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ARE MINI-MED POLICIES REALLY HEALTH INSURANCE?

HEARING

BEFORE THE

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

DECEMBER 1, 2010

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SENATE COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

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ARE MINI-MED POLICIES REALLY HEALTH INSURANCE?

WEDNESDAY, DECEMBER 1, 2010

U.S. SENATE,
COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION,
Washington, DC.

The Committee met, pursuant to notice, at 2:35 p.m. in room SR–253, Russell Senate Office Building, Hon. John D. Rockefeller IV, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

The CHAIRMAN. This hearing will come to order.

And I want to apologize, not for those of us who are here, but for those who aren't here, because, at least on the Democratic side, there would be a lot of people here, but we're having 3 days of three-and-a-half-hour caucuses. And how much are we getting done? That's something that only I can tell you, but I can't. And so, some will be coming in. And the problem, basically, is that most committees aren't having hearings during the lameduck session, and Senator Hutchison and I don't see the reason for that. We think it's a good time for hearings. But, if people are sitting in a caucus until 3:30 or 4, that makes it harder. So, I do apologize to you, and I apologize for keeping you waiting.

Let me make my opening statement, and then Senator Hutchison. And then, if others, there not being many, want to just say a brief word, that would fine. Is that all right with you?

Senator HUTCHISON. Yes.

The CHAIRMAN. OK.

More than a million Americans wake up and go to work every day thinking they have health insurance, but I think the fact is, they don't. They don't have the kind of comprehensive health insurance that most people in this hearing room most certainly do have. They have something called "limited-benefit," or "mini-medical" insurance.

Now, this is an insurance product that has been around for a couple of decades, but it didn't really get going until two of the largest insurance companies started marketing them, and those were Cigna and Aetna. They started selling it, and then it became much more popular.

Wendell Potter, who sort of made his name when he came before this committee and told us about how Aetna gets rid of people they don't want to have to insure because their risks might be too high—and he's, you know, a formidable person and he testified be-

fore our committee last year about these plans. And he called them "fake insurance"—his words—designed to earn big profits for the insurers but provide little value to customers.

Now, this is how mini-meds work. Most people in this hearing room probably don't have much experience with mini-meds, as I indicated. But, if you work at a restaurant or a retail chain in this country, or if you're a young adult working a part-time or temporary job, while you're looking for a permanent one, mini-med insurance might be the only option that you have.

Employers who offer this health insurance to their employees make a nice pitch. They hand out a nice glossy, happy people abound everywhere. But, the statistics aren't quite as good. So, here it is. That's what McDonald's hands out to its hourly restaurant employees.

[The information referred to is contained in the appendix.]

And part of what underlies this hearing—my point of view—is, what are human beings, and how are they to be treated? And if you're a corporate person or you're an hourly person, does that make a difference in terms of how you should be insured? Are you less valuable because you're not a corporate person? Or are you more valuable because you are a corporate person? Or is everybody equally valuable? Well, they will be in 2014, when we get our [Patient Protection and Affordable Care Act] state exchanges going. But, we have to get from here to there.

So, this little booklet I held up tells new McDonald's employees how they can get health insurance plans that will help them, "pay for the medical care you need when you're sick, injured, or have an ongoing medical condition." Comprehensive statement. And all those great benefits only cost McDonald's employees as little as $14 a week, deducted out of their paycheck. But, buried in the fine print of this policy, in confusing industry jargon, which we've become very familiar with on this committee—not just on health insurance, but a lot of other ways that people manage to take money out of other people's pockets and put it in theirs, it's a very different story. The true story is, the McDonald's mini-med policy will not pay for your bills if you a have serious health problem. And I can go into that later.

A McDonald's employee, named Katrina Fulton, from Monticello, Kentucky, learned this lesson the hard way. She thought she had health insurance through her McDonald's job, until she needed treatment for her colitis. Now she has more than $10,000 in unpaid medical bills. But, on the other hand, it said that, "pay for the medical care you need when you're sick, injured, or have an ongoing medical condition." Told one thing, reality another thing.

The mini-med insurance policy most commonly sold to McDonald's hourly employees like Mrs. Fulton has an annual limit of $2,000. So, if you're in the hospital, you use up your $2,000 just for the room you have, the bed you sleep in. It doesn't get you IV, it doesn't get you an X-ray, it doesn't get you a CAT scan, it doesn't get you any medication, it doesn't get you any gauze, any bandages, any anything. And so, that's the thing—they say $20,000, but actually, it's $2,000. Keep that in mind as I go along.

