempted from legislation to remove limits.

Raise the Cap Coalition

The Honorable Henry Waxman
Chairman
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Joe Barton
Ranking Member
House Committee on Energy and Commerce
2322-A Rayburn House Office Building
Washington, DC 20515

September 16, 2009

RE: Provision to Eliminate Lifetime Limits on Private Insurance in HR 3200

Dear Chairman Waxman and Ranking Member Barton:

On behalf of the undersigned organizations and millions of Americans with chronic diseases and conditions, thank you for your efforts to reform our healthcare system so that there will be adequate, affordable health care for all Americans. We strongly support the insurance market reforms included in HR 3200, especially the elimination of lifetime and annual limits on benefits. However, we are concerned about the delayed implementation of this provision for existing plans, and urge you to expedite its implementation.

Lifetime limits on private insurance pose a considerable problem for individuals with chronic diseases and conditions. Many private insurers continue to set lifetime caps on health coverage at \$2-\$3 million; no additional coverage is provided once these limits are reached. A person with a high cost chronic disease or condition could exhaust their benefits in as few as 5 years, or even in one or two in the case of a medical crisis. Increasing or eliminating lifetime caps would result in savings for state and federal governments, since individuals with high medical costs would be able to maintain their private insurance rather than be forced onto Medicaid. Independent analysis by PricewaterhouseCoopers found that more than \$11 billion over ten years would be saved by raising lifetime caps.

HR 3200 eliminates lifetime caps in "qualified health benefit plans" offered through the Exchange or through new employer-based plans as of 2013; existing group plans are exempt from this requirement until 2018. Since most people with chronic diseases and conditions have employer-sponsored insurance plans, as it is often prohibitively expensive for them to secure individual market insurance, these people could be subject to lifetime limits for an additional 9 years. This is simply too long.

We respectfully request that you amend HR 3200 to implement the elimination of lifetime caps in the next plan year after the law is enacted, similar to the enactment of the language prohibiting insurance policy rescissions. Rescissions are similar to lifetime caps in that both are insurance company practices which penalize people who submit high-cost claims. Rescissions may have a more immediate impact since they occur following the submission of claims, but the end result is the same: a person with a serious medical condition loses insurance coverage. In both cases, people are forced to make difficult decisions about their jobs, residences and even family life to secure new coverage.

Alternatively, we propose an interim policy for lifetime caps following the path in HR 1085, the bi-partisan Health Insurance Coverage Protection Act. HR 1085 sets a minimum lifetime cap for

all plans at \$5 million in plan years one and two, and \$10 million for plan years three and four, with an inflationary update for subsequent plans years. The minimum lifetime cap could be in place until caps are eliminated in 2013 and 2018, as the bill currently sets forth. This approach of implementing an interim policy is similar to the approach that the Education and Labor Committee took with respect to pre-existing condition exclusions.

Individuals with chronic diseases and disorders must not be impeded in accessing necessary health care nor should they be impoverished with unreasonable lifetime limits on benefits. We respectfully ask that you implement the elimination of lifetime caps in the next plan year following enactment of the law, or at least provide an interim policy to phase-in the elimination of caps more quickly.

Sincerely,

Alpha-1 Association
 Alpha-1 Foundation
 American Cancer Society Cancer Action Network
 American Heart Association/American Stroke Association
 Arthritis Foundation
 Autism Society
 Baxter Healthcare Corporation
 Brain Injury Association of America
 Breast Cancer Network of Strength
 Christopher and Dana Reeve Foundation
 Committee of Ten Thousand
 Cooley's Anemia Foundation
 Crohn's and Colitis Foundation of America
 CSL Behring
 GBS/CIDP Foundation International
 Grifols
 Hemophilia Federation of America
 Huntington's Disease Society of America

Immune Deficiency Foundation
 Interstitial Cystitis Association
 Kids With Heart National Association for Children's Heart Disorders, Inc
 National Family Caregivers Association
 National Gaucher Foundation
 National Health Council
 National Hemophilia Foundation
 National Marfan Foundation
 National MS Society
 National Organization for Rare Disorders
 National Patient Advocate Foundation
 Patient Services Incorporated
 Pediatric Stroke Network
 Plasma Protein Therapeutics Association
 Platelet Disorder Support Association
 Prevent Blindness America
 Pulmonary Hypertension Association
 Scleroderma Foundation
 Sjögren's Syndrome Foundation



1834 Beech Street • Knoxville, Tennessee 37920
(865) 579-1530 • Fax (865) 609-1876 • www.ramusa.org

October 9, 2009

Re: Testimony of Stan Brock, Remote Area Medical Volunteer Corps, for the
Committee on Energy and Commerce, Subcommittee on Oversight and Investigations
Hearing: "Insured but Not Covered: The Problem of Underinsurance,"
Scheduled for October 15, 2009, 1:30pm

In 1992, REMOTE AREA MEDICAL® (RAM), a charity formed to provide free
medical relief overseas, began receiving requests for services in the United States,
including dental procedures, eye exams, free eyeglasses, and primary health care. Today,
64% of our work is in America. We run about 30 expeditions per year and have
completed 581.

Some 45,000 volunteers have delivered \$40 million worth of free care in over 400,000
patient encounters and treatment to more than 64,000 animals.

***Remote Area Medical is a 501 (c) (3) charitable organization with no paid employees using
an airborne force of volunteers dedicated to serving mankind, providing free health care, veterinary services and
technical and educational assistance in remote and rural areas of the United States and around the world.***

Our most sought-after services are dental and vision with over 55,000 patients served in the U.S. in each specialty. Demographics reveal that 94% of the patients are adults, with 83% between ages 21 and 64, reflecting a transition from childhood-covered programs to uninsured status prior to receiving Medicare benefits. 16% of them visit a hospital emergency room in the event of sickness, undergoing extensive tests caused by the practice of defensive medicine, while dentists and eye doctors are unaffordable, leading to long lines of desperate Americans at RAM free clinics.

The greatest impediment RAM programs face is regulation in 49 states preventing willing practitioners from crossing state lines to provide free care. Even during declared emergencies reciprocity between states is a complex matter that current legislation under the Uniform Emergency Volunteer Practitioners Act (UEVHPA) cannot adequately address. The sole exception is the Volunteer Health Care Services Act of Tennessee. Since 1995 a doctor can show up at a RAM event in Tennessee with license in hand and get to work – no bureaucratic application process, no fees, and no unnecessary background investigations. In 1997, Representative John J. Duncan, Jr., introduced House Concurrent Resolution 69 in an effort to persuade states to adopt the Tennessee model. H.C.R. 69 was referred to the Committee of Commerce. Despite endorsement by the American Medical Association in 1998 it gained no ground nationwide.

RAM events attract thousands of uninsured and underinsured patients and require large numbers of doctors. Patient volume invariably exceeds the number of local providers willing or available to volunteer free services. This gap can only be filled by reinforcing

our teams with volunteers licensed in other states. There are more than 179,000 dentists in America and 800,000 physicians. They pass a nationally standardized competency test and graduate from a nationally accredited school. Many like to travel and will do so at their own expense to provide free care – some do so in other countries because volunteering outside of the U.S. is easier than overcoming bureaucratic hurdles to help those 47 million uninsured here in America.

This demonstrates the need for all states to adopt the Tennessee model as proposed in the failed H.C.R. 69 initiative. That need was recently emphasized at a REMOTE AREA MEDICAL® event in Los Angeles. In 8 days, RAM treated 6,344 patients for a value of free care exceeding \$2.8 million. But, those numbers could have been doubled. We had 100 dental chairs and 20 lanes of eye exam equipment, yet on some days, we could only recruit 25 California-licensed dentists and 5 or 6 eye specialists. By comparison, in rural southwest Virginia, where laws were relaxed to allow the partial use of out-of-state doctors, RAM treated 2,715 patients in only 2 ½ days, a patient number not attained in Los Angeles until the 4th day, while thousands of uninsured California residents were turned away.

RAM patient surveys indicate that some 46% carry no insurance, 23% are on Medicaid and 18% on Medicare. Dental and vision insurance is carried by less than 1%. Self-induced health issues wrought by the culture of poverty, caused by fast foods, smoking, and lack of exercise are aggravated by the problems of access: Patients don't have

access to the doctor; the doctor cannot cross state lines to have access to the patients; and the doctor does not have reasonable access to protection from lawsuits.

RAM data proves that allowing doctors to cross state lines dramatically increases service to the underserved. If the Tennessee statute was enacted by all 50 states, or possibly at the federal level (for example under the Interstate Commerce Provisions of the Constitution), volunteers would respond en masse, and serve millions of uninsured Americans at NO COST to the government or the taxpayer.



Dear Individual Member,

We would like to welcome you to Blue Cross of California and extend our thanks for choosing our health plan.

This booklet provides a complete statement of all the benefits available to you. Please read it carefully to be sure you fully understand your benefits, coverage, limitations and exclusions. For your convenience, at the front of this Combined Evidence of Coverage and Disclosure Form is a brief summary of the benefits provided by this booklet. This is only a summary; the agreement contains the exact terms and conditions of coverage.

Additionally, please keep this booklet in a convenient place so you may refer to it whenever you have a question about your coverage.

If you have any questions regarding your eligibility, claims status or your benefits under this Combined Evidence of Coverage and Disclosure Form, please feel free to contact our Customer Service Department at 1-800-333-0912 or at the address listed on your identification card.

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7891 (1871)

Revised 04-01-2003

HEALTH PLAN BENEFITS AND COVERAGE MATRIX			
Contract Code: 7891 BLUE CROSS INDIVIDUAL PPO SHARE \$2,500			
This matrix is intended to be used to help you compare coverage benefits and is a summary only. The evidence of coverage and plan contract should be consulted for a detailed description of coverage benefits and limitations.			
This is an overview of coverage. The Evidence of Coverage (EOC) contains the exact terms and conditions of coverage. You have a right to view the EOC prior to enrollment. To obtain a copy of the EOC, please call 1 800 333-0912.			
Benefit	Your Copayment/Coinsurance		Special Limitations
	In Network	Out Of Network	
Annual Deductible	\$2,500		
Lifetime Maximums	\$5,000,000 lifetime maximum Benefits paid by Blue Cross		
Professional Services	30% of Negotiated Fee Rate (NFR)	50% of the Negotiated Fee Rate (NFR) plus all charges in excess of the NFR	Office Visits not subject to Deductible.
Outpatient Services	Preferred Participating Providers: 30% of the NFR Participating Providers: 30% of the NFR plus \$500 admission charge for surgery or Infusion Therapy	All charges except \$380 per day	The \$500 admission charge will not be applied towards the Member's Yearly Maximum Copayment/Coinsurance Limit. The \$500 admission charge will not be required for Ambulatory Surgical Centers or Medical Emergency services.
Hospitalization Services	Preferred Participating Hospitals: 30% of the NFR Participating Hospitals: 30% of the NFR plus \$500 admission charge	All charges except \$650 per day	The \$500 admission charge will not be applied towards the Member's Yearly Maximum Copayment/Coinsurance Limit.

Benefit	Your Copayment/Coinsurance		Special Limitations
	In Network	Out Of Network	
Emergency Health Coverage	30% of the NFR	<p>Within California: Physician: 30% of the Customary and Reasonable (C&R) charges or billed charges, whichever is less plus all charges in excess of C&R Hospital: 30% of C&R charges or billed charges, whichever is less, plus all charges in excess of C&R for the 1st 48 hours. After 48 hours, if you are stabilized and could be transferred to a Participating Provider, you pay all charges except \$650 per day. Ambulatory Surgical Center (ASC): 30% of C&R charges plus all charges in excess of C&R Ambulance services: 30% of C&R charges plus all charges in excess of C&R</p>	<p>Emergency Room services in the state of CA. for both Participating and Non-Participating Providers are subject to an additional \$30 Copayment per visit which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services.</p> <p>If the Member has not been stabilized sufficiently to be safely transferred to a Participating facility after the first 48 hours, then the Member's payment will remain at 30% of C&R charges or billed charges, whichever is less, plus all charges in excess of C&R until his/her condition permits transfer to a Participating facility.</p> <p>Please refer to your EOC for further information about emergency care outside of California.</p> <p>The \$30 Emergency Room Copayment and Coinsurance paid on allowable charges will be applied towards the Member's Yearly Maximum Copayment/Coinsurance Limit.</p>
Ambulance Services Other Than in a Medical Emergency or Without an Authorized Referral	30% of the NFR	50% of the NFR plus all charges in excess of the NFR	

Benefit	Your Copayment/Coinsurance		Special Limitations
	In Network	Out Of Network	
Prescription Drug Coverage	<p>Retail Pharmacies Generic: \$10 Copayment</p> <p>Brand: After \$500 Brand Name Deductible \$30 Copayment</p> <p>Brand Name Drugs requested by Subscriber: \$30 Copayment plus the difference between Brand & Generic</p> <p>Self-administered injectable Drugs (except Insulin): 30% of the NFR</p> <p>Mail Order: Generic: \$10 Copayment</p> <p>Brand: After \$500 Brand Name Deductible \$30 Copayment</p>	<p>Retail Pharmacies: Copayment as stated for Participating Pharmacies plus 50% of the Drug Limited Fee Schedule (DLFS) and all charges in excess of the DLFS.</p> <p>Mail Order Not Applicable</p>	<p>Copayment applies for each 30-day supply; 60-day supply available through mail order for an additional Copayment.</p> <p>Brand Name Prescription Deductible: Two (2) Member family maximum Brand Name Deductible applies to Brand Name Prescriptions purchased through Mail Order and at Participating and Non-Participating Pharmacies combined.</p> <p>Refer to EOC for Prescription Drug Exclusions and Limitations.</p>
Durable Medical Equipment (Medical Supplies & Equipment)	30% of the NFR	50% of the NFR plus all charges in excess of the NFR	<p>Footwear limited to a maximum of \$200 per Year for Participating and Non-Participating Providers combined.</p> <p>Refer to EOC for all other Exclusions and Limitations.</p>

Benefit	Your Copayment/Coinsurance		Special Limitations
	In Network	Out Of Network	
Mental Health Services	<p>Inpatient Services: All of the NFR except \$175 per day</p> <p>Professional Services: All of the NFR except \$25 per visit</p> <p>Services for Severe Mental Illnesses and Serious Emotional Disturbances of a Child:</p> <p>Benefits provided the same as for any other medical condition. Amounts you pay for these services will apply toward Your Deductible and Yearly Maximum Copayment/Coinsurance Limit.</p>	<p>Inpatient Services: All charges except \$175 per day</p> <p>Professional Services: All charges except \$25 per visit</p> <p>Services for Severe Mental Illnesses and Serious Emotional Disturbances of a Child:</p> <p>Benefits provided as any other medical condition</p>	<p>Inpatient Services: 30 days per Year maximum, combined with Chemical Dependency Services.</p> <p>Professional Services: One visit per day, 20 visits per Year combined with Chemical Dependency Services.</p> <p>Mental Health Services limitations do not apply to Treatment of Severe Mental Illnesses and Serious Emotional Disturbances of a Child.</p>
Chemical Dependency Services	<p>Inpatient Services: All of the NFR except \$175 per day</p> <p>Professional Services: All of the NFR except \$25 per visit</p>	<p>Inpatient Services: All charges except \$175 per day</p> <p>Professional Services: All charges except \$25 per visit</p>	<p>Inpatient Services: 30 days per Year maximum, combined with Inpatient Mental Health Services.</p> <p>Professional services: One visit per day, 20 visits per Year maximum, combined with Mental Health Services.</p>
Home Health Services	30% of the NFR	All charges except \$75 per visit	60 visits per Year maximum for Participating/Non-Participating Providers combined, up to 4 hours each visit.
Pregnancy and Maternity Services	30% of the NFR	50% of the NFR plus all charges in excess of the NFR	Requires an additional \$1,000 Copayment per pregnancy. This Copayment will not be applied to the Yearly Maximum Copayment/Coinsurance Limit.
Physical Therapy, Occupational Therapy, Chiropractic Care	30% of the NFR	All charges except \$25 per visit	12 visits per Year maximum for Participating/Non-Participating Providers combined, additional visits as authorized by Blue Cross if Medically Necessary.
Skilled Nursing Facility	30% of the NFR	All charges except \$150 per day	100 days per Year maximum for Participating/Non-Participating Providers combined

Benefit	Your Copayment/Coinsurance		Special Limitations
	In Network	Out Of Network	
Infusion Therapy	30% of the NFR	Professional and Administering expenses: All charges in excess of \$50 per day for all expenses except Drugs. Drugs: All charges in excess of the Average Wholesale Price (AWP) plus all charges in excess of the per day maximum	Combined covered maximum will not exceed \$500 per day for Non-Participating Providers only.
Acupuncture and Acupressure	All of the NFR except \$25 per visit	All charges except \$25 per visit	24 visits per Year maximum for Participating/Non-Participating combined. Not subject to Deductible.
Outpatient Speech Therapy	30% of the NFR	30% of C&R charges plus all charges in excess of C&R	50 visits per Year maximum; additional visits are covered as authorized by Blue Cross if Medically Necessary. Refer to the EOC for additional information.
Yearly Maximum Copayment/Coinsurance Limit	\$5,000 per Member per Year, 2 Member maximum	Not Applicable	Amounts you pay for: Acupuncture and Acupressure, Non-Participating Physical Therapy, Occupational Therapy and Chiropractic Care services, and services under the benefit entitled Mental or Nervous Disorders and Substance Abuse (except Severe Mental Illnesses and Serious Emotional Disturbances of a Child) do not accumulate to your Yearly Maximum Copayment/Coinsurance Limit. In addition, Prior Authorization Copayments, Prescription Drug Copayments, the additional Maternity Copayment and Hospital admission charges do not apply to your Yearly Maximum Copayment/Coinsurance Limit. Refer to your EOC for additional information about your Yearly Maximum Copayment/Coinsurance Limit.