The mini-med insurance policy most commonly sold to McDonald's hourly employees, like Mrs. Fulton, has that $2,000 limit.

Anything more than $2,000, and McDonald's workers pay that out of their own pockets.

So, what will $2,000 cover in our healthcare system? Not much. It won't cover the cost of having a baby—that's about $9,000—and it won't cover 1 year of healthcare for a person with diabetes—that's about $7,000, on average. And, as we're going to hear from our witnesses today, the cost of treating a health problem like cancer, which I grant is dramatic, but which is something that many, many, many millions of people have or have suffered or will suffer in this country, can easily exceed $50,000 or even $100,000 on an annual basis. And it can be a lot more if you have to get into brain surgery.

So, today we're going to learn more about mini-med insurance policies. Some people are going to say that, even though these mini-med policies have skimpy coverage, they are, "better than nothing for consumers." I want to destroy that phrase before this hearing is over, but I won't do it in my opening statement. They say that McDonald's employees and other workers should be grateful that they have this coverage, even though it won't protect them against the cost of a serious illness or accident. But, we're going to hear people argue that mini-med insurance is worse than nothing. I will argue that too, because of the sense of security and expectations and leading people down beautiful roads that end up with large brick walls. It gives people a false sense of security. It lets them think they have health insurance, when they really don't. By the time they realize they don't have real health insurance, it's already too late. They have already received a huge hospital bill or have had their testing or surgery canceled because the so-called "health insurance" is worthless and will not cover those things.

I'm very pleased to say that the days of these mini-med plans are numbered. The new healthcare reform law—not loved by all, but by this person—is slowly putting an end to health plans that place caps on essential health services. That will happen with the state exchanges. Annual limits will no longer be legal. Lifetime limits will no longer be legal. If you're going to provide insurance—you make money on some, you lose on others.

Mr. Potter talked to us about the five largest health insurance companies, not involved in mini-med particularly, but he said that in 2009 they made $14.8—or $14.6 billion [$14.5 billion] worth of profit, while at the same time, using the power of recision—that is, the power to cut people off even though they have a policy—they cut people off. They cut off 3 million people, those five companies, in that year, while they were making this kind of money. That is disturbing.

Well, I'm very glad that you came. I have over-talked, and I will probably continue to do that. Senator Hutchison will keep me under control. But, my point is, it's not 2014 yet. All of this will disappear then. McDonald's won't be able to offer these plans then.

There are more than a million Americans today who are covered by these policies and who really don't know if the plans are doing more harm than good. No reason why they should.

So, I thank you all for coming, and I turn now to my very distinguished Co-Chair, Senator Hutchison from Texas.

STATEMENT OF HON. KAY BAILEY HUTCHISON,
U.S. SENATOR FROM TEXAS

Senator HUTCHISON. Thank you, Mr. Chairman.

I'm glad that you have called this hearing on mini-meds, because, of course, they have received a lot of attention recently, especially since the passage of the Healthcare Reform Act. Much attention has been paid to the related decisions by the Department of Health and Human Services to grant waivers and create carveouts from the healthcare law's requirements for mini-meds in order to avoid swelling the ranks of the uninsured.

These policies are not a new phenomenon. They've been around since the 1980s. And, for the better part of the last decade, there has been a public debate about whether such limited, but affordable, policies are, on balance, a reasonable option for employers and their employees. Now we're addressing the question, under the shadow of a law that appears to presuppose the answer.

To answer this question, we have several very important witnesses, including one from Texas. I'm very pleased that Dr. Devon Herrick is here from the National Center for Policy Analysis. The center has been very much a leader in the area of alternatives for better healthcare coverage. And I'm glad you're here.

I do think, Mr. Chairman, however, that someone from the Department of Health and Human Services also should be required to testify before we make any decisions about mini-meds.

This past summer, the Health and Human Services Department acknowledged the need for a waiver of the healthcare law's ban on annual benefit limits so that individuals covered by mini-meds would not be denied access to needed services or experience more than a minimal impact on premiums.

To date, 111 employers and insurers, covering more than a million people, have received such waivers from the Department of Health and Human Services. While these include chain restaurants like McDonald's, which is represented at today's hearing, the biggest single waiver, for 351,000 people, was for the United Federation of Teachers Welfare Fund, a New York union providing coverage for city teachers.

Just last week, the Department of Health and Human Services announced it would also give mini-meds a special, one-year reprieve from the law's medical loss ratio provisions. Mini-med insurers will be permitted to multiply their medical care expenditures by a factor of two to meet the law's requirement that 80 to 85 percent of premium revenues be spent on the delivery of healthcare. In announcing this special consideration for mini-meds, the Department of Health and Human Services expressed concern about the possibility of over 1 million individuals who have coverage through these plans losing all coverage completely.

I recognize this is not a hearing on the Health and Human Services waivers, but these waivers do call attention to the question of whether mini-meds provide an option for some consumers who would have no option if they were eliminated.

Nevertheless, I appreciate that your point, Mr. Chairman, that a $2,000 limit on benefits seems very unrealistic. If that is, in fact, the case, that is not a good limit. However, a $750,000 limit, which is required in the healthcare reform bill, is also going to be exces-

sive for a number of people to be able to afford, including some small businesses. Surely there is something in between here that would create a more reasonable alternative.

Without the recent waivers, I think the healthcare reform bill could very well keep employees from having any coverage whatsoever, including coverage which would at least give them the ability to have check-ups and for their children to have shots and that sort of thing. So, I think we need to be very careful in treading on this ground, as we look at yet another piece of the healthcare reform bill that may have gone so far overboard as to throw the baby out with the bath water, so to speak.

Thank you very much.

The CHAIRMAN. Thank you, Senator Hutchison.

I've talked at length—do you want to make a statement?

Senator ENSIGN. Just very briefly.

The CHAIRMAN. Yes. Let me just make this statement, then go to you.

The—to Senator Ensign—the—I've talked with Kathleen Sebelius [Secretary, U.S. Department of Health and Human Services (HHS)]—these waivers are entirely temporary, and—as you indicated, in some cases, they're just a year; and, in all cases, they don't go beyond the beginning of the state exchanges in 2014. So, it's a very temporary business, and I think they did it for whatever reason. I also would agree with you, it would be better if we had somebody here. It would be a crowded table, but it would be better.

Senator Ensign.

STATEMENT OF HON. JOHN ENSIGN,
U.S. SENATOR FROM NEVADA

Senator ENSIGN. Thank you, Mr. Chairman.

Just very briefly, I wish that not only someone from HHS was here, but also from the Congressional Budget Office, simply because it would be an opportunity to obtain answers to questions. Questions, such as, did the CBO take into account these mini-med plans and potential for people dropping their health insurance in these mini-med plans and then dumping the people—those employees—into the exchanges? And were those costs figured into whether or not this bill was actually going to hurt the deficit, or not? I think that's a significant issue that needs to be answered from CBO, because this bill was said to have reduced the deficit, and yet, we're seeing all kinds of unintended consequences with this new healthcare law. The mini-med problem is just one of many.

Mr. Chairman, you said, in your opening statement, that these things do more harm than good. My question—which is kind of a rhetorical question—would be, if they do more harm than good, then why did HHS grant waivers? I mean, if they're doing more harm than good, then shouldn't HHS just say, "Sorry, that's the way the law is, we're not going to grant to any waivers," if, in fact, they were doing more harm than good? But, what I think HHS recognized is that it is better to have at least some insurance than no insurance, and that's why they're granting these waivers. At least, HHS should be here to answer that question.

So, thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Ensign.

And if there are no other statements to be made, let's go to our panel. And we'll start with Mr. Stephen "Finnan"——

Mr. FINAN. "Finan."

The CHAIRMAN.—Senior Director of Policy at the American Cancer Society.

STATEMENT OF STEPHEN FINAN,
SENIOR DIRECTOR OF POLICY,
AMERICAN CANCER SOCIETY CANCER ACTION NETWORK

Mr. FINAN. Good afternoon, Mr. Chairman——

The CHAIRMAN. And, incidentally, all of your statements are already in the record, so you don't have to leaf through the whole pages, if you don't want to.

Mr. FINAN. Thank you.

Good afternoon, Mr. Chairman, Ranking Member Hutchison, and distinguished members of the Committee.