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INTRODUCTION

Blue Cross of California ("Blue Cross") enters into this Agreement ("Agreement") with you based upon the answers submitted by you and your Family Members on the signed Individual Enrollment Application. In consideration for the payment of the Subscription Charges stated in this Agreement, we will provide the services and benefits listed in this Agreement to you and your eligible Family Members.

For your convenience, at the front of this Agreement and Combined Evidence of Coverage and Disclosure Form, is a brief summary of the benefits provided by this booklet. The disclosure form is a summary only; the Agreement contains the exact terms and conditions of coverage. Please read the Agreement completely and carefully. Individuals with special health care needs should carefully read those sections that apply to them.

YOU HAVE THE RIGHT TO VIEW THE AGREEMENT PRIOR TO ENROLLMENT

Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A participating Physician may, after notice from us, be subject to a reduced Negotiated Fee Rate in the event the participating Physician fails to make routine referrals to Participating Providers, except as otherwise allowed (such as for emergency services). Hospitals and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis. For additional information, you may contact us at 1-800-333-0912 or you may contact your participating Physician.

Some Hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your Family Member might need:

- Family planning;
- Contraceptive services, including emergency contraception;
- Sterilization, including tubal ligation at the time of labor and delivery;
- Infertility treatments;
- Abortion

You should obtain more information before you schedule an appointment. Call your prospective doctor, medical group, or clinic, or call customer service toll free at 1-800-333-0912 to ensure that you can obtain the health care services that you need.

If your provider has been terminated and you feel you qualify for continuation of services, you must request that services be continued. This can be done by calling 1-800-333-0912.

In this Agreement, "we," "us" and "our" mean Blue Cross. You are the eligible Subscriber whose application has been accepted by us. "You" and "your" shall also mean any eligible Family Members who were listed on your application and were accepted by us for coverage under this Agreement. When we use the word "Member" in this Agreement we mean you and any eligible Family Member covered under this Agreement.

The benefits of this Agreement are provided only for those services that Blue Cross determines are Medically Necessary and a Covered Service. If you have any questions as to whether a service is covered, consult this Agreement or call us at 1-800-333-0912. Our customer service representatives can assist you in determining the benefits of your Plan and, if necessary, help you obtain Prior Authorization for the types of benefits that require Prior Authorization. Our customer service representatives can also assist you with the selection of a Participating Provider in your area from our Participating Provider Directory and can give you information on some of our "Programs To Keep You Well." A Participating Provider directory, or information on Participating Providers, may be obtained by calling our customer service department toll free at 1-800-333-0912 or by accessing our website at www.bluecrossca.com. The Participating Provider directory is updated quarterly and lists providers that have a Prudent Buyer Plan Participating Provider Agreement in effect with us. Working together as partners in your health care can make your medical experiences less stressful and more cost effective to you.

YOU HAVE TEN (10) DAYS FROM THE DATE OF DELIVERY TO EXAMINE THIS AGREEMENT. IF YOU ARE NOT SATISFIED, FOR ANY REASON, WITH THE TERMS OF THIS AGREEMENT, YOU MAY RETURN THE AGREEMENT TO US WITHIN THOSE 10 DAYS. YOU WILL THEN BE ENTITLED TO RECEIVE A FULL REFUND OF ANY SUBSCRIPTION CHARGES PAID. THIS AGREEMENT WILL THEN NO LONGER BE IN EFFECT.

IF, DURING THE FIRST TWO YEARS OF MEMBERSHIP UNDER THIS AGREEMENT, WE DISCOVER ANY MATERIAL FACTS THAT YOU OR YOUR ELIGIBLE FAMILY MEMBERS KNEW, BUT DID NOT DISCLOSE ON YOUR APPLICATION, WE WILL CANCEL THIS AGREEMENT BACK TO ITS EFFECTIVE DATE.

CHOICE OF CONTRACTING HOSPITAL, SKILLED NURSING FACILITY, ATTENDING PHYSICIAN AND OTHER PROVIDERS OF CARE: Nothing contained in this Agreement restricts or interferes with your right to select the Contracting Hospital, Skilled Nursing Facility, attending Physician, or other providers of your choice.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Throughout this Agreement, you will find key terms which will appear with the first letter of each word capitalized. When you see these capitalized words you should refer to the PART entitled, DEFINITIONS of this Agreement where the meanings of these terms or words are defined. Some key terms may be defined within a specific benefit description.

PROGRAMS TO KEEP YOU WELL**Keeping You Healthy**

Blue Cross is concerned about your health. Through health education you learn ways to improve your family's health, and how to stay healthy. Your doctor will have information on diet, exercise, how to stop smoking and more. Blue Cross can help you learn to take care of yourself and your family. Ask your doctor for information about available services.

Blue Cross also helps you learn more about good health habits. We offer:

MedCall

The Blue Cross MedCall system provides you with 24-hour health care information, seven days a week, from a registered nurse. Nurses that can help you decide what to do about your medical concerns and give you current, accurate medical information on a wide range of topics. The same toll free number also gives you access to a comprehensive audio health library of recorded information on over 430 health topics. For your health question, just call MedCall at 1-800-249-3617.

Well Baby And Well Child Care

Well child visits are for children up to and including 6 years. During these visits, the doctor checks the child's health, hearing, vision and dental needs. Immunizations (baby shots) are given during these visits. Ask your doctor when you are to bring your child in for the next appointment.

Preventive Care Services

Preventive care services are offered through our HealthyCheck Centers to children from the age of 7 years through 18 years and adults age 19 years and above. Children receive a physical assessment with age appropriate laboratory tests and vision and hearing tests and also any immunizations which may be necessary. Adults receive a physical assessment and can have their cholesterol checked and receive flu shots when medically appropriate. You can also take advantage of the counseling, literature and videos on health related issues available to you during your visit. Call today to make an appointment at one of our HealthyCheck Centers.

Adult Preventive Services

These services include an annual pap examination, breast exams, mammography testing, appropriate screening for breast cancer, PSA's, and the Office Visit related to these services. Please review this Agreement to find out more about your coverage. These services are provided at your Physician's office and not at the HealthyCheck Centers.

Pregnancy Services

If you are pregnant, you should call your doctor right away to start your pregnancy care. It is also important that you call Blue Cross at 1-800-769-4896 to notify us of your estimated date of delivery, your Physician's name and the Hospital you plan to go to for delivery of your child. Please call us no later than 12 weeks into your pregnancy. After delivery of your child, or if you experience problems in your pregnancy (persistent bleeding and/or vomiting after 12 weeks, or signs of early labor), we request that you (or someone representing you) notify us at 1-800-769-4896 within 24 hours of delivery or onset of problems.

Health Management Programs

Blue Cross of California's Health Management Programs provide Members who have a chronic condition with the tools they need to be more active and enjoy a fuller life. All programs rely on a partnership among patients, their health care providers and Blue Cross to ensure the best care. If you would like more information on our asthma and congestive heart failure health management programs, you can call toll free 1-888-642-4908.

PART I ELIGIBILITY

Who is Eligible for Coverage

The **Subscriber** is the person listed as the applicant whose Individual Enrollment Application has been approved and accepted by us for coverage under this Agreement.

Family Members are the following Members of the Subscriber's family who are eligible and accepted under this Agreement:

- The Subscriber's lawful spouse of the opposite sex.
- Any children of the Subscriber or the Subscriber's enrolled spouse who are under age 19.
- Any unmarried children of the Subscriber or the enrolled spouse who are between the ages of 19 and their 23rd birthday, provided they are dependent upon them for at least half of their support. If your dependent does not meet the qualifications to remain as a dependent on your plan, Blue Cross will automatically enroll your dependent, if a resident of California, on the same Plan, under his/her own social security number.
- Any of the Subscriber's or enrolled spouse's children who continue to be both incapable of self support due to continuing mental retardation or physical handicap and who are still at least one-half dependent upon the Subscriber or the enrolled spouse for support. We must receive written proof of such handicap and dependency within thirty-one (31) days of the child reaching the limiting age and as often as we may require thereafter. Two years after receipt of the initial proof, we may require no more than annual proof of the continuing handicap and dependency.
- Newborns of the Subscriber or the Subscriber's enrolled spouse for the first thirty-one (31) days of life. TO CONTINUE COVERAGE, THE NEWBORN MUST BE ENROLLED AS A FAMILY MEMBER BY NOTIFYING BLUE CROSS IN WRITING WITHIN SIXTY (60) DAYS OF BIRTH AND THE SUBSCRIBER WILL BE RESPONSIBLE FOR ANY ADDITIONAL SUBSCRIPTION CHARGES DUE EFFECTIVE FROM THE DATE OF BIRTH.

NEWBORNS OF THE SUBSCRIBER'S DEPENDENT CHILDREN ARE NOT COVERED UNDER THIS AGREEMENT.

- A child being adopted by the Subscriber will have coverage up to thirty-one (31) days from the date on which the adoptive Child's birth parent or appropriate legal authority signs a written document granting the Subscriber or the enrolled Spouse the right to control health care for the adoptive Child, or absent this document, the date on which other evidence exists of this right. TO CONTINUE COVERAGE, THE ADOPTED CHILD MUST BE ENROLLED AS A FAMILY MEMBER BY NOTIFYING US IN WRITING WITHIN SIXTY (60) DAYS OF THE DATE THE SUBSCRIBER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED AND THE SUBSCRIBER WILL BE RESPONSIBLE FOR ANY ADDITIONAL SUBSCRIPTION CHARGES DUE EFFECTIVE FROM THE DATE THE SUBSCRIBER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED.

When the Member Becomes Ineligible

A Member becomes ineligible for coverage under this Agreement when:

1. The Subscriber does not pay the subscription charges when due, subject to the grace period.
2. The spouse is no longer married to the Subscriber.
3. The child fails to meet the eligibility rules listed above.
4. The Member fails to cancel any other coverage upon becoming enrolled under this Agreement.
5. A Member is absent from California for more than six (6) months. Over age dependents: if your dependent is absent from California for more than six (6) months, in a state in which UNICARE Life & Health Insurance Company writes individual policies, you may submit an application for a UNICARE product. The type of coverage offered will be at the discretion of UNICARE.

Notice of Change in Eligibility

You must notify us of all changes affecting any Member's eligibility under this Agreement within thirty (30) days of the change.

PART II MAXIMUM COMPREHENSIVE BENEFITS

Lifetime Maximum

The combined total of all benefits paid under this Agreement is limited to a maximum amount of \$5,000,000 during each Member's lifetime, as long as this Agreement remains in effect.

Any additional limits on the number of visits or days covered are stated in the PARTS entitled, BENEFIT COPAYMENT/COINSURANCE LIST and/or COMPREHENSIVE BENEFITS: WHAT IS COVERED BY BLUE CROSS.

Deductible

Before we pay for any medical benefits, you must satisfy your \$2,500 Yearly Deductible per Member. The medical Deductible is described in the following PART entitled BENEFIT COPAYMENT/COINSURANCE LIST.

Copayments/Coinsurance

You will be required to pay a Copayment/Coinsurance for services received while you are covered under this Plan. Your Copayment/Coinsurance may be a fixed dollar amount per day, visit or it may be a percentage of eligible charges. It could also be a combination of a fixed dollar amount and a percentage of eligible charges. Hospital admission charges and some Copayments/Coinsurance (e.g., Prior Authorization and maternity) **will not** be applied toward your Yearly Maximum Copayment/Coinsurance Limit and **will continue to be required** even after your Yearly Maximum Copayment/Coinsurance Limit has been reached. **Refer to the PART entitled BENEFIT COPAYMENT/COINSURANCE LIST to determine your Copayment/Coinsurance responsibility for Covered Services for Participating and Non-Participating Providers.**

Yearly Maximum Copayment/Coinsurance Limit

The Yearly Maximum Copayment/Coinsurance Limit for **Participating/Preferred Participating and/or Non-Participating Providers**, also referred to as the out of pocket maximum, is **\$5,000** per Member per Year. For a family, when two (2) Members of an enrolled family have met their Yearly Maximum Copayment/Coinsurance Limit, no further Copayment/Coinsurance will be required for Participating/Preferred Participating and/or Non-Participating Providers for the remainder of that Year.

Your Yearly Deductible for Covered Services will apply towards your Yearly Maximum Copayment/Coinsurance Limit.

Exception: Amounts you pay for the following services rendered by either Participating or Non-Participating Providers will **not** accumulate toward satisfying your Yearly Maximum Copayment/Coinsurance Limit and you will continue to be required to pay Copayments/Coinsurance for those services even after your Yearly Maximum Copayment/Coinsurance Limit has been reached: Acupuncture and Acupressure, and services under the benefit entitled, Mental or Nervous Disorder and Substance Abuse (other than Severe Mental Illnesses and Serious Emotional Disturbances of a Child). Amounts you pay for Physical Therapy, Occupational Therapy and Chiropractic Care services rendered by Non-Participating Providers will not apply to your Yearly Maximum Copayment/Coinsurance Limit and you will continue to be required to pay Copayments for these services even after your Yearly Maximum Copayment/Coinsurance Limit has been reached.

Note: You will continue to be responsible for amounts over our allowed payment for the above listed services rendered by either a Participating or Non-Participating Provider.

In addition, Hospital admission charges, the additional \$1,000 maternity Copayment, Prescription Drug Copayments and Prior Authorization Copayments will **not** accumulate toward satisfying your Yearly Maximum Copayment/Coinsurance Limit and will continue to be required even after your Yearly Maximum Copayment/Coinsurance Limit has been reached.

PART III BENEFIT COPAYMENT/COINSURANCE LIST

For a detailed description of what is covered, see the PART entitled, COMPREHENSIVE BENEFITS: WHAT IS COVERED BY BLUE CROSS.