My name is Stephen Finan, Senior Director of Policy at the American Cancer Society Cancer Action Network, or ACS CAN. We are the advocacy affiliate of the American Cancer Society, a nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer through research, education, advocacy, and services.

ACS CAN is grateful for the Committee's interest in the so-called "mini-med" health insurance plans. Today I'd like to share with you what our organization has learned about the underinsured, and paint a picture all too common in America of how cancer patients and survivors with inadequate insurance face barriers and financial burdens in getting the quality healthcare they need to fight their disease.

As defined by the American Cancer Society, adequate health insurance ensures the timely access to the full range of evidence-based healthcare services, including prevention and primary care, disease treatment, and survivorship. Coverage should be comprehensive and protect the individual from incurring catastrophic expenditures.

So, what does being underinsured really mean for a cancer patient with a mini-med health insurance policy? Cancer is approximately 200 separate diseases, and, not surprisingly, the cost of treatment can vary enormously.

In 2009, ACS CAN commissioned a study to examine the adequacy of 4 serious medical conditions: stage II breast cancer, stage III colon cancer, myocardial infarction, or heart attack, and type I diabetes. It compared coverage features to simulate claim scenarios developed to illustrate potential care needs of patients with serious and chronic conditions.

For the stage II breast cancer case scenario, estimated charges for treatment billed by providers, institutions, and suppliers totaled approximately $111,300. For the stage III colon cancer case, care costs an estimated $252,000. Under the scenarios outlined in the study for the heart disease patient, the estimated charges totaled about $77,800. For the diabetes scenario, allowed charges for treatment billed by providers, labs, and pharmacies totaled over $7,100 for 1 year.

Clearly, such expenses are not financially viable for a patient with a mini-med policy that has a low annual limit or other tight restrictions on benefits.

Earlier this year, ACS CAN commissioned a nationwide poll among households with a cancer patient age 18 or older. Among the findings, half the families with somebody under 65 with cancer said they have had difficulty affording healthcare costs such as premiums, co-pays, and prescription drugs. Nearly one-third of families with someone under 65 with cancer have had trouble paying for basic necessities or other bills, and nearly a quarter have been contacted by a collection agency. Additional findings from this poll are provided in the statement I submitted for the record.

The American Cancer Society offers a program called the Health Insurance Assistance Service, or HIAS, through its call center in Austin, Texas. HIAS is a free resource that connects callers with health insurance specialists who work to address their needs.

Brian, from South Carolina, is one example of a patient we have heard from who is facing the excruciating choice of saving their life or their life savings as a result of inadequate health coverage. At age 25, Brian was recently diagnosed with testicular cancer. He is a full-time college student and works part-time at a retail store. The plan his employer offers has a $10,000 annual limit on benefits. He has already exceeded that limit and now has to pay for his treatment out of pocket. But, he continues to pay the premium so he can keep his coverage in the next plan year.

Mr. Melville, a cancer patient whose experience you will hear in a minute, also called HIAS. And we brought his story to the attention of the Committee.

The mini-meds are a perfect example of why reform is so crucial. Adequate coverage at affordable prices has long been unattainable for many Americans, and the problem, in recent years, has grown worse. If we want all Americans to have meaningful access to quality healthcare, we need to change the insurance market rules, provide subsidies to lower-income/middle-income families, streamline administrative costs, and greatly increase transparency and accountability. The Affordable Care Act provides a solid framework for achieving these goals.

ACS CAN acknowledges that, to maintain stability in the insurance market, all plans may not be able to immediately conform to the law's requirements in the requisite amount of time. Immediate compliance could result in termination of coverage for people who would otherwise have no other coverage alternative at all. That's why the law gives the administration the power to temporarily waive certain requirements. But, at the same time, we cannot allow cancer patients to fall into financial ruin because they unknowingly purchase inadequate coverage.

HHS must take steps to require plans with waivers to improve their products between now and 2014, and to make plan participants fully aware of the exception. A waiver this year should not be a free ride until 2014.

To make reform meaningful, we must find ways to work together with pragmatic intent to ensure implementation helps improve healthcare for cancer patients, and others with significant medical needs.

Thank you, Mr. Chairman.
[The prepared statement of Mr. Finan follows:]

PREPARED STATEMENT OF STEPHEN FINAN, SENIOR DIRECTOR OF POLICY, AMERICAN CANCER SOCIETY CANCER ACTION NETWORK

Introduction

Good afternoon, Mr. Chairman, Ranking Member Hutchinson and distinguished members of the Committee. My name is Stephen Finan, Senior Director of Policy at the American Cancer Society Cancer Action Network (ACS CAN). We are the advocacy affiliate of the American Cancer Society, a nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer through research, education, advocacy, and services.

ACS CAN is grateful for the Committee's interest in so-called "mini-med" health insurance plans. Throughout the health care reform debate over the past 2 years, ACS CAN's goal was to use the "cancer lens" to bring national attention to significant problems in the nation's health care system. One of the less visible but very significant problems that we see among cancer patients is being "underinsured"—having insurance that offers too little coverage to fully address the needs of a serious medical condition like cancer.

Today, I'd like to share with you what our organization has learned about the underinsured and paint a picture—all too common in America—of how cancer patients and survivors with inadequate insurance face barriers to and financial burdens from getting the quality health care they need to fight their disease.

American Cancer Society's Commitment to Access to Care

Cancer death rates have decreased by 21 percent among men and 12 percent among women since the early 1990s. Despite this significant progress, the American Cancer Society realizes that its long-term goals of reducing the incidence and mortality of cancer cannot be achieved unless the coverage gaps that exist within the current health care system are addressed. The challenge lies in the fact that even among those who are considered insured, more than 25 million are underinsured. Many underinsured are left with the extraordinary dilemma of either incurring serious and potentially ruinous out-of-pocket financial expenses to obtain necessary treatment, or curtailing essential treatment, thereby putting their health and possibly their lives in jeopardy.

Defining Adequate Health Insurance

The issue of underinsurance is an underappreciated, and at times overlooked, problem of adequacy of coverage. As defined by the American Cancer Society, adequate health insurance ensures timely access to the full range of evidence-based health care services, including prevention and primary care necessary to maintain health, avoid disease, overcome acute illness, and live with chronic illness. These services encompass the complete continuum of evidence-based cancer care for treatment and support needs, including clinical trials. Coverage should be comprehensive and protect the individual from incurring catastrophic expenditures.

Cancer and the "Underinsured"

So what does being underinsured really mean for a cancer patient with a mini-med health insurance policy?

Cancer is approximately 200 separate diseases, and not surprisingly, the costs of treatment can vary enormously. However, it is possible to provide examples of costs that illustrate the problem of underinsurance.

In 2009, ACS CAN commissioned a study by the Georgetown Health Policy Institute to examine the adequacy and transparency of coverage under the Blue Cross Blue Shield standard option plan offered through the Federal Employees Health Benefit Program for four serious medical conditions: stage II breast cancer; stage III colon cancer; myocardial infarction (heart attack); and type I diabetes. It compared coverage features to simulated claims scenarios developed to illustrate potential care needs of patients with serious and chronic conditions, and estimated what patient out-of-pocket treatment costs would be under the plan.

In the scenario used in the study for the breast cancer case, the disease was detected following a routine screening mammogram. Approximately 30 percent of

breast cancers are diagnosed as stage II.[1] Standard treatment for this patient would include breast conserving surgery (lumpectomy), chemotherapy, Herceptin therapy, radiation therapy, and hormone therapy, as well as various medications and a wig prescribed for treatment side effects. The patient also receives short term counseling for depression. From start to finish, these treatments would take place over 87 weeks. Hormone therapy (taken orally) and other follow-up care and screening would continue beyond this time frame.

Under this scenario, estimated allowed charges (reflecting insurer negotiated discounts) for treatment billed by providers, institutions, and suppliers total approximately $111,300.

For the stage III colon cancer case, the male patient undergoes surgery to remove the affected part of his colon. He then undergoes 12 rounds of chemotherapy, involving a combination of drugs at two-week intervals. As often happens with colon cancers diagnosed at later stages, the cancer does come back and screening indicates it has spread to the liver.[2] The patient is hospitalized for a second surgery to remove the tumors, and then resumes chemotherapy. A series of subsequent treatments fail and active treatment then ceases. The patient is referred to hospice care and he dies 8 weeks later.

From diagnosis to date of death, care takes place over 124 weeks at an estimated cost of $252,433.