Your Deductible each Year for services is \$2,500 per Member. During each Year, each Member is responsible for all expense incurred for Covered Services up to the Deductible amount. This amount must be recorded on our files as payable by the Member to the provider of service. A claim must be submitted in order for us to record your eligible covered Deductible expense. We will record your Deductible in our files in the order in which your claims are processed, not necessarily in the order in which you receive the service or supply. The first two (2) Members of an enrolled family to satisfy their individual Deductibles in full will satisfy the Deductible for the entire family. Once the family Deductible is satisfied, no further Deductible is required for the remainder of that Year. However, we will not credit any Deductible over and above the family Deductible maximum that was applied but did not satisfy an individual Member's Deductible amount in full.

Your Yearly Deductible for Covered Services will apply towards your Yearly Maximum Copayment/Coinsurance Limit.

If you submit a claim for services which have a maximum payment limit (e.g., Physical Therapy, Occupational Therapy and Chiropractic Care performed by a Non-Participating Physician, or Mental or Nervous Disorder and Substance Abuse) and your Deductible is not satisfied, we will apply only the allowed per visit or per day amount, whichever applies, toward your Deductible amount.

Note: No Deductible is required for all covered Office Visits, Acupuncture and Acupressure, Well Baby and Well Child Office Visits or Preventive Care Office Visits.

Your personal financial costs when using Non-Participating Providers will be considerably higher than when you use Participating Providers. You will be responsible for any balance of a provider's bill which is above the allowed amount payable under this Agreement for Non-Participating Providers. See the **Special Circumstances** section of this Provider Copayment/Coinsurance List for situations that may reduce your payment responsibility when utilizing a Non-Participating Provider.

No benefits are provided for Non-Contracting Hospitals within California for inpatient Hospital services or outpatient surgical procedures except as specifically stated in the section entitled, **Special Circumstances**.

<u>BENEFIT</u>	<u>YOUR PAYMENT RESPONSIBILITY</u>
INPATIENT HOSPITAL	
Preferred Participating Hospital	30% of the Negotiated Fee Rate.
Participating Hospital	30% of the Negotiated Fee Rate plus \$500 admission charge.*
Non-Participating Hospital	All charges in excess of \$650 per day unless Special Circumstances apply.

BENEFIT**YOUR PAYMENT RESPONSIBILITY****OUTPATIENT HOSPITAL, AMBULATORY SURGICAL CENTERS AND EMERGENCY ROOM**

Preferred Participating Provider	30% of the Negotiated Fee Rate.
Participating Provider	30% of the Negotiated Fee Rate plus \$500 admission charge* when visit is related to surgery or Infusion Therapy.
Non-Participating Provider	All charges in excess of \$380 per day unless Special Circumstances apply.

Emergency Room services in the state of California, for both Participating and Non-Participating Providers are subject to an additional \$30 Copayment per visit, which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services.

*The Member is responsible for a \$500 admission charge per admission for inpatient services or when an outpatient visit is related to surgery or Infusion Therapy at a Participating Hospital. This admission charge is separate from any Deductible required by this Agreement. It does not apply toward satisfying the Member's Yearly Deductible or Yearly Maximum Copayment/Coinsurance Limit. The admission charge will not be required for Medical Emergency admissions or Ambulatory Surgical Centers.

SKILLED NURSING FACILITY

Limited to 100 days per Year combined for Participating and Non-Participating Providers.

Participating Skilled Nursing Facility	30% of the Negotiated Fee Rate.
Non-Participating and Out of State	All charges in excess of \$150 per day.

HOME HEALTH CARE SERVICES

Limited to 60 visits per Year combined for Participating and Non-Participating Providers, up to 4 hours or less each visit.

Participating Provider	30% of the Negotiated Fee Rate.
Non-Participating Provider	All charges in excess of \$75 per visit.

PROFESSIONAL SERVICES

(Including Office Visits)

Participating Provider	30% of the Negotiated Fee Rate.
Non-Participating Provider	50% of the Negotiated Fee Rate plus all charges in excess of the Negotiated Fee Rate unless Special Circumstances apply.

BENEFIT**YOUR PAYMENT RESPONSIBILITY****MEDICAL SUPPLIES, EQUIPMENT AND FOOTWEAR**

Footwear limited to a maximum benefit of \$200 per Year combined for Participating and Non-Participating Providers.

Participating Provider	30% of the Negotiated Fee Rate.
Non-Participating Provider	50% of the Negotiated Fee Rate plus all charges in excess of the Negotiated Fee Rate.

**AMBULANCE
IN A MEDICAL EMERGENCY OR WITH AN AUTHORIZED REFERRAL**

Participating Provider	30% of the Negotiated Fee Rate.
Non-Participating Provider	30% of Customary and Reasonable Charges plus all charges in excess of Customary and Reasonable.

**AMBULANCE
OTHER THAN IN A MEDICAL EMERGENCY OR WITHOUT AN AUTHORIZED REFERRAL**

Participating Provider	30% of the Negotiated Fee Rate.
Non-Participating Provider	50% of the Negotiated Fee Rate plus all charges in excess of the Negotiated Fee Rate.

DENTAL INJURY

Participating Provider	30% of the Negotiated Fee Rate.
Non-Participating Provider	50% of the Negotiated Fee Rate plus all charges in excess of the Negotiated Fee Rate unless Special Circumstances apply.

INFUSION THERAPY

Participating Provider	30% of the Negotiated Fee Rate.
The combined maximum payment we will make for all Infusion Therapy services (administrative, professional and Drugs) received by Non-Participating Providers will not exceed \$500 per day.	
Non-Participating Provider	Administrative and Professional Services: All charges in excess of \$50 per day. Drugs: All charges in excess of the Average Wholesale Price plus all charges in excess of the per day maximum payment indicated above.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY and/or CHIROPRACTIC CARE

Non-Participating Provider payments for these benefits will not be applied to the Member's Yearly Maximum Copayment/Coinsurance Limit. Members may receive these services up to 12 visits per Year combined for Participating and Non-Participating Providers. Additional visits will be covered as authorized by Blue Cross, but only if Blue Cross determines that additional treatment is Medically Necessary. Blue Cross will authorize a specific number of additional visits

Participating Provider	30% of the Negotiated Fee Rate.
Non-Participating Provider	All charges except \$25 per visit.

BENEFIT**YOUR PAYMENT RESPONSIBILITY****ACUPUNCTURE and ACUPRESSURE**

Limited to 24 visits per Year combined for Participating and Non-Participating Providers. Payments for this benefit will not be applied toward the Yearly Member's Maximum Copayment/Coinsurance Limit. No Deductible is required.

Participating Provider	All of the Negotiated Fee Rate except, \$25 per visit.
Non-Participating Provider	All charges except \$25 per visit.

PREGNANCY and MATERNITY CARE

After your additional \$1,000 Copayment per pregnancy, Hospital charges are paid as any other illness. This Copayment is **in addition to** the Yearly Deductible and will not be applied toward the Member's Yearly Maximum Copayment/Coinsurance Limit. Refer to the Inpatient Hospital section of this BENEFIT COPAYMENT/COINSURANCE LIST.

Professional Charges

Participating Physician	\$1,000 Copayment plus 30% of the Negotiated Fee Rate.
Non-Participating Physician	\$1,000 Copayment plus 50% of the Negotiated Fee Rate plus all charges in excess of the Negotiated Fee Rate.

WELL BABY and WELL CHILD CARE

Up to and including 6 years of age for Office Visits and/or services received in a Physician's office. No Deductible is required

Participating Provider	40% of the Negotiated Fee Rate.
Non-Participating Provider	50% of the Negotiated Fee Rate for the Office Visit and all other Covered Services related to that visit plus all charges in excess of the Negotiated Fee Rate.

PREVENTIVE CARE SERVICES

For Members age 7 to adult. No Deductible is required, however, Copayments paid at HealthyCheck Centers do not accumulate toward satisfying your Yearly Deductible.

Performed at HealthyCheck Centers only	\$25 per Member per visit.
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This benefit does not apply to Non-Participating Providers.

BENEFIT

YOUR PAYMENT RESPONSIBILITY

MENTAL or NERVOUS DISORDERS and SUBSTANCE ABUSE

Except for the treatment of Severe Mental Illnesses and Serious Emotional Disturbances of a Child. The payments for this benefit will not be applied toward the Member's Yearly Maximum Copayment/Coinsurance Limit.

Inpatient Hospital and Day Treatment Program

Participating or Preferred Participating Providers

All of the Negotiated Fee Rate **except** \$175 per day. Limited to 30 days per Year. After 30 days, you pay all charges for the remainder of that Year.

Non-Participating Provider

All charges **except** \$175 per day. Limited to 30 days per Year. After 30 days, you pay all charges for the remainder of that Year.

Professional Services
(Inpatient and Outpatient Physician Services)

Participating Provider

All of the Negotiated Fee Rate **except** \$25 per visit. Limited to 1 visit per day and 20 visits per Year.

Non-Participating Provider

All charges **except** \$25 per visit. Limited to 1 visit per day and 20 visits per Year.

SEVERE MENTAL ILLNESSES and SERIOUS EMOTIONAL DISTURBANCES of a CHILD

Benefits provided as any other medical condition.

SMOKING CESSATION PROGRAM

Participating Providers and Non-Participating Providers

Once your Deductible is met, all charges **except** a \$50 lifetime reimbursement.

FOREIGN COUNTRY PROVIDERS

For initial treatment of a Medical Emergency only.

All Providers

30% of Customary and Reasonable Charges **plus** all charges in excess of Customary and Reasonable.

Note: You are responsible, at your expense, for obtaining an English language translation of foreign country provider claims and medical records.

BENEFIT

YOUR PAYMENT RESPONSIBILITY

OTHER ELIGIBLE PROVIDERS

The following class of providers do not enter into Participating agreements with us and your payment responsibility for these providers is as indicated below: a blood bank, a Dentist (D.D.S.), an optometrist (O.D.), a dispensing optician, a speech pathologist, an audiologist, a respiratory therapist.

All Providers Listed Above	30% of Customary and Reasonable Charges plus all charges in excess of Customary and Reasonable.
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The providers listed above must be licensed according to state and local laws to provide covered medical services.

SPECIAL CIRCUMSTANCES

Authorized Referral

Non-Participating Hospital (inpatient or outpatient) Physician, Ambulatory Surgical Center	30% of Customary and Reasonable Charges plus all charges in excess of Customary and Reasonable Charges.
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For Medical Emergencies Within California

Your payment responsibility for Covered Services received from Non-Participating Providers, including Ambulance, will be at the Participating percentage for emergency services as described below.

Emergency Room services for both Participating and Non-Participating Providers are subject to an additional \$30 Copayment per visit, which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services.

Non-Participating Physician	30% of Customary and Reasonable Charges or billed charges, whichever is less plus all charges in excess of Customary and Reasonable.
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Non-Participating Provider	<p>Hospitals and Non-Contracting Hospitals: 30% of Customary and Reasonable Charges or billed charges, whichever is less, plus all charges in excess of Customary and Reasonable for the first 48 hours. After 48 hours, all charges in excess of \$650 per day.*</p> <p>Ambulatory Surgical Centers: 30% of Customary and Reasonable Charges plus all charges in excess of Customary and Reasonable.</p> <p>Ambulance: 30% of Customary and Reasonable Charges plus all charges in excess of Customary and Reasonable.</p>
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* If the Member has not been stabilized sufficiently to be safely transferred to a Participating facility after the first 48 hours, then the Member's payment will remain at 30% of the Customary and Reasonable Charge **plus** all charges in excess of Customary and Reasonable until his/her condition permits transfer to a Participating facility.

BLUECARD PROGRAM**FOR MEDICAL EMERGENCIES OUTSIDE OF CALIFORNIA**

The Blue Cross and Blue Shield Association, of which we are a member/Independent Licensee, administers a program called the **BlueCard Program**, in which we participate, which allows our Members to have the reciprocal use of Participating Providers that contract with other Blue Cross and/or Blue Shield Plans. Providers available to you through the BlueCard Program have not entered into contracts with Blue Cross of California. If you have any questions or complaints about the BlueCard Program, please call us at 1-800-333-0912.

If you are traveling outside of California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield Participating Provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate with a local Blue Cross and/or Blue Shield Plan.

In order for you to receive access to whatever reductions in out-of-pocket expenses may be available, we must abide by the rules BlueCard Program rules, as set by the Blue Cross and/or Blue Shield Association.

When you obtain health care services through the BlueCard Program outside of California, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The Negotiated Price that the on-site Blue Cross and/or Blue Shield ("Host Blue") passes on to us.

Often, this "Negotiated Price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The Negotiated Price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The Negotiated Price will also be adjusted in the future to correct for over-or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Subscriber liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state mandate Subscriber liability calculation methods that differ from the usual BlueCard method noted above in the preceding paragraph four of this item or require a surcharge, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

BLUECARD PROVIDER TYPES**PPO Providers**

These are primarily Hospitals and Physicians who participate in a BlueCard PPO network and have agreed to provide PPO Members with health care services at a discounted rate that is generally lower than the rate charged by Traditional Providers.

Traditional Providers

These are providers who might not participate in a BlueCard PPO network, but have agreed to provide PPO Members with health care services at a discounted rate.

Non-Participating Providers

These are providers that do not have a contract with their local Blue Cross and/or Blue Shield plan and have not accepted the BlueCard PPO or Traditional Provider negotiated rates.

To locate a BlueCard PPO or Traditional Provider, when outside of California, call 1-800-810-BLUE (2583) or visit the BlueCard web site address: www.bluecares.com/bluecard. When traveling outside the United States, in cases of emergencies only, call 1-800-810-BLUE (2583) to inquire about providers that may participate in the BlueCard Worldwide Program.

BENEFIT

YOUR PAYMENT RESPONSIBILITY

MEDICAL NON-EMERGENCIES OUTSIDE OF CALIFORNIA

Physician

PPO Provider	30% of the BlueCard Provider's Negotiated Price.
Traditional Provider*	50% of the BlueCard Provider's Negotiated Price.
Non-Participating Provider	50% of the BlueCard Provider's Negotiated Price plus all charges in excess of the BlueCard Negotiated Price.

Hospital or Ambulatory Surgical Center

PPO Provider	30% of the BlueCard Provider's Negotiated Price.
Traditional Provider*	50% of the BlueCard Provider's Negotiated Price.
Non-Participating Provider	Hospital: You pay all charges in excess of \$650 per day. Ambulatory Surgical Centers: You pay all charges in excess of \$380 per day.

* If there are no PPO Providers in the area your payment responsibility will be 30% of the BlueCard Provider's Negotiated Price.

MEDICAL EMERGENCIES OUTSIDE OF CALIFORNIA

Your payment responsibility, for Covered Services received from Non-Participating Providers, including Ambulance, will be at the Participating percentage for emergency services as described below.

Physician

PPO Provider	30% of the BlueCard Provider's Negotiated Price.
Traditional Provider	30% of the BlueCard Provider's Negotiated Price.
Non-Participating Provider	30% of the Customary and Reasonable Charges plus all charges in excess of Customary and Reasonable.

Hospital or Ambulatory Surgical Center

PPO Provider	30% of the BlueCard Provider's Negotiated Price.
Traditional Provider	30% of the BlueCard Provider's Negotiated Price.
Non-Participating Provider	Hospital: 30% of the Customary and Reasonable Charges plus all charges in excess of Customary and Reasonable Charges for the first 48 hours. After 48 hours all charges in excess of \$650 per day.** Ambulatory Surgical Centers: 30% of Customary and Reasonable Charges plus all charges in excess of Customary and Reasonable.

If a Member has not been stabilized sufficiently to be safely transferred to a BlueCard PPO or Traditional facility after the first 48 hours, then the Member's payment will remain at 30% of Customary and Reasonable Charges **plus all charges in excess of Customary and Reasonable, until his/her medical condition permits transfer to a PPO or Traditional facility.

PART IV COMPREHENSIVE BENEFITS: WHAT IS COVERED BY BLUE CROSS

Before we pay for any benefits, you must satisfy your Deductible. The medical Deductible is described in the preceding PART entitled BENEFIT COPAYMENT/COINSURANCE LIST.