The two other scenarios in the study cover coronary artery disease and diabetes. Under the scenarios outlined in the study for the heart disease patient the estimated allowed charges (reflecting insurer negotiated discounts) for treatment billed by providers, institutions, and suppliers total about $77,800. For the diabetes scenario, the patient has well-controlled diabetes. For a patient with this type of diabetes self-management needs, the charge for any single item or service is relatively modest, but ongoing. For example, test strips cost approximately $1 each, but the patient would use about 1,400 strips per year. Under this scenario, allowed charges (reflecting insurer negotiated discounts) for treatment billed by providers, labs, and pharmacies total over $7,100 for one year.

So what does this mean for a patient with a mini-med policy that has a $2,000 or $10,000 annual limit? Recognizing that these expenses will likely occur over 2 years, a person with the stage II breast cancer who received the full course of treatment could face over $90,000 in out-of-pocket expenses, and the colon cancer patient could face $220,000 in out-of-pocket expenses. Obviously, such expenses are not financially viable for middle-income families.

The problem of paying costly medical bills affects middle-class families, particularly those with chronic diseases such as cancer. Often insurance policy deductibles, co-payments and limits on health services may leave cancer patients without access to the timely, lifesaving treatment they need. Cancer patients may have to deal with major financial burdens because of out-of-pocket costs in addition to their cancer diagnosis.

Earlier this year, ACS CAN commissioned a nationwide poll among households with a cancer patient age 18 or older.[3] Among the findings:

- Half of families with someone under 65 with cancer (49 percent) say they have had difficulty affording health care costs, such as premiums, co-pays, and prescription drugs in the past 2 years.
- Nearly one-third of families with someone under 65 with cancer (30 percent) have had trouble paying for basic necessities or other bills, and 23 percent have been contacted by a collection agency. About one in five (21 percent) has used up all or most of their savings, and one in six (18 percent) has incurred thousands of dollars of medical debt.
- As a result of costs, one in three individuals under age 65 diagnosed with cancer (34 percent) has delayed needed health care in the past 12 months, such as putting off cancer-related tests or treatments, delaying cancer-related checkups, not filling a prescription, or cutting pills. Of those currently in active cancer treatment, one in three (33 percent) has put off some type of health care in the past due to costs.

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[1] Ali, Sohrab, "Female Breast Cancer Incidence, Stage at Diagnosis, Treatment, and Mortality in North Carolina," North Carolina Public Health studies, June 2006.

[2] Recent studies suggest that patients diagnosed with late-stage colon cancer have a 35.7 percent reoccurrence rate within 5 years. See "Intensive Surveillance Beneficial in Early-Stage Colon Cancer," Health Day News, June 30, 2009. Available at *http://www.clevelandclinicmeded.com/news/Article.aspx?AID=628515&setSpecialty=true*.

[3] Facing Cancer in the Health Care System. Lake Research Partners and Bellwether Research & Consulting, May, 2010. The sample size was 1,011.

- Four in ten families (42 percent) with insurance say their premiums and/or co-pays have increased in the past 12 months for the family member with a cancer diagnosis, and one in four (25 percent) says his or her deductible has gone up.
- One-third (34 percent) of those under age 65 said they had problems with insurance coverage of cancer treatment such as the plan not paying for care or less than expected, reaching the limit of what the plan would pay, or delaying or skipping treatment because of insurance issues.

A 2006 study analyzed data from the Medical Expenditures Panel Survey (MEPS).[4] The MEPS household survey, sponsored by the Agency for Health Care Research and Quality (AHRQ), collects information from the non-elderly, non-institutionalized U.S. population. The survey asked American families questions about health insurance coverage, health care utilization, and health care expenditures. In this study, the researchers defined "underinsured" as people with insurance spending 10 percent or more of their tax-adjusted family income on health care services, including insurance premiums. Nearly 1 in 3 (28.8 percent) cancer patients who are insured have an out-of-pocket health care burden that exceeds 10 percent of their family income. More than 1 in 9 cancer patients with insurance have out-of-pocket health care burdens exceeding 20 percent of their family income in health care expenditures. It is important to note that this definition of underinsured only measures those who actually spent more than 10 percent of their income on health services. There are undoubtedly many more people who didn't spend more than that for financial reasons but instead chose to curtail necessary services. Though uncounted, these people, too, are underinsured.