All Covered Services are subject to the Yearly Deductible including limited benefits such as Non-Participating Physical Therapy, Occupational Therapy and/or Chiropractic Care, Mental or Nervous Disorders and Substance Abuse, and Smoking Cessation except as specifically indicated in this Agreement.

Described below are the types of services covered under this Agreement for the treatment of a covered illness, injury or condition. Before you review this list of Covered Services take a moment to review the Definitions of NEGOTIATED FEE RATE and CUSTOMARY AND REASONABLE CHARGES. Knowing the meaning of these terms will greatly assist you in determining the benefits of this Agreement and your Copayment/Coinsurance responsibility.

Another term you should become familiar with is "Prior Authorization." Prior Authorization begins when your Physician provides medical information to us prior to a specific service or procedure taking place so that we can determine if it is Medically Necessary and a Covered Service. All organ and tissue transplants require Prior Authorization. The PART entitled PRIOR AUTHORIZATION PROCEDURES describes in detail how to obtain Prior Authorization.

Hospital Services

- A Hospital room with two or more beds. If a private room is used, we will only allow up to the prevailing two-bed room rate.
- Care in special care units.
- Operating rooms, delivery rooms and special treatment rooms.
- Supplies and services such as laboratory, cardiology, pathology and radiology rendered while in the facility.
- Drugs and medicines including oxygen given to you during your stay.
- Use of the emergency room.
- Outpatient services and supplies, including those in connection with outpatient surgery performed at an Ambulatory Surgical Center.
- Outpatient Day Treatment Program services when rendered at a psychiatric facility.

Skilled Nursing Facilities

Limited to 100 days per Year combined for Participating and Non-Participating Providers.

You must be under the active supervision of a Physician treating your illness or injury.

- A room with two or more beds.
- Special treatment rooms.
- Laboratory tests.
- Physical therapy, occupational therapy, speech therapy, oxygen and other respiratory therapy.
- Drugs and medicines given to you during your stay.

Professional Services and Supplies

- Services of a Physician including surgeons and specialists.
- Services of an anesthesiologist or anesthesiologist.
- Outpatient speech therapy when following surgery, injury or otherwise as Medically Necessary. Members may receive these services up to 50 visits per Year. Additional visits will be covered when authorized by Blue Cross, but only if Blue Cross determines that additional treatment is Medically Necessary. Blue Cross will authorize a specific number of additional visits.
- Outpatient diagnostic radiology and laboratory services.
- Cancer screening tests approved by the federal Food and Drug Administration (FDA) and the Office Visit associated with performing those tests when ordered by your Physician, registered nurse practitioner or certified nurse midwife. This includes screening for breast, cervical, ovarian and prostate cancer.
- Mammogram examinations when ordered by your Physician, registered nurse practitioner or certified nurse midwife.
- Radiation therapy and hemodialysis treatment.
- Surgical implants.
- Artificial limbs or eyes.
- Prosthesis to achieve symmetry after mastectomy.
- The first pair of contact lenses or eyeglasses when required as a result of covered eye surgery.
- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products. Autologous blood donations will be covered only when the blood is transfused back into the patient.
- Acupuncture and Acupressure rendered by a Physician. **Note:** All supplies used in conjunction with the Acupuncture and Acupressure treatment will be included in the payment for the visit and will not be reimbursed in addition to the visit.
- Physical Therapy, Occupational Therapy and/or Chiropractic Care visits, when rendered by a Physician. Members may receive these services up to 12 visits per Year combined for Participating and Non-Participating Providers. Members may receive these services in additional visits authorized by Blue Cross, but only if Blue Cross determines that additional treatment is Medically Necessary. Blue Cross will authorize a specific number of additional visits.
- Footwear services in relation to preparation and dispensing of custom footwear necessary to treat an injury or illness.
- FDA approved medications that may only be dispensed by or under direct supervision of a Physician.
- Injectable contraceptives, except Norplant, when administered in a Physician's office.
- Hepatitis B and varicella zoster (chicken pox) vaccines for Members age 7 through 18 and the Office Visit associated with administering that vaccination when ordered by your Physician.
- Reconstructive performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function; or create a normal appearance, to the extent possible.
- Ambulance service (i.e. base charge, mileage and non-reusable supplies) to transport you to or from a Hospital or Skilled Nursing Facility when Medically Necessary. Payment of benefits for ambulance services will be made directly to the provider of service unless proof of payment is received by us prior to the benefits being paid. If requested through a 911 call, ambulance charges are covered if you reasonably believed that a Medical Emergency existed even if you are not transported to a Hospital.

IN SOME AREAS A 911 EMERGENCY RESPONSE SYSTEM HAS BEEN ESTABLISHED. THIS SYSTEM IS ONLY TO BE USED WHEN THERE IS AN EMERGENCY MEDICAL CONDITION THAT REQUIRES AN EMERGENCY RESPONSE.

PLEASE USE THIS SYSTEM FOR MEDICAL EMERGENCIES ONLY.

Second Opinions

If you choose to obtain a second opinion, you may do so without a referral from your Physician. However, visits associated with a second opinion are subject to all benefits, limitations and exclusions of this Agreement. You may ask your Physician for a referral to a Participating Provider, if you choose a Non-Participating Provider, your payment responsibility may be significantly more.

Medical Supplies and Equipment

Rental or purchase of dialysis equipment and supplies and other long lasting medical equipment and supplies when ordered by your Physician. The equipment or supply must be for medical use to treat a health problem, and only for the use of the person for whom it was prescribed.

Note: Coverage does not include orthopedic shoes or shoe inserts, arch supports, disposable sheaths and supplies, correction appliances or support appliances and supplies such as stockings or personal comfort items as indicated in PART entitled EXCLUSIONS AND LIMITATIONS: WHAT IS NOT COVERED BY BLUE CROSS.

Rental charges that exceed the reasonable purchase price of the equipment are not covered. Blue Cross determines whether the item meets the above conditions.

Dental

- Up to three (3) days of inpatient Hospital services when a Hospital stay is Medically Necessary due to an unrelated medical condition.
- Services of a Physician or Dentist treating an accidental injury to your natural teeth when you receive treatment within one year following the injury. Damage to your teeth due to chewing or biting is not an accidental injury.
- General anesthesia for dental procedures in a Hospital or surgery center for enrolled Members:
 - Under seven (7) years of age.
 - Developmentally disabled, regardless of age.
 - Whose health is compromised and general anesthesia is Medically Necessary, regardless of age.

Pregnancy and Maternity Care

- Doctor visits for prenatal and postnatal care and genetic testing of the fetus.
- Routine nursery care for a newborn.
- Hospital services in connection with a pregnancy and inpatient Physician services for normal delivery, cesarean section and complications of pregnancy.

The mother and her newborn shall be entitled to Inpatient Hospital coverage for a period of no less than 48 hours following a normal delivery and no less than 96 hours following a delivery by cesarean section. The decision to discharge the mother and newborn before the 48 or 96 hour time period can only be made by the treating Physician in consultation with the mother. If the mother is discharged early, then the mother and newborn will be covered for a post-discharge follow-up visit within 48 hours of the discharge when prescribed by the treating Physician.

Please call us at 1-800-769-4896 within the first twelve (12) weeks of your pregnancy to notify us of your estimated date of delivery, your Physician's name, and the name of the Hospital you have chosen for delivery of your child.

Note: All services related to pregnancy and maternity care for normal delivery, Cesarean section, elective abortion or complications of pregnancy are subject to a \$1,000 Copayment per pregnancy. This Copayment is in addition to the Yearly Deductible and will not be applied toward the Member's Maximum Copayment/Coinsurance Limit. Charges are applied to this Copayment after your Yearly Deductible is satisfied. This Copayment applies to all pregnancy and maternity care in the order in which claims are processed, not necessarily in the order in which the Member has received services.

Well Baby and Well Child Care

No Deductible is required.

For Members up to and including 6 years of age for Office Visits and/or services received in a Physician's office.

- Childhood immunizations and the routine physical examination associated with the immunization.
- Medically appropriate radiology services, laboratory tests and procedures in connection with the examination.
- Routine hearing and vision tests.

Preventive Care

For Members age 7 to adult

Blue Cross will offer clinically effective preventive care services at designated HealthyCheck Centers on an annual basis. These HealthyCheck Centers are located in state licensed medical facilities. Call 1-800-274-WELL (9355) to make an appointment.

Note: We cannot schedule an appointment for preventive care services until you have selected and have been seen by a Physician and have signed a release form allowing us to send the results of your preventive care visit to your Physician. **You must be free of any illness or condition to receive services at the HealthyCheck Centers.**

- **Children (ages 7 through 18)**

The following services available only at HealthyCheck Centers:

- Physical assessment with a health history.
- Blood pressure check.
- Age appropriate laboratory tests.
- Vision and hearing tests.
- Counseling and literature on health related issues.
- Immunization history with shots given based on immunization records.
- Other medically appropriate tests and procedures as indicated.

- **Adults (age 19 and above)**

The following services are available only at HealthyCheck Centers:

- Physical assessment with a health history.
- Blood pressure check.
- Fingertick cholesterol and glucose measurement check.
- Tetanus immunization when medically appropriate.
- Influenza vaccine when medically appropriate.
- Counseling and literature on health related issues.
- Other medically appropriate tests and procedures as indicated.

Note: Other services are available for an additional Copayment.

Treatment for Diabetes

Medical services and supplies provided for the treatment of diabetes are paid on the same basis as any other medical condition. Benefits will be provided for covered expenses for:

1. The following Diabetes Equipment and Supplies:

- Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.
- Insulin Pumps.
- Pen delivery systems for insulin administration.
- Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.

- Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

These covered equipment and supplies are covered under your plan's benefits for durable medical equipment (See Medical Supplies and Equipment).

2. Diabetes Outpatient Self-Management Training Program which:
 - Is designed to teach a Member who is a patient, and covered Members of the patient's family about the disease process and the daily management of diabetic therapy;
 - Includes self-management training, education, and medical nutrition therapy to enable the Member to properly use the equipment, supplies, and medications necessary to manage the disease; and
 - Is supervised by a Physician.

Diabetes education services are covered under plan benefits for professional services by Physicians.

3. The following items are covered under your Prescription Drug benefits:
 - Insulin, glucagon, and other Prescription Drugs for the treatment of diabetes
 - Insulin syringes.
 - Urine testing strips and lancets.

These items must be obtained either from a retail Pharmacy or through the mail service program. See the PART entitled YOUR PRESCRIPTION DRUG BENEFITS.

Phenylketonuria (PKU)

Coverage for the testing and treatment of phenylketonuria (PKU) is paid on the same basis as any other medical condition. Coverage for treatment of phenylketonuria (PKU) shall include those formulas and special food products that are part of a diet prescribed by a licensed Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the Plan. The diet must be deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).

Coverage for the cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. "Formula" means an enteral product or products for use at home. The formula must be prescribed by a Physician, nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, and as Medically Necessary for the treatment of phenylketonuria (PKU). Most formulas used in the treatment of PKU are obtained from a Pharmacy and are covered under your plan's Prescription Drug benefits. Refer to the PART entitled YOUR PRESCRIPTION DRUG BENEFITS. Special food products that are not obtained from a Pharmacy are covered as medical supplies under your plan's medical benefits.

"Special food product" means a food product that is all of the following:

1. Prescribed by a Physician or nurse practitioner for the treatment of phenylketonuria (PKU) and
2. Is consistent with the recommendations and best practices of qualified health professionals with expertise in the treatment and care of, phenylketonuria (PKU).
3. Used in place of normal food products, such as grocery store foods, used by the general population.

Note: It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.

Mental or Nervous Disorders and Substance Abuse (except for the treatment of Severe Mental Illnesses and Serious Emotional Disturbances of a Child)

Services must be for treatment of Substance Abuse (such as drug or alcohol dependence), or a Mental or Nervous Disorder which can be improved by standard medical practice.

- Inpatient Hospital services and Day Treatment Program Centers are limited to \$175 per day up to a maximum payment of \$5,250 per Year, 30 days per Year.
- Inpatient or outpatient Physician's services are limited to \$25 per visit (one visit per day) and 20 visits per Year.

Treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child

Benefits for Covered Services and supplies provided for the treatment of specific Severe Mental Illnesses and Serious Emotional Disturbances of a Child are paid on the same basis as any other medical condition. See the PART entitled, DEFINITIONS. These services are subject to all terms, conditions, limitations, and exclusions, stated in this Agreement, including all Maximum Comprehensive Benefits.

Clinical Trials

If a Member is diagnosed with cancer and accepted into a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer, Blue Cross will cover all routine patient care costs related to the clinical trial on the same basis as any other medical condition if the Member's treating Physician, who is providing the health care services to the Member under this Agreement recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Member. The clinical trial must have a therapeutic intent and not just be to test toxicity. Coverage for clinical trials is restricted to Participating Providers in California, unless the protocol for the clinical trial is not provided for at a California Hospital or by a California Physician.

Benefits are paid on the same basis as any other medical condition and are subject to any applicable Copayments, Coinsurance and Deductibles. In the case of Covered Services for a clinical trial provided by a Non-Participating Provider, Blue Cross will pay based on the Negotiated Fee Rate subject to the applicable Copayments, Coinsurance and Deductibles. However, the Member will be responsible for charges in excess of the Negotiated Fee Rate.

The treatment provided in a clinical trial must either:

1. Involve a Drug that is exempt under federal regulations from a new Drug application or
2. Be approved by one of the following:
 - One of the National Institutes of Health
 - The federal Food and Drug Administration, in the form of an investigational new Drug application
 - The United States Department of Defense
 - The United States Veterans Administration

Covered Services include costs associated with the provision of health care services, including Drugs, items, devices and services which would otherwise be covered under this plan, including:

- Health care services typically provided absent a clinical trial.
- Health care services required solely for the provision of the investigational Drug, item, device or service
- Health care services required for the clinically appropriate monitoring of the investigational item or service.
- Health care services provided for the prevention of complications arising from the provision of the investigational Drug, item, device or service.
- Health care services needed for the reasonable and necessary care arising from the provision of the investigational Drug, item, device or service, including the diagnosis or treatment of the complications.

Covered Services will not include the following:

- Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.
- Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses, that a Member may require as a result of the treatment being provided for purposes of the clinical trial.
- Any item or services that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under this Agreement.
- Health care services customarily provided by the research sponsors free of charge to Members enrolled in the trial.

Note: You will be financially responsible for the costs associated with non-Covered Services. Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to Independent Medical Review as described in the PART entitled GRIEVANCE PROCEDURES.

Organ and Tissue Transplants

Prior Authorization is required. You will be responsible for an additional \$250 Copayment if Prior Authorization is not obtained.

Blue Cross has established a network of transplant facilities known as Centers of Expertise (COE) to provide services for specified organ and tissue transplants. These include heart, liver, lung, heart/lung, kidney, simultaneous pancreas/kidney, pancreas, bone marrow harvest and transplant; including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures. Charges for these specified transplants and related services are only covered when approved and performed only at a Blue Cross approved COE.

Note: A Participating Provider in the Prudent Buyer Plan Network is not necessarily a Center of Expertise transplant facility.

You or your Physician must obtain Prior Authorization for all services related to specified organ and tissue transplants listed above. However, it is ultimately your responsibility to ensure that Prior Authorization is obtained. **Prior Authorization can be initiated by calling 1-888-613-1130.** The following **services** are provided to you in connection with a covered organ or tissue transplant, if you are the organ or tissue donor:

- An organ or tissue donor who is not an enrolled Member is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.
- For enrolled Members who require cord blood storage, the storage must be considered Medically Necessary, according to the Blue Cross criteria for cord blood storage. In addition, it must be stored at a designated Blue Cross facility.

The following **travel expense benefits** will be provided for the recipient or donor in connection with a covered organ or tissue transplant. To receive these benefits the COE must be 250 miles or more from the recipient or donor's home. All travel benefits must receive Prior Authorization by Blue Cross in advance.

- Travel expenses will be provided for the recipient and one companion per transplant but are limited to six (6) trips per transplant.

Travel expenses include:

- Transportation to and from the COE not to exceed \$250 per trip for each person for round trip coach airfare.

- Hotel accommodations not to exceed \$100 per day, for up to 21 days per trip and is limited to one room.
- Meal expenses not to exceed \$25 per day for each person for up to 21 days per trip. Tobacco, alcohol and drug expenses are excluded from coverage.
- Travel expenses will be provided for the donor per transplant and is limited to one (1) trip per transplant.

Travel expenses include:

 - Transportation to and from the COE not to exceed \$250 for round trip coach airfare.
 - Hotel accommodations not to exceed \$100 per day, for up to 7 days, and is limited to one room.
 - Meal expenses not to exceed \$25 per day, up to 7 days, and is limited to one person. Tobacco, alcohol and drug expenses are excluded from coverage.

Each year thousands of people's lives are saved by organ transplants. The success rate of transplants is rising, but more donations are needed. This is a unique opportunity to give the Gift of Life. Anyone who is 18 years of age or older and of sound mind may become a donor when he or she dies. Minors may become donors with a parent or guardian's consent. Organ and tissue donation may be used for transplants and research. Today, it is possible to transplant about 25 different organs and tissues. Your decision to become a donor could someday save or prolong the life of someone you know, even a close friend or family member. If you decide to become a donor, talk it over with your family. Let your Physician know your intentions as well. Obtain a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card.

Smoking Cessation

We will pay up to \$50 per Member per lifetime toward any smoking cessation program designed to end the dependence on nicotine.

Infusion Therapy

If services are performed in the home, those services must be billed by and performed by a provider licensed by state and local laws.

A **Course of Therapy** is defined as Physician prescribed Infusion Therapy for a period ninety (90) days or less.

Covered Services include:

- Drugs and other substances used in Infusion Therapy.
- Professional services to order, prepare, dispense, deliver, administer, train or monitor including clinical Pharmacy support and any Drugs or other substances used in a Course of Therapy.
- All necessary durable, reusable supplies and durable medical equipment including but not limited to: pump, pole, and electric monitor.
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.

Infusion Therapy benefits will not be provided for:

- Compounding fees such as charges for mixing or diluting Drugs, medicines or solutions or incidental supplies including disposable items such as cotton swabs, tubing, syringes and needles for Drugs adhesive bandages and intravenous starter kits. No separate benefit is provided for these services and supplies. These services and supplies are included in the charges for the Drugs and durable medical equipment used.
- Drugs and medicines not requiring a Prescription.
- Drugs labeled "Caution, limited by Federal Law to Investigational use" or Drugs prescribed for experimental use.
- Drugs or other substances obtained outside the United States.
- Non-FDA approved homeopathic medications or other herbal medications.

- Charges by a Non-Participating Provider exceeding the Average Wholesale Price of a Drug as determined by the manufacturer. The Average Wholesale Price includes the preparation of the finished product. The Average Wholesale Price (AWP) is the average of the list prices that the manufacturers producing the Drug suggest that a wholesaler charge a Pharmacy for the Drug. The Member will be responsible for any charges in excess of the Average Wholesale Price of a Drug for Non-Participating Providers.

Note: Medical Supplies and Equipment used in Infusion Therapy will not be reimbursed under any other benefit of this Agreement.

Home Health Care

A Physician must order the Home Health Care and renew the order at least once every thirty (30) days. Providers in California must be a California licensed Home Health Agency or Visiting Nurse Association. Limited to 60 visits per Year for Participating and Non-Participating Providers combined.

A visit is defined as 4 hours or less of service provided by one of the following providers:

- A registered nurse;
- A licensed therapist for physical, occupational, speech or respiratory therapy;
- A medical social service worker;
- Services of a health aide employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association. A health aide is covered only if you're also receiving the services of a registered nurse or licensed therapist employed by the same organization and the registered nurse is supervising the services.
- Private Duty Nursing when Medically Necessary and approved by Blue Cross.

Note: We will not cover personal comfort items under this Home Health Care benefit. All Home Health services and supplies related to Infusion Therapy are included in the Infusion Therapy benefit.

PART V EXCLUSIONS AND LIMITATIONS: WHAT IS NOT COVERED BY BLUE CROSS

Contraceptive Drugs or devices including Norplant and Norplant kits except injectable contraceptives when administered by a Physician, and except as specifically outlined under the PART entitled YOUR PRESCRIPTION DRUG BENEFITS and except an alternate FDA approved contraception method requiring a Physician's Prescription required because of your medical condition.

Cosmetic Surgery or other services that are performed to alter or reshape normal structures of the body in order to improve appearance.

Custodial Care: Custodial care is care that does not require the services of trained medical or health professionals, such as, but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered. Domiciliary, or rest cures for which facilities, and/or services of a general acute Hospital are not medically required including resident treatment centers are also excluded.

Dental Services: Dentures, bridges, crowns, caps, clasps, habit appliances, partials, or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums, except as specifically stated for Dental Care under the benefits section of this Agreement. **Dental Implants:** materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of implants. **Orthodontic Services:** Braces, other orthodontic appliances, orthodontic services.

Diagnostic Admissions: Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Educational Services except as specifically provided or arranged by Blue Cross.

Excess Amounts: Any amounts in excess of the maximum amounts stated in the PART entitled BENEFIT COPAYMENT/COINSURANCE LIST of this Agreement.

Experimental: Any medical, surgical and/or other procedures, services, products, Drugs or devices including implants, whose use is mainly limited to laboratory and/or animal research except as specifically stated under Clinical Trials in the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY BLUE CROSS. Blue Cross has discretion to make this determination. However, if a Member has a life-threatening or seriously debilitating condition and Blue Cross determines that requested treatment is not a covered service because it is experimental, a Member may request an Independent Medical Review. Refer to the PART entitled GRIEVANCE PROCEDURES.

Food or Dietary Supplements, except for formulas and special food products as specifically stated under the section Phenylketonuria (PKU) in the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY BLUE CROSS. They must be prescribed by a Physician in consultation with a metabolic disease specialist and deemed Medically Necessary to prevent complications of PKU. Coverage is only to the extent that the prescribed formulas and special food products exceeded the cost of a normal diet.

Government Services: Any services you actually received that were provided by a local, state or federal government agency except when payment under this Agreement is expressly required by federal or state law. Blue Cross will not cover payment for these services if you are not required to pay for them or they are given to you for free. Veterans' Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.

Hearing Aids and Routine Hearing Tests: Routine hearing tests except where provided for under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY BLUE CROSS under Well Baby and Well Child Care and/or Preventive Care.

Infertility Treatment: Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.

Investigational: Any medical, surgical and/or other procedures, services, products, Drugs or devices (including implants) except as specifically stated under Clinical Trials in the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY BLUE CROSS: (a) which do not have final approval from the appropriate governmental regulatory body; or (b) which are not supported by scientific evidence which permits conclusions concerning the effect of the service, Drug or device on health outcomes; or (c) which do not improve the health outcome of the patient treated; or (d) which are not as beneficial as any established alternative; or (e) whose results outside the investigational setting cannot be demonstrated or duplicated; or (f) which are not generally approved or used by Physicians in the medical community. Blue Cross has discretion to make this determination. However, if a Member has a life-threatening or seriously debilitating condition and Blue Cross determines that requested treatment is not a covered service because it is investigational, a Member may request an Independent Medical Review. Refer to the PART entitled GRIEVANCE PROCEDURES.

Mental or Nervous Disorders and Substance Abuse: Treatment of Mental or Nervous Disorders and Substance Abuse, including nicotine use or psychological testing except as specifically stated under the benefit sections of this Agreement. **However, medical services provided to treat medical conditions that are caused by behavior of the Member that may be associated with Mental or Nervous conditions (e.g., self-inflicted injuries) and treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child are not subject to these limitations.**

Non-Contracting Hospital: No benefits are provided for care or treatment furnished in a Non-Contracting Hospital, except as described in the PART entitled BENEFIT and COPAYMENT/COINSURANCE LIST in this Agreement.

Non-Duplication of Medicare: We will not provide benefits that duplicate any benefits you would be entitled to receive under Medicare. This exclusion applies to all Parts of Medicare in which you can enroll without paying additional premium. However, if you have to pay an additional premium to enroll in Part A, B or C of Medicare this exclusion will apply to that particular Part of Medicare for which you must pay only if you have enrolled in that Part.

If you have Medicare, your Medicare coverage will not affect the services covered under this Agreement, except as follows:

1. Your Medicare coverage will be applied first (primary) to any services covered by both Medicare and under this Agreement.
2. If you receive a service that is covered both by Medicare and under this agreement, our coverage will apply only to the Medicare Deductibles, Coinsurance and other charges for Covered Services that you must pay over and above what's payable by your Medicare coverage.
3. For a particular claim, the combination of Medicare benefits and the benefits we will provide under this Agreement for that claim will not be more than the allowed Covered Expense you have incurred for the Covered Services you received.

We will apply any expenses paid by Medicare for services covered under this Agreement toward your Deductible.

Not Covered: Services received before your Effective Date or during an inpatient stay that began before your Effective Date. Services received after your coverage ends.

Not Medically Necessary: Services or supplies that are not defined as Medically Necessary.

Nutritional Counseling, except Diabetes.

Outpatient Speech Therapy, except following surgery, injury, or otherwise as Medically Necessary.

Personal Comfort Items: Items which are furnished primarily for your personal comfort or convenience, air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators, and supplies for comfort, hygiene or beautification.

Pre-existing Conditions: No payment will be made for services or supplies for the treatment of a Pre-existing Condition during a period of six (6) months following your effective date. However, this limitation does not apply to a child born to or newly adopted by an enrolled subscriber or spouse. Also, if you were covered under Qualifying Prior Coverage within 62 days of becoming covered under this Agreement, the time spent under the Qualifying Prior Coverage will be used to satisfy, or partially satisfy, the six (6) month period.

Private Duty Nursing: Except as expressly provided under the section entitled, Home Health Care in the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY BLUE CROSS.

Routine Physical Exams except as outlined under section entitled Preventive Care in the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY BLUE CROSS. Routine physical exams or tests except when performed at one of our HealthyCheck Centers.

Services For Which You Are Not Legally Obligated To Pay: Services for which you have no legal obligation to pay or for which no charge would be made if you did not have health plan or insurance coverage, except services received at a non-governmental charitable research Hospital.

Services from Relatives: Professional services received from a person who lives in the Member's home or who is related to the Member by blood, marriage or adoption.

Sex Change: Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to Sex Changes.

Telephone and Facsimile Consultations: Consultations provided by telephone or facsimile machines.

Unlisted Services: Services not specifically listed in this Agreement as Covered Services.

Vision Care: Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams and routine eye refractions, except as specifically stated under the benefit sections of this Agreement. **Certain Eye Surgeries:** Any eye surgery solely for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia), astigmatism and/or farsightedness (presbyopia).

Weight Reduction: Services primarily for weight reduction, treatment of obesity, or any care which involves weight reduction as a main method of treatment except Medically Necessary treatment of morbid obesity.

Workers' Compensation: Any condition for which benefits are recovered or can be recovered, either by any workers' compensation law or similar law even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to Workers' Compensation law or similar law, we will provide the benefits of this plan for such conditions, subject to our right to a lien or other recovery under section 4903 of the California Labor Code or other applicable law.

PART VI YOUR PRESCRIPTION DRUG BENEFITS

The coverage and benefits for outpatient Prescription Drugs described in this Agreement are provided through an arrangement with Blue Cross Pharmacy Plan, a health care service plan licensed by the Department of Managed Health Care. Blue Cross Pharmacy Plan will administer claims for Prescription Drugs provided by licensed retail Pharmacies to Members eligible to receive Prescription Drug benefits under this Agreement.

Blue Cross of California uses a preferred list of Drugs, sometimes called a Formulary, to help your doctor make prescribing decisions. This list of Drugs is updated quarterly by a committee consisting of doctors and Pharmacists so that the list includes Drugs that are safe and effective in the treatment of disease. If you have a question regarding whether a Drug is on the Blue Cross Preferred Drug List, please call 1-800-700-2533.

Non-Formulary or non-preferred Drugs which have a Formulary or non-Prescription equivalent are not covered unless the prescribing doctor writes "Do not substitute" or "Dispense as written" on the Prescription. Some medications may require written Prior Authorization from Blue Cross. Please call 1-800-700-2533 for a list.

Definitions

Average Wholesale Price (AWP) is the average of the list prices that the manufacturers producing the Drug suggest that a wholesaler charge a Pharmacy for the Drug.

Blue Cross Negotiated Fee is the fee that Blue Cross Pharmacy Plan has negotiated with the Participating Pharmacy under a Participating Pharmacy Agreement for covered Prescriptions. Participating Pharmacies have agreed to charge eligible Blue Cross Members no more than the negotiated fee for covered Prescriptions.

Brand Name Prescription Drug (Brand Name) is a Prescription Drug that has been patented.

Drug Limited Fee Schedule is the maximum amount that Blue Cross Pharmacy Plan will consider for payment when your Prescription is filled at a Non-Participating Pharmacy and is the lesser of billed charges or the Average Wholesale Price.

Drugs mean Prescription Drugs approved by the State of California or the Food and Drug Administration for general use by the public. For purposes of this benefit, Insulin will be deemed a Prescription Drug.

Formulary is a list of Drugs which Blue Cross has determined to be safe and cost-effective based on available medical literature.

Generic Prescription Drug (Generic) is a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

Maintenance Prescription Drugs are Prescription Drugs which are taken for an extended period of time to treat a medical condition.

Non-Participating Pharmacy is a Pharmacy which does not have a Participating Pharmacy Agreement in effect with or for the benefit of Blue Cross Pharmacy Plan at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Participating Pharmacy is a Pharmacy which has a Participating Pharmacy Agreement in effect with or for the benefit of Blue Cross or Blue Cross Pharmacy Plan at the time services are rendered. Call your local Pharmacy or call customer service at 1 800 700-2533. Some Participating Pharmacies display a Blue Cross "Rx" decal so that you can easily identify them.

Pharmacy means a licensed retail Pharmacy.

Prescription means a written order issued by a Physician.

Self-administered injectable Drugs are injectable Drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family member.

Your Prescription Drug benefits are as follows:

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. If there are patterns of over-utilization or misuse of Drugs, we will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over-utilization of Drugs.

Brand Name Prescription Deductible

Each Member must meet a Brand Name Prescription Deductible amount of \$500 each Year. This Deductible is separate from the annual Deductible for medical benefits and does not accumulate towards satisfying the medical Yearly Maximum Copayment/Coinsurance Limit. This Brand Name Prescription Deductible applies to Brand Name Prescription Drugs purchased through the Mail Order Prescription Drug Program and at Participating and Non-Participating Pharmacies combined. The first two (2) Members of an enrolled family to satisfy their Brand Name Prescription Deductible in full will satisfy this Deductible for the entire family. Once the family Brand Name Deductible is satisfied, no further Brand Name Deductible is required for the remainder of that Year. However, we will not credit any Brand Name Deductible over and above the family Brand Name Deductible maximum that was applied but did not satisfy an individual Member's Brand Name Deductible amount in full.

What is Covered

- Outpatient Drugs and medications which Federal and/or State of California law restrict to sale by Prescription only.
- Insulin and syringes prescribed and dispensed for use with Insulin. Lancets and test strips for use in monitoring diabetes.
- All non-infused compound Prescriptions which contain at least one covered Prescription ingredient.
- Oral Contraceptive Drugs prescribed for birth control. **Not covered under Mail Order Prescription Drug Program.** If your Physician determines that oral contraceptive Drugs are not medically appropriate, coverage for another FDA approved Prescription contraceptive method will be provided.
- Drugs and medications prescribed for the treatment of impotence and/or sexual dysfunction must be authorized in advance by Blue Cross and are limited to eight (8) tablets/units per 30 day period. **Not covered under Mail Order Prescription Drug Program.**
- Phenylketonuria (PKU) formulas and food products. These formulas are subject to the Copayment for Brand Name Drugs and the Brand Name Prescription Deductible.