Cancer patients with inadequate coverage have higher medical costs and must deal with the additional stress of financial instability. A 2006 survey of cancer patients and their families found that one in five cancer patients with insurance uses all or most of their savings when dealing with the financial costs of cancer.[5] Medical debt is an important cause of bankruptcy filing in the U.S. Another study examined the causes of bankruptcy and found that 1.9–2.2 million Americans experienced bankruptcy related to medical problems in 2001.[6] Among those with illnesses that led to bankruptcy, their out-of-pocket costs average $11,854 and three-quarters had insurance at the time of their diagnosis. Among those interviewed with medical bankruptcy, 1 in 10 of the families had a cancer diagnosis.

Despite having insurance, many cancer patients and survivors experience major financial burdens. The situation of the underinsured is difficult to measure because wide variation exists among health insurance plans and people do not realize they are underinsured until they have a health crisis such as cancer. Furthermore, studies like the one I previously mentioned use a narrow definition to measure the number of underinsured. While we use these studies to talk about the underinsured, they do not illustrate the whole picture.

The Health Insurance Assistance Service

The Health Insurance Assistance Service (HIAS) is a service offered through the American Cancer Society's National Cancer Information Center (NCIC) in Austin, Texas. HIAS is a free resource that connects callers with health insurance specialists who work to address their needs. The health insurance specialists at NCIC handle inquiries about health insurance, coverage dynamics, and state programs—all specific to the caller's needs. To date HIAS has logged more than 30,000 calls from all 50 states and the District of Columbia. Unfortunately, HIAS is able to help relatively few people to actually find coverage because the current health insurance coverage is often unavailable to cancer patients due to pre-existing condition clauses and when available, is often unaffordable for middle-class Americans.

Many calls received by HIAS are from people recently diagnosed or in treatment for cancer. The primary problem for these people is affordability—the accumulation of co-pays and deductibles has reached a level that they can no longer afford. Few programs exist that alleviate the financial burdens of out-of-pocket costs or provide care when a patient reaches a benefit limit within their insurance policy. In addition, the Society receives calls from patients that have reached the limit of their benefits or need additional services that are not covered by their plan. Among the calls from insured cancer patients, nearly three-quarters (71 percent) stated their insurance was inadequate to meet their medical needs.

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[4] Banthin JS, Bernard DM. Changes in financial burdens for health care: National estimates for the population younger than 65 years, 1996 to 2003. *JAMA* 2006; 296: 2712–19.

[5] *USA Today*, the Kaiser Family Foundation, the Harvard School of Public Health. National survey of households affected by cancer, August 1–September 14, 2006.

[6] Himmelstein DB, Warren E, Thorne D, Woolhandler S. Illness and injury as contributors to bankruptcy. *Health Aff* 2005; Web exclusive: 63–73.

Within the HIAS data base, we are seeing callers who are reaching annual or lifetime limits on coverage. With the variation in insurance policies, there are many types of caps on coverage, including overall limits on benefits and limits on specific types of benefits such as outpatient visits.

The following are just two examples of patients we've heard from who are having to make the tough choice between saving their life or their lifesavings:

> Orlin is a 61-year-old Iowa man who was recently diagnosed with recurrent prostate cancer. His insurance plan through his job at an international security company has a $3,500 annual cap on benefits and a $250 annual maximum on prescriptions. Orlin quickly exceeded these limits and now pays out-of-pocket for his treatment. He and his wife have already amassed $25,000 in medical debt.
>
> Brian is a 25-year-old man from South Carolina who was recently diagnosed with testicular cancer. He is a full-time college student and works part-time at a big box retail store. The employer-sponsored benefit plan he has from his job has a $10,000 annual limit on benefits. While he has already exceeded that limit and now has to pay for his treatment out-of-pocket, he continues to pay the premiums, so he can keep his limited-benefit plan in the new year.

Underinsurance and the Affordable Care Act

The Affordable Care Act (ACA) makes tremendous strides toward eliminating the kinds of problems that arise from mini-meds and other plans that offer inadequate coverage. The law provides a framework for an essential benefits package; it eliminates lifetime limits and phases out annual limits by 2014; and most importantly for many of today's enrollees in mini-med plans, it offers subsidies to assist individuals and families below 400 percent of the federal poverty level, and there will be out-of-pocket limits in all plans, except those that are grandfathered. And finally, the ACA makes great strides in empowering consumers with information, such as enhancing consumer disclosures, rating plans in the exchanges, and standardizing administrative processes.