Note: Generic Drugs will be dispensed by Participating Pharmacies unless the Prescription specifies a Brand Name and states "Dispense as written" or "Do not substitute" or no Generic Drug equivalent exists.

Conditions of Service

The Drug or medicine must:

- Be prescribed in writing by a Physician and be dispensed by a licensed retail pharmacist or by mail through the Mail Order Prescription Drug Program within one year of being prescribed, subject to Federal or State laws.
- Be approved for use by the Food and Drug Administration.
- Be for the direct care and treatment of the Member's illness, injury or condition.
- Not be used while the Member is an inpatient in any facility.

The Prescription must not exceed a 30-day supply unless ordered by mail through the Mail Order Prescription Drug Program, in which case the limit is a 60-day supply.

When you go to a Participating Pharmacy

When you present your ID card at a Participating Pharmacy, you will have the following Copayment/Coinsurance for each covered Prescription and/or refill:

- \$10 Copayment for Generic Drugs.
- \$30 Copayment for Brand Name Drugs, after a \$500 per Member (two (2) Member family maximum) per calendar Year Brand Name Drug Deductible has been satisfied if Generic is not available or if your Physician indicates "Do not substitute" on the Prescription.
- \$30 Copayment **plus** the difference between Brand Name and Generic equivalent for Brand Name Drugs requested by the Member, after a \$500 per Member (two (2) Member family maximum) per calendar Year Brand Name Drug Deductible has been satisfied.
- 30% of the Negotiated Fee Rate for Self-administered injectable Drugs, except Insulin.

When you go to a Non-Participating Pharmacy

If you purchase a Prescription Drug from a Non-Participating Pharmacy, you will have to pay for the full cost of the Drug and submit a claim to:

**Blue Cross Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165**

Claim forms and customer service are available by calling 1 800 700-2533. Mail the claim form with the appropriate portion completed and signed by the pharmacist to Blue Cross no later than 15 months after the date of dispensing.

The rate of reimbursement by Blue Cross is as follows:

- **When your Prescription is filled at a Non-Participating Pharmacy within the State of California:** The reimbursement will be 50% of the Drug Limited Fee Schedule amount less the Copayment/Coinsurance as stated for Participating Pharmacies.
- **When your Prescription is filled at a Non-Participating Pharmacy outside the State of California:** The reimbursement will be 50% of the Drug Limited Fee Schedule amount less the Copayment/Coinsurance as stated for Participating Pharmacies.

Note: Refer to the Definitions section of this PART for the definition of Drug Limited Fee Schedule.

When You Order By Mail

Your Mail Order Prescription Drug Program is administered by Blue Cross Pharmacy Plan under contract with Blue Cross. Your mail order Prescription is filled by an independent, licensed Pharmacy. Blue Cross does not dispense Drugs or fill Prescriptions. Oral contraceptives are not covered for purchase through the Mail Order Prescription Drug Program.

Maintenance Drugs can be purchased through the mail, requiring only the following Copayment to be submitted for each Prescription:

- **Generic Drugs:** You pay a \$10 Copayment for each Prescription and/or refill for each 30-day supply or a \$20 Copayment for up to a maximum 60-day supply.
- **Brand Name Drugs:** After a \$500 per Member (two (2) Member family maximum) per calendar Year Brand Name Deductible, you pay a \$30 Copayment for each Prescription and/or refill for each 30-day supply or a \$60 Copayment for up to a maximum 60-day supply.

The first mail order Prescription you submit must include a completed Patient Profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Member need only the Prescription and Copayment to be enclosed. You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail service Pharmacy.

Note: Some Prescription Drugs and/or medicines are not available for purchase through the Mail Order Prescription Drug program including: oral contraceptives, Drugs not on the Formulary, Drugs and medications for the treatment of impotence and/or sexual dysfunction, injectables, including Self-administered Injectables except Insulin, and antibiotics. Please check with the Mail Order Prescription Drug Program Customer Service Department at 1-866-274-6825 for availability of the Drug or medicine.

Prescription Drug Exclusions and Limitations

IN ADDITION TO ANY LIFETIME MAXIMUMS, LIMITATIONS ON PRE-EXISTING CONDITIONS OR ANY OTHER EXCLUSIONS OR LIMITATIONS CONTAINED IN THIS ENTIRE AGREEMENT, PRESCRIPTION DRUGS AND REIMBURSEMENT WILL NOT BE FURNISHED FOR:

- Drugs or medications which may be obtained without a Physician's Prescription, except Insulin and Niacin for cholesterol lowering.
- Prescription Drugs which have non-Prescription equivalents.
- Non-medicinal substances or items. **Including:** Pharmaceuticals to aid smoking cessation (e.g., Nicorette) or any Prescription product containing nicotine.
- Contraceptive devices prescribed for birth control except as specifically stated under the section entitled What is Covered under this PART. Drugs and medications used to induce non-spontaneous abortions. Oral contraceptives purchased through mail order.
- Dietary Supplements, herbs, vitamins, cosmetics, health or beauty aids, or similar products which are not FDA approved to treat, diagnose, prevent or cure a medical condition. However, formulas prescribed by Physician for the treatment of phenylketonuria are covered.
- Drugs taken while you are in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent Hospital or similar facility.
- Any expense incurred in excess of the Blue Cross Negotiated Fee at a Participating Pharmacy.
- Any expense incurred in excess of the Drug Limited Fee Schedule at a Non-Participating Pharmacy.
- Any Drug labeled "Caution, limited by Federal law to investigational use" or Non-FDA approved investigational Drugs. Any Drug or medication prescribed for experimental indications.
- Syringes and/or needles, except those dispensed for use with Insulin.
- Durable medical equipment, devices, appliances, and supplies, except lancets and test strips for use in the monitoring of diabetes.

- Immunizing agents, biological sera, blood, blood products or blood plasma. Oxygen.
- Professional charges in connection with administering, injecting or dispensing of Drugs. Infusion medications.
- Drugs and medication dispensed or administered in an outpatient setting, including, but not limited to, outpatient Hospital facilities and doctor's offices.
- Drugs used for cosmetic purposes (e.g., Retin-A for wrinkles).
- Drugs used for the primary purpose of treating infertility.
- Drugs used for weight loss except when Medically Necessary.
- Drugs obtained outside of the United States.
- Allergy desensitization products, allergy serum.
- All Infusion Therapy except Self-administered injectables and aerosols, is excluded under this Agreement except where specifically stated under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY BLUE CROSS.
- Non-Formulary medications, unless a Physician denotes medical necessity by writing "Do not substitute" or "Dispense as written" on the Prescription order are not covered.
- Treatment of impotence and/or sexual dysfunction must be Medically Necessary and documentation of a confirmed diagnosis of erectile dysfunction must be submitted to Blue Cross for review. Drugs and medications for treatment of impotence and/or sexual dysfunction are limited to eight (8) tablets/units per 30-day period. **Not covered under Mail Order Prescription Drug Program.**

Claims and Customer Service:

For **Retail Pharmacy** information, please write to:

Blue Cross Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165
or call 1-800-700-2533

For **Mail Order Prescription Drug Program** information, please write to:

Blue Cross of California Mail Order Prescription Drug Program
P.O. Box 961025
Fort Worth, TX 76161-9863
or call 1-866-274-6825

PART VII PRIOR AUTHORIZATION PROCEDURES

IMPORTANT: Prior Authorization of a procedure or a facility stay for medical necessity is not a guarantee that benefits will be paid. Payments are based on the terms of your coverage and are subject to all exclusions and limitations of your Blue Cross coverage.

All organ and tissue transplants for heart, liver, lung, heart/lung, kidney, simultaneous pancreas/kidney, pancreas, bone marrow harvest and transplant including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures requires Prior Authorization. The Blue Cross Prior Authorization process evaluates in advance whether certain admissions, surgeries or services related to organ and tissue transplants, peripheral stem cell replacements and similar procedures are Medically Necessary and are the appropriate length of stay.

Note: All travel benefits related to covered organ and tissue transplants must receive Prior Authorization by Blue Cross.

You or your Physician must obtain Prior Authorization for all services related to specified organ and tissue transplants listed above. However, it is ultimately your responsibility to ensure that Prior Authorization is obtained. **Prior Authorization can be initiated by calling 1-888-613-1130.** Whenever Prior Authorization has not been performed for an admission related to organ and tissue transplants you will be required to pay a \$250 Copayment. **This Copayment is in addition to any other Copayment required by this Plan and will not apply toward satisfying your Yearly Deductible or Yearly Maximum Copayment/Coinsurance Limit.**

For a copy of the Medical Necessity Review Process, contact 1-800-333-0912.

PART VIII ALTERNATIVE BENEFITS

In order for a Member to obtain medically appropriate care in a more economical and cost effective way when extensive long-term treatment is required, Blue Cross may recommend an alternative plan of treatment which includes services not covered under this Agreement.

Blue Cross makes treatment suggestions only; any decision regarding treatment belongs to the Member and the Member's Physician. When alternative treatments are to be provided, both the Member or Member's guardian and the Member's Physician must agree, in writing, with the terms and conditions of Blue Cross' recommended substitution of benefits. Alternative benefits paid are accumulated toward any lifetime maximums under this Agreement.

Benefits are provided for such alternative treatment plan only on a case-by-case basis. Blue Cross has absolute discretion in deciding whether or not to offer to substitute benefits for any Member, which alternative benefits may be offered and the terms of the offer. Blue Cross' substitution of benefits in a particular case in no way commits Blue Cross to do so in another case or for another Member. Also, it does not prevent Blue Cross from strictly applying the express benefits, limitations and exclusions of the Agreement at any other time or for any other Member.

PART IX GENERAL PROVISIONS

Benefits Not Transferable: You and your eligible Family Members are the only persons entitled to receive benefits under this Agreement. FRAUDULENT USE OF SUCH BENEFITS WILL RESULT IN CANCELLATION OF THIS AGREEMENT AND APPROPRIATE LEGAL ACTION WILL BE TAKEN.

Conformity with Law: Any provision of this Agreement which, on its effective date, is in conflict with any applicable statute, regulations or other law is hereby amended to conform with the minimum requirements of such law.

Continuation of Care after Termination of Provider: Subject to the terms and conditions set forth below, Blue Cross will pay benefits to a Member at the Participating Provider level for Covered Services subject to applicable Copayments/Coinsurance, Deductibles and other terms rendered by a provider whose participation we have terminated.

- The Member must be under the care of the Participating Provider at the time of our termination of the provider's participation, the provider shall continue to provide services to the Member in accordance with the terms and reimbursement allowances of this Agreement, and the provider must agree to the conditions as set by the Medical Department.
- Blue Cross will only furnish such benefits for the continuation of services by a terminated provider for:
 - an acute or serious chronic condition up to ninety (90) days or longer if necessary for safe transfer
 - a high risk pregnancy, or
 - a pregnancy in the second or third trimester.
- Such benefits will not apply to providers who voluntarily leave their Provider Group Network or choose not to renew their agreement and providers who have been terminated due to medical disciplinary or quality of care reasons.
- If your provider has been terminated and you feel you qualify for continuation of services, you must request that services be continued. This can be done by calling 1-800-333-0912.

In accordance with California law, Members will not be required to pay any Participating Provider for amounts owed to that provider by Blue Cross even in the unlikely event that Blue Cross fails to pay the Provider. This does not include Copayment/Coinsurance, Deductibles and services or supplies that are not a benefit of this Agreement. Members are liable, however, to pay Non-Participating Providers for any amounts not paid to them by Blue Cross.

Form or Content of Agreement: NO AGENT OR EMPLOYEE OF OURS IS AUTHORIZED TO CHANGE THE TERMS, CONDITIONS OR BENEFITS OF THIS AGREEMENT. Any changes can only be made through an endorsement signed and authorized by one of our officers.

Governing Law: Blue Cross is subject to the requirements of the Knox-Keene Health Care Service Act of 1975, as amended, as set forth at Chapter 2.2 of Division 2 of the California Health and Safety Code and at Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulation, and any provision required to be stated herein by either of the above shall bind Blue Cross whether or not provided in this Agreement. This Agreement shall be construed and enforced in accordance with the laws of the State of California.

Notice: We will meet any notice requirements by mailing the Notice to you at the address listed on our records. You will meet any notice requirements by mailing the notice to: Blue Cross of California at the P.O. Box indicated on your Identification Card.

Out of California Providers: The Blue Cross and Blue Shield Association, of which we are a member/Independent Licensee, administers a program called the "BlueCard Program" in which we participate which allows our Members to have the reciprocal use of Participating Providers that contract with other Blue Cross and/or Blue Shield Plans. Providers available to you through the BlueCard Program have not entered into contracts with Blue Cross of California. If you have any questions or complaints about the BlueCard Program, please call us at 1-800-333-0912. If you are outside of California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield Participating Provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate with a local Blue Cross and/or Blue Shield Plan. In order for you to receive access to whatever reductions in out-of-pocket expenses may be available, we must abide by the BlueCard Program rules, as set by the Blue Cross and Blue Shield Association.

When you obtain health care services through the BlueCard Program outside of California, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The Negotiated Price that the on-site Blue Cross and/or Blue Shield ("Host Blue") passes on to us.

Often, this "Negotiated Price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The Negotiated Price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The Negotiated Price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Subscriber liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state mandate Subscriber liability calculation methods that differ from the usual BlueCard method noted above in the preceding paragraph of this item or require a surcharge, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

When traveling outside the United States, in cases of emergencies only, call 1-800-810-BLUE (2583) to inquire about providers that may participate in the BlueCard Worldwide Program.

Payment to Providers and Provider Reimbursement: Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. Hospitals or other health care facilities may be paid either a fixed fee or on a discounted fee for service basis. We pay the benefits of this Agreement directly to Contracting Hospitals, Participating Hospitals, Participating Physicians, medical transportation providers, certified nurse midwives and registered nurse practitioners and other Participating Providers, whether or not you have authorized an assignment of benefits. We may pay Hospitals, Physicians and other providers of service or the person or persons having paid for your Hospital or medical services directly when you assign benefits in writing no later than the time of filing proof of loss (claim). These payments fulfill our obligation to you for those services.

Blue Cross shall provide written notice to you within a reasonable period of time of any Participating Provider's termination or breach of, or inability to perform under, any provider contract, if Blue Cross determines that you or your Family Members may be materially and adversely affected thereby.

Prior Blue Cross Coverage: If the Member was covered by a prior Individual Coverage Blue Cross Agreement which is replaced by this Agreement, benefits used under the prior Agreement will be charged against the benefits payable under this Agreement.

Receipt of Information: We are entitled to receive from any provider of service information about you which is necessary to administer claims on your behalf. By submitting an application for coverage, you have authorized every provider who has furnished or is furnishing care to disclose all facts, opinion or other information pertaining to your care, treatment, and physical conditions, upon our request. You agree to assist in obtaining this information if needed. Failure to assist us in obtaining the necessary information when requested may result in the delay or rejection of your claims until the necessary information is received.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. Contact our customer service department at 1-800-333-0912 for a copy.

Relationship of Parties: We are not responsible for any claim for damages or injuries suffered by the Member while receiving care in any Hospital or Skilled Nursing Facility.

Right of Recovery: When the amount paid by us exceeds the amount for which we are liable under this Agreement, we have the right to recover the excess amount from you unless prohibited by law.

Submission of Claims: Either the Subscriber or provider of service must claim benefits by sending Blue Cross properly completed claim forms itemizing the services or supplies received and the charges. These claim forms must be received by Blue Cross within 15 months from the date the services or supplies are received. Blue Cross will not be liable for benefits if it does not receive completed claim forms within this time period. Claim forms must be used; cancelled checks or receipts are not acceptable.

Terms of Coverage:

- In order for you to be entitled to benefits under this Agreement your coverage under this Agreement must be in effect on the date you receive the service or supply, except as specifically provided under in the PART entitled TERMS OF YOUR AGREEMENT. Under this Agreement, an expense is incurred on the date the Subscriber or Family Member receives a service or supply for which the charge is made.
- This Agreement, including all terms, benefits, conditions, limitations and exclusions, may be changed by us as provided in the PART entitled TERMS OF YOUR AGREEMENT.
- The benefits to which you may be entitled will depend on the terms of coverage as set out in the Agreement in effect on the date you receive the service or supply.
- **Workers' Compensation Insurance:** This Agreement does not take the place of or affect any requirement for, or coverage by, workers' compensation insurance.

PUBLIC POLICY PARTICIPATION

We have established a public policy committee (that we call our Consumer Relations Committee) to advise our Board of Directors. This Committee advises the Board about how to assure the comfort, dignity and convenience of the people we cover. The committee consists of Members covered by our health plan, Participating Providers and a member of our Board of Directors. The Committee may review our financial information and information about the nature, volume and resolution of the complaints we receive. The Consumer Relations Committee reports directly to our Board.

Payments of benefits under this Agreement do not regulate the amounts charged by providers of medical care or attempt to evaluate those services.

HOWEVER, THE AMOUNT OF BENEFITS PAYABLE UNDER THIS AGREEMENT WILL BE DIFFERENT FOR NON-PARTICIPATING PROVIDERS THAN FOR PARTICIPATING PROVIDERS. PLEASE READ THE BENEFIT SECTIONS CAREFULLY TO DETERMINE THOSE DIFFERENCES.

BECAUSE WE CARE ABOUT THE QUALITY OF THE SERVICE PROVIDED TO OUR CUSTOMERS, YOUR TELEPHONE CALL TO US MAY BE RANDOMLY OBSERVED OR RECORDED TO ENSURE THAT WE ARE ACHIEVING THAT GOAL.

PART X GRIEVANCE PROCEDURES

If you have a question about your eligibility, your benefits under this Agreement, or concerning a claim, please call customer service at 1-800-333-0912, or you may write to us. Please address your correspondence to Blue Cross of California, P.O. Box 9086, Oxnard, CA 93031-9086, marked to the attention of the Customer Service Department listed on your identification card. Our customer service staff will answer your questions or assist you in resolving your issue.

If you are not satisfied with the resolution based on your initial inquiry, you may request a copy of the Plan Grievance Form to complete and return to us, or ask the customer service representative to complete the form for you over the telephone. Your issue will then become part of our formal grievance process and will be resolved accordingly.

All grievances received by us will be acknowledged in writing. After we have reviewed your grievance, we will send you a written statement on its resolution or pending status. If your case involves an imminent threat to your health, including, but not limited to, the potential loss of life, limb, or major bodily function, review of your grievance will be expedited.

If you are dissatisfied with the resolution of your grievance, or if your grievance has not been resolved after at least thirty (30) days, you may submit your grievance to the Department of Managed Health Care. For review prior to binding arbitration see the section Department of Managed Health Care. If your case involves an imminent threat to your health, as described above, you are not required to complete our grievance process or to wait at least thirty (30) days, but may immediately submit your grievance to the Department of Managed Health Care for review.

You may at any time pursue your ultimate remedy, which is Binding Arbitration. See the PART entitled BINDING ARBITRATION.

If a Member has had coverage denied because proposed treatment is determined by us to be investigational or experimental, that Member may ask for review of that denial by an external, independent medical review organization contracting with the Department of Managed Health Care. A request for review may be submitted to the Department of Managed Health Care in accordance with the procedure described under "Independent Medical Review of Grievances involving a disputed Health Care Service."

To qualify for external review, all of the following conditions must be satisfied:

- The Member has a life-threatening or seriously debilitating condition.
 - A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the condition or disease is interrupted and/or a condition or disease with a potentially fatal outcome where the end-point of clinical intervention is survival.
 - A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.

- The proposed treatment must be recommended by a Participating Physician, or a board certified or board eligible Physician qualified to treat the Member, who has certified in writing that it is more likely to be beneficial than standard treatment, and who has provided the supporting evidence.
- If external independent review is requested by the Member or by a qualified Non-Participating Physician, as described above, the requester must supply two items of acceptable scientific support (as defined below).
- Within five (5) business days of the request by a qualified Member for external independent review, we will give the reviewing panel all relevant medical records and documents for review, and any information submitted by the Member or the Member's Physician. Any subsequent information received will be forwarded to the review panel within five (5) business days. The external independent review organization will render an opinion within thirty (30) days of the request (or seven (7) days in the case of an expedited review), except the reviewer may ask for three (3) more days if there was any delay in receiving the necessary records.

"Acceptable scientific support" is the following sources:

- Peer reviewed scientific studies published in medical journals with national recognized standards;
- Medical journals recognized by the Secretary of Health and Human Services under Section 1861 (t) (2) of the Social Security Act;
- The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopeia-Drug Information;
- Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medica, Medline, MEDLARS database Health Services Technology Assessment Research;
- Finding, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

Independent Medical Review of Grievances involving a Disputed Health Care Service

You may request an Independent Medical Review ("IMR") of disputed health care services from the Department of Managed Health Care (DMHC) if you believe that we have improperly denied, modified, or delayed health care services. A "disputed health care service" is any health care service eligible for coverage and payment under your plan that has been denied, modified, or delayed by us, in whole or in part, because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must provide you with an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service.

Eligibility

The DMHC will review your application for IMR to confirm that:

1. a. Your provider has recommended a health care service as Medically Necessary,
 - b. You have received urgent care or emergency services that a provider determined was Medically Necessary, or
 - c. You have been seen by a Participating Provider for the diagnosis or treatment of the medical condition for which you seek independent review;
2. The disputed health care service has been denied, modified, or delayed by us based in whole or in part on a decision that the health care service is not Medically Necessary; and
3. You have filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If your grievance requires expedited review you may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is Medically Necessary, we will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within thirty (30) days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three (3) business days.

For more information regarding the IMR process, or to request an application form, please call our customer service department toll free at 1-800-333-0912.

Department of Managed Health Care

The Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll free telephone number **(1-888-HMO-2219)** to receive complaints regarding health plans. The hearing and speech impaired may call the department's direct toll free number **(1-877-688-9891(TDD))** or use the California Relay Service's toll free telephone numbers **(1-800-735-2929(TTY))** or **(1-888-877-5378 (TTY))** to contact the department. The department's Internet website (<http://www.HMOHELP.CA.GOV>) has complaint forms and instructions online.

If you have a grievance against your health plan, you should first telephone your plan at 1-800-333-0912 and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than thirty (30) days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

PART XI BINDING ARBITRATION

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Agreement, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any disputes regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply.

The Member and Blue Cross agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by court or jury.

California Health & Safety Code section 1363.1 requires that any arbitration agreement include the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."

The Member and Blue Cross agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations, the Member waives any right to pursue, on a class basis, any such controversy or claim against Blue Cross and Blue Cross waives any right to pursue, on a class basis, any such controversy or claim against the Member.

The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings.

The arbitration is initiated by the Member making written demand on Blue Cross. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the Member and Blue Cross, or by order of the court, if the Member and Blue Cross cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to whom the parties have agreed, in which cases, Blue Cross will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to: Blue Cross of California, P.O. Box 9086, Oxnard, California 93031-9086.

COMPLAINTS

If you have a complaint about services from Blue Cross or your health care provider, contact Blue Cross at 1-800-333-0912 or address indicated on your Identification Card.

PART XII TERMS OF YOUR AGREEMENT

The Effective Date of your coverage is printed on your Blue Cross Identification Card.

A. Blue Cross may terminate, cancel or decline to renew this Agreement in the event of any of the following:

1. Your failure to pay subscription charges as required herein.

If you fail to pay subscription charges as they become due, Blue Cross may terminate this Agreement as of the last day of the grace period. Nevertheless, Blue Cross will terminate this Agreement only upon first giving you a written Notice of Cancellation at least fifteen (15) days prior to that termination. The Notice of Cancellation shall state that this Agreement shall not be terminated if you make appropriate payment in full within fifteen (15) days after Blue Cross issues the Notice of Cancellation. You are not entitled to a grace period until you have made your first payment to us. If you need covered benefits during the grace period, coverage will be provided, however, we will deduct the subscription charges due from any benefits we pay.

The Notice of Cancellation also shall inform you that, if this Agreement is terminated for nonpayment and you wish to apply for reinstatement, you may be required to submit a new application for coverage and will be required to submit any dues that are owed, in addition to a \$50 reinstatement fee, and that Blue Cross either may decline to permit reinstatement in Blue Cross' sole discretion or may permit reinstatement upon such terms and conditions as Blue Cross shall determine appropriate in its sole discretion;

2. Upon the return or dishonor by the bank of the third check for payment of subscription charges in any twelve-month period for any reason.

3. Your or any Family Member's fraud or deception in the submission of claims or use of services or facilities of Blue Cross, or your knowingly permitting such fraud or deception by another.

4. The occurrence of any other event permitting termination, cancellation or non-renewal described below.

Blue Cross may terminate, cancel or decline to renew this Agreement when required to effectuate the purposes of the Knox-Keene Health Care Service Plan Act of 1975, with the consent of the Director of the Department of Managed Health Care. Additionally, Blue Cross may incorporate into this Agreement any of the following bases for termination, cancellation or non-renewal upon thirty-one (31) days prior written notice to you: a) if there is an amendment to the Knox-Keene Act, or a change in the applicable interpretations thereof, which expands the basis upon which a health plan may terminate, cancel or decline to renew individual subscriber Agreements, or b) if the Director of the Department of Managed Health Care approves of good causes for termination, cancellation or non-renewal of an individual subscriber Agreement of Blue Cross, other than as set forth in this Agreement.

5. On the first of the month following our receipt of your written notice to cancel.

6. Upon becoming ineligible for this coverage. See the section, Notice of Change in Eligibility, in the PART entitled ELIGIBILITY.

7. If you are in the Hospital or Skilled Nursing Facility on the date we cancel your coverage on written notice (except for the reasons described in section A., paragraphs 1, 2, 3, 5 or 6) benefits will continue until whichever of the following occurs first:

- The date of discharge from the Hospital or Skilled Nursing Facility, or
- Care or treatment is no longer Medically Necessary, or
- The maximum benefits have been furnished.

- B. We have the right to modify this Agreement, including change subscription charges, if we give you thirty (30) days written notice.
1. We will not modify this Agreement on an individual basis, but only for all Members in the same class and covered under the same plan as you.
 2. The modification will take effect on the date listed in the notice.

If this Agreement is terminated for any cause any subscription charges received by Blue Cross for periods occurring after the effective date of that termination, less any amounts due to Blue Cross, will be refunded to you, and Blue Cross shall have no further liability or responsibility with regard to any Members under this Agreement. If the termination is for any reason other than you or a Family Member's fraud or deception in the use of services or facilities of Blue Cross or knowingly permitting such fraud or deception by another, Blue Cross will make this refund to you within thirty (30) days.

Your coverage may not be terminated because of your health status or requirements for health care services. If you believe that your coverage has been terminated for either of these reasons, you may request a review of the matter by the Director of Department of Managed Health Care.

Any written notice will be officially given by us when it is mailed to your address as it appears on our records.

You should address any written notice to us at: Blue Cross of California, at the P. O. Box indicated on your identification card.

PART XIII NON-DUPLICATION OF BLUE CROSS BENEFITS

If, while covered under this Individual Agreement, you are also covered by another Blue Cross of California Individual Agreement:

1. You will be entitled only to the benefits of the Agreement with the greater benefits, and
2. We will refund any subscription charges received under the Agreement with the lesser benefits, covering the time period both Agreements were in effect. However, any claims payments made by us under the Agreement with the lesser benefits will be deducted from any such refund of subscription charges.

PART XIV THIRD PARTY LIABILITY

Under some circumstances, a third party may be liable or legally responsible by reason of negligence, an intentional act, or the breach of a legal obligation of such third party for an injury, disease, or other condition for which a Member receives Covered Services. In that event, any benefits we pay under this Agreement for such Covered Services will be subject to the following:

- We will automatically have a lien upon any amount you receive from the third party or the third party's insurer or guarantor by judgment, award, settlement or otherwise. Our lien will be in the amount of the benefits we pay under this Agreement for treatment of the illness, disease, injury or condition for which the third party is liable. Our lien will not exceed the amount we actually paid for those services, if we paid the provider other than on a capitated basis, and, if we paid the provider on a capitated basis, our lien will not exceed 80% of the usual and customary charges for those services in the geographic area in which they were rendered. In addition, if you engaged an attorney to gain your recovery from the third party, one-third of the monies due you under any final judgment, compromise, or settlement agreement and, if you did not engage an attorney, our lien shall not be for a sum in excess of one half of the monies due you under any final judgment, compromise or settlement agreement. Where a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien shall be reduced by the same comparative fault percentage by which your recovery was reduced. Our lien is subject to a pro rata reduction commensurate with your reasonable attorney's fees and costs in accordance with the common fund doctrine.
- You agree to advise us in writing of your claim against a third party within sixty (60) days of making such claim, and that you will take such action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our lien rights. You agree not to take any action that may prejudice our rights or interests under this Agreement. You agree also that failing to give us such notice, or failing to cooperate with us, or taking action that prejudices our rights will be a material breach of this Agreement. In the event of such material breach, you will be personally responsible and liable for reimbursing to us the amount of benefits we paid.
- We will be entitled to collect on our lien even if the amount recovered by or for the Member (or his or her estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss suffered by the Member.

PART XV CONVERSION PRIVILEGE

- Members who are 65 years of age or older may apply for a Blue Cross Plan which supplements Medicare benefits.
- Family Members who lose eligibility for coverage under this Agreement may apply for their own coverage.
- If your dependent does not meet the qualifications to remain as a dependent on your plan, Blue Cross will automatically enroll your dependent, if a resident of California, on the same plan, under his/her own social security number.
- The written application for Conversion coverage must be submitted to us within thirty-one (31) days of the loss of eligibility. We will not need proof of good health.
- If you move outside of California, you will not be eligible for a Conversion Plan or Medicare Supplement Plan with Blue Cross of California. Options to continue individual coverage include the following:
 - Transfer your coverage to the Blue Cross or Blue Shield Plan serving your new address. The type of coverage offered will be at the discretion of the new Blue Cross or Blue Shield Plan.
 - Submit an application for a UNICARE Life & Health Insurance Company policy in a state in which UNICARE offers individual policies and coverage shall be subject to UNICARE's acceptance or rejection according to its underwriting standards.
- SERVICES, BENEFITS AND SUBSCRIPTION CHARGES UNDER A CONVERSION AGREEMENT OR MEDICARE SUPPLEMENT MAY NOT BE THE SAME AS THOSE PROVIDED UNDER THIS AGREEMENT.

PART XVI DEFINITIONS

Here are the meanings of some of the words or terms used in this booklet. While reading this booklet, if you see a term that is capitalized you should refer to these definitions.

Ambulatory Surgical Center is a freestanding outpatient surgical facility. It must be licensed according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Authorized Referral occurs when a Member, because of his or her medical needs requires the services of a specialist who is a Non-Participating Physician or requires special services or facilities not available at a Participating Hospital, but only when:

1. There is no Participating Physician who practices in the appropriate specialty or there is no Participating Hospital or Participating Ambulatory Surgical Center which provides the required services or has the necessary facilities within a 30-mile radius of the principal residential address as reflected on our files or within the county in which the principal residence is located whichever is less, and
2. The Member is referred to the Non-Participating Provider by a Participating Physician, and
3. The referral has been authorized by Blue Cross before services are rendered.

BlueCard Program allows Blue Cross Members to take advantage of discounts available through Blue Cross and Blue Shield Plans for Covered Services rendered in other states. Discounts may be available through Blue Cross and Blue Shield Plans for Covered Services in other countries, only when emergency treatment is required.

Blue Cross of California ("Blue Cross") is a health care service plan. We are regulated by the Department of Managed Health Care.

Coinsurance is the percentage amount due and payable by the Member to the provider of care after your Deductible is satisfied.

Contracting Hospital is a Hospital that has a contract with us to provide care to our Members. However, this does not necessarily make it a Participating Hospital. A list of Contracting Hospitals will be sent to you on request.

Copayment is the amount due and payable by the Member to the provider of care.

Cosmetic Surgery is surgery that is performed to alter or reshape normal structures of the body in order to improve appearance. **Reconstructive Surgery** is surgery that is Medically Necessary and appropriate that is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: to improve function, or to create a normal appearance, to the extent possible.

Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.

Covered Services are services that are Medically Necessary services or supplies which are listed in the benefit sections of this Agreement and for which you are entitled to receive benefits.

Customary and Reasonable Charge is the average price that a majority of doctors charged for a particular procedure based on where the procedure is performed and the complexity and severity of the treatment.

Day Treatment Program is an outpatient Hospital based program that is licensed according to state and local laws to provide outpatient care and treatment of Mental or Nervous Disorders and Substance Abuse under the supervision of psychiatrists.

Deductible means the amount of charges you must pay for any Covered Services and Prescription Drugs before any benefits are available to you under this Agreement. Your Yearly Deductible is stated in the PART entitled BENEFIT COPAYMENT/COINSURANCE LIST. Your Brand Name Prescription Drug Deductible is stated in the PART entitled YOUR PRESCRIPTION DRUG BENEFITS.

Diabetes Equipment and Supplies means the following items for the treatment of insulin-using diabetes or non-insulin-using diabetes and gestational diabetes as Medically Necessary or medically appropriate:

- blood glucose monitors
- blood glucose testing strips
- blood glucose monitors designed to assist the visually impaired
- insulin pumps and related necessary supplies
- ketone urine testing strips
- lancets and lancet puncture devices
- pen delivery systems for the administration of insulin
- podiatric devices to prevent or treat diabetes related complications
- insulin syringes
- visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin

Diabetes Outpatient Self-Management Training Program includes: training provided to a qualified Member after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of Diabetes Equipment and Supplies; additional training authorized on the diagnosis of a Physician or other health care practitioner of a significant change in the qualified Member's symptoms or condition that requires changes in the qualified Member's self-management regime; and periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes. Diabetes Outpatient Self-Management Training must be provided by a health care practitioner or provider who is licensed, registered or certified in California to provide appropriate health care services.

Home Health Agencies and Visiting Nurse Associations must be licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and they must be approved as a home health care provider under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

Hospital is a facility which provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians. It must be licensed as a general acute care Hospital according to state and local laws. It must also be registered as a general Hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations.

For the purpose of Severe Mental Illnesses and Serious Emotional Disturbances of a Child only, the term "Hospital" includes an acute psychiatric facility which is a Hospital specializing in psychiatric treatment or a designated psychiatric unit of a Hospital licensed by the state to provide 24 hour acute inpatient care for persons with psychiatric disorders. For the purposes of this plan, the term "acute psychiatric facility" also includes a psychiatric health facility which is an acute 24 hour facility as defined in California Health and Safety Code 1250.2. It must be:

1. Licensed by the California Department of Health Services;
2. Qualified to provide short term inpatient treatment according to state law;
3. Accredited by the Joint Commission on Accreditation of Health Care Organizations, and
4. Staffed by an organized medical or professional staff which includes a Physician as medical director, and
5. Actually providing an acute level of care.

Infusion Therapy is the administration of Drugs (Prescription substances) by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Agreement, it shall also include Drugs administered by aerosol (into the lungs) and by a feeding tube.

Medical Emergency is a sudden, serious, and unexpected acute illness, injury, psychiatric or medical condition including without limitation sudden and unexpected severe pain which could permanently endanger health if medical or psychiatric treatment is not received immediately. Final determination as to whether services were rendered in connection with a Medical Emergency will rest solely with us.

Outside the State of California Medical Emergencies include urgently needed services to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the Member returns to Blue Cross' service area.

Medically Necessary are procedures, supplies, equipment or services that Blue Cross of California determines to be:

1. appropriate for the symptoms, diagnosis or treatment of a medical condition, and
2. provided for the diagnosis or direct care and treatment of the medical condition, and
3. within the standards of good medical practice within the organized medical community, and
4. not primarily for the convenience of the patient's Physician or another provider, and
5. the most appropriate procedure, supply, equipment or service which can be safely provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
 - There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than other possible alternatives; and
 - Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
 - For Hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

In determining medical necessity, we will take into account the results of a review by our medical directors and/or by independent medical professionals selected by us, including professionals who treat the type of disease or condition involved.

Member shall mean both the Subscriber and all other Family Members who are enrolled for coverage under this Agreement.

Mental or Nervous Disorders and Substance Abuse are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A Mental or Nervous Disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (e.g. seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior. Some Mental or Nervous Disorders are: schizophrenia, manic depressive and other conditions usually classified in the medical community as psychosis; drug, alcohol or other substance addiction or abuse; depressive phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; hypochondria; personality disorders (including paranoid, schizoid, dependent, antisocial and borderline); dementia and delirious states; post traumatic stress disorder; hyperkinetic syndromes (including attention deficit disorders); adjustment reactions; reactions to stress; anorexia nervosa and bulimia. Any condition meeting this definition is a Mental or Nervous Disorder no matter what the cause. One or more of these conditions may be specifically excluded in this Agreement. **However, medical services provided to treat medical conditions that are caused by behavior of the Member that may be associated with these mental conditions (e.g., self-inflicted injuries) and treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child are not subject to these limitations.**

Negotiated Fee Rate is the amount of payment that Blue Cross has negotiated with the Participating Provider under a Prudent Buyer Participating Agreement.

Negotiated Price (out of state, or in cases of emergency some foreign country Providers only) often consists of a simple discount which reflects the actual price paid by the on-site Blue Cross and/or Blue

Shield Licensee/plan. However sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or specified group of providers. The Negotiated Price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The Negotiated Price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Non-Contracting Hospital is a Hospital that does not have a standard contract nor a Prudent Buyer Participating Hospital Agreement with Blue Cross of California. No benefits are available for care furnished in Non-Contracting Hospitals in California except for Medical Emergencies as outlined in the Special Circumstances section of the PART entitled BENEFIT COPAYMENT/COINSURANCE LIST.

Non-Participating Provider is one of the following providers which does NOT have a Prudent Buyer Plan Participating Provider Agreement with Blue Cross in effect at the time services are rendered:

- A Hospital
- A Physician
- An Ambulatory Surgical Center
- A Home Health Agency or Visiting Nurse Association
- A facility which provides diagnostic imaging services
- A clinical laboratory
- A home Infusion Therapy provider
- A Skilled Nursing Facility
- A licensed ambulance company
- A durable medical equipment outlet

Only a portion of the amount which a Non-Participating Provider charges for services will be paid by Blue Cross. The Member will be responsible for any billed charges over the amount allowed under this Agreement. See the PART entitled BENEFIT COPAYMENT/COINSURANCE LIST to determine your payment responsibility when using Non-Participating Providers.

Office Visit is when you go to a Physician's office and have one or more of **ONLY** the following three services provided:

- History (gathering of information on an illness or injury)
- Examination
- Medical Decision Making (the Physician's actual diagnosis and treatment plan)

For purposes of this Definition, Office Visit will not include any other services while at the office of a Physician (e.g., any surgery, Infusion Therapy, diagnostic X-ray, laboratory, pathology, and radiology) or any other services performed other than or in addition to any of the three services specifically listed above.

Participating Provider is one of the following providers that has a Prudent Buyer Plan Participating Provider Agreement in effect with us and has negotiated certain charges as the Negotiated Fee Rate they will charge our Members for Covered Services under this Agreement. The exception would be when Prior Authorization is not obtained.

- A Hospital
- A Physician
- An Ambulatory Surgical Center
- A Home Health Agency or Visiting Nurse Association
- A facility which provides diagnostic imaging services
- A clinical laboratory

- A home Infusion Therapy provider
- A Skilled Nursing Facility
- A licensed ambulance company
- A durable medical equipment outlet

A directory of Participating Providers is available upon request through our Customer Service Representatives.

Physician means:

- A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice where the care is provided, or
- One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this Agreement, and when benefits would be payable if the services were provided by a Physician as defined above:
 - A dentist (D.D.S.)
 - An optometrist (O.D.)
 - A dispensing optician
 - A podiatrist or chiropodist (D.P.M. or D.S.C.)
 - A psychologist
 - A chiropractor (D.C.)
 - A certified registered nurse anesthetist
 - An acupuncturist
 - A clinical social worker (C.S.W. or L.C.S.W.)
 - A marriage, family and child counselor (M.F.C.C.)
 - A physical therapist (P.T. or R.P.T.)*
 - A speech pathologist*
 - An audiologist*
 - An occupational therapist (O.T.R.)*
 - A respiratory therapist*
 - A psychiatric mental health nurse
 - A Physician assistant*
 - A certified nurse midwife
 - A registered nurse practitioner

Note: The providers indicated by asterisks (*) are covered only by referral of a Physician as defined above.

Pre-existing Condition means an illness, injury, disease or physical condition for which medical advice, diagnosis, care or treatment, including the use of Prescription Drugs was recommended or received from a licensed health practitioner during the six (6) months immediately preceding the Member's effective date of coverage.

Prior Authorization is determination by Blue Cross whether certain admissions, procedures, surgeries, Prescription Drugs or services are Medically Necessary and are the appropriate length of stay, if applicable. Refer to the PART entitled PRIOR AUTHORIZATION PROCEDURES.

Preferred Participating Hospital is a Hospital that has entered into a Preferred Participating Agreement with Blue Cross. A list of these Preferred Participating Hospitals is available upon request from our Customer Service Representatives.

Qualifying Prior Coverage is any individual or group plan that provides medical, Hospital and surgical coverage, including continuation or conversion coverage, or coverage under a publicly sponsored program such as CHAMPUS, Indian Health Service or tribal organization medical coverage, Peace Corps medical coverage, a state health benefits risk pool, Medicare or Medicaid. Qualifying Prior Coverage does not include accident only, credit, disability income, Medicare supplement, long term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans.

Serious Emotional Disturbances of a Child is defined by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. The child must also meet one or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one Year without treatment.
2. The child is psychotic, suicidal, or potentially violent.
3. The child meets special education eligibility requirements under California law.

Severe Mental Illnesses includes the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism
- Anorexia nervosa
- Bulimia nervosa

Note: Coverage for Severe Mental Illnesses and Serious Emotional Disturbances of a Child will be provided in accordance with the Plan provisions for Severe Mental Illnesses and not in accordance with the Plan provisions for Mental or Nervous Disorders.

Skilled Nursing Facility is a facility that provides continuous nursing services. It must be licensed according to state and local laws and be recognized as a Skilled Nursing Facility under Medicare.

For purposes of Severe Mental Illnesses and Serious Emotional Disturbances of a Child only, a Skilled Nursing Facility will also include a residential treatment center which is an inpatient treatment facility where the Member resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a Mental Disorder or Substance Abuse. The facility must be licensed to provide psychiatric treatment of mental disorders or rehabilitative treatment of Substance Abuse according to state and local laws.

Year is a twelve-month period starting each January 1 at 12:01 a.m. Pacific Standard Time.

PART XVII SUBSCRIPTION CHARGES

The subscription charges are payable in advance and due the first of the month.

There are three billing options available:

1. Quarterly (3 months)
2. Bi-monthly (2 months)
3. Monthly (1 month)

The monthly billing option is available only to individuals who are paying by the Blue Cross Checking Account Deduction Program (the monthly subscription charge is deducted directly from the Subscriber's checking account).

IMPORTANT: If you are enrolled in the Blue Cross Checking Account Deduction Program, you must give us thirty (30) days advance written notice to: change banks, change account numbers, change account names, stop deduction, or re-start eligible deductions. If we do not receive your written request at least thirty (30) days in advance of your subscription charge due date, we will not be able to make the requested change in time to coincide with your subscription charge due date. For the above listed changes a new authorization form is required. We will send you the necessary form upon request by calling us at 1-800-333-0912.

Subscription charges are based upon attained age. If you are enrolled under a Subscriber and spouse or family coverage, the subscription charges will be based upon either the age of the Subscriber or the spouse, whichever is younger. We will recalculate your age for each billing and your subscription charges will be automatically adjusted to the new rate.

Subscription charges are established for a specific regional area within which the Subscriber resides. If you change residence you may be subject to a change in subscription charges. Such a change in subscription charges will be effective on the 1st of the month following written notification of the change of residence. If you do not notify us and we later learn of your change in residential address, at our option, we may bill you for the difference in subscription charges from the date your address changed.

You will be responsible for an additional \$25 charge for any check which is returned or dishonored by the bank as non-payable to Blue Cross for any reason.

Please be sure to read the PART entitled TERMS OF YOUR AGREEMENT for additional terms and conditions.

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November 2, 2009

Mr. David Null
5401 Castlevue Lane
Garland, TX 75044

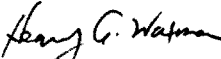
Dear Mr. Null:

Thank you for appearing before the Subcommittee on Oversight and Investigations on October 15, 2009, at the hearing entitled "Insured But Not Covered: The Problem of Underinsurance".

Pursuant to the Committee's Rules, attached are written questions for the record directed to you from certain Members of the Committee. In preparing your answers, please address your response to the Member who submitted the questions and include the text of the question with your response, using separate pages for responses to each Member.

Please provide your responses by November 16, 2009, to Earley Green, Chief Clerk, in Room 2125 of the Rayburn House Office Building and via e-mail to Earley.Green@mail.house.gov. Please contact Earley Green or Jennifer Berenholz at (202) 225-2927 if you have any questions.

Sincerely,



Henry A. Waxman
Chairman

Attachment

The Honorable Michael Burgess

1. When you encountered difficulties with your insurance policy, did you contact the Texas State Insurance Commissioner? If not, why not. If yes, then what did they find was wrong with your policy?

Congressman Burgess, thank you for your question and your opening comments at the Under-insurance Hearing. It is an excellent question and the short answer is no, I did not contact the Texas State Insurance Board regarding our insurance policy.

There are a few factors that prevented me from calling them. I had appealed to the Commissioner's office years before regarding an auto accident. While waiting, motionless, in a turn lane for traffic to clear, a wheel fell off another vehicle and struck my vehicle. Although my car was not even moving, I was somehow found at fault by the other insurance company. I explained the event to commissioner's office. To my amazement the Commissioner agreed citing vehicle damage is an assumed risk of driving and likened it to a rock thrown by a tire. Since then I have little faith in that office to use common sense to interpret a policy.

While I'm not a lawyer, I did take business law at the University of North Texas, which is in your 26th district as a matter of fact. I learned enough to know the policy was a contract written by an attorney and probably iron clad. In my mind, the Commissioner would have simply agreed that the language of the actual contract had been executed properly and would not consider any of our circumstantial conversations with the agent as to the implied applicability and fitness of the policy to the hypothetical scenario I presented during our meetings. That would be a matter for the court system and we lacked time, money and energy immediately following Tatum's transplant and long recovery to pursue litigation against an insurance companies team of attorney's. We felt we really had no available recourse and were simply an example of "Buyer Beware" gone wrong.

Again, thank you for your question and your work on this subcommittee.

Respectfully,

David Null

Mr. STUPAK. That concludes our hearing. This meeting of the subcommittee is adjourned.
[Whereupon, at 5:25 p.m., the subcommittee was adjourned.]