Last June, HHS issued an interim final regulation regarding annual limits. It set a minimum limit of $750,000 for plans years after September 23, 2010, and those limits will rise each year through 2013 until they reach $2 million. There is no annual limit in plans after 2014. The regulation also recognized that some plans which currently have much lower annual limits might not be able to comply without imposing significant premium increases or reductions in benefits. Thus, plans can request a waiver. In September, HHS issued guidance on waivers, and since then, it is our understanding that over 100 plans with approximately 1.2 million enrollees have been granted waivers as of November 1.

We recognize the dilemma that exists. Clearly, plans with limits as low as $1,000 are of little value to a person with cancer. Such plans provide the appearance of insurance, but they provide no protection against potential financial ruin. Nonetheless, no one wants to see massive disruptions in the market as we transition to the full insurance reforms in 2014, and therefore, waivers may be warranted for some plans.

A waiver, though, should come with some obligations on the part of the plans. Last month, HHS issued guidance requiring plans to notify enrollees of a waiver including an explanation of the reason for it and the protection that would otherwise have applied. This is a critical step toward consumer education and empowerment. We commend HHS for taking this step toward consumer education and transparency, and we strongly believe the administration should be even more expansive in increasing disclosures and insurer transparency in the coming months and years. However, we strongly believe that HHS must take steps to require plans with waivers to improve their products between now and 2014; a waiver this year should not be a free ride until then.

The mini-meds are a perfect example of why health care reform is so crucial. Adequate coverage at affordable prices is no longer attainable for many Americans. If we want all Americans to have meaningful access to quality health care, we need to change the insurance market rules, provide subsidies, streamline administrative processes and greatly increase transparency and accountability. The Affordable Care Act provides a solid framework for achieving these goals, and it is ACS CAN's intent to work with all interested parties to implement the law successfully so that the health system works for people with cancer and other serious medical conditions. We know we must find ways to work together with pragmatic intent to assure implementation helps improve health care for cancer patients and other groups.

The CHAIRMAN. Thank you very much.

Mr. Eugene Melville.

STATEMENT OF EUGENE MELVILLE, CANCER PATIENT, RIVERSIDE, CA

Mr. MELVILLE. Good afternoon, Chairman Rockefeller.

The CHAIRMAN. Where are you from?

Mr. MELVILLE. Pardon me?

The CHAIRMAN. Where are you from?

Mr. MELVILLE. I'm living in Riverside, California. I grew up in Boston, Massachusetts.

The CHAIRMAN. OK. But, you flew from California.

Mr. MELVILLE. Yes, I came in from California.

The CHAIRMAN. Thank you.

Mr. MELVILLE. Good afternoon, Chairman Rockefeller, Ranking Member Hutchison, and distinguished members of the Committee.

I would like to thank you for the opportunity to share my story with you. My name is Eugene Melville. I am from Riverside, California. And I was recently diagnosed with oral cancer.

I was asked to attend today's hearings to discuss the difficulties I am having with getting the treatment I need, because of the limitations of my current health insurance coverage. The American Cancer Society Cancer Action Network, ACS CAN, was able to make the Committee aware of my story because I called the American Cancer Society's Health Information Assistance Service for help with trying to get access to the medical services I need to fight this disease.

I'm hopeful that my story will demonstrate why the adequacy of health insurance coverage is so important. The last thing anyone wants to be told when they are diagnosed with cancer is that their health insurance provides inadequate coverage to fully address the treatment that they need. However, that's what has happened to me, and that's the reason why I traveled here today.

I have worked for a big-box retail chain for several years. I do not plan to identify my employer during this testimony today as I am not here to drag their name through the mud. The problem is that bad health insurance is offered in the marketplace.

The health insurance that I currently have is a policy my company offers to part-time employees through Aetna. When I purchased the insurance, my understanding at the time was that the policy had a $20,000 annual limit on benefits. I knew my policy had limitations. However, I thought the policy would at least provide some financial buffer if something catastrophic happened to me.

Well, I went to the doctor, for what I thought was an injury from a car accident in July of this year. However, during his examination, my doctor became concerned about a lump in my neck. The doctor referred me for diagnostic screening and a biopsy. The biopsy showed that I had cancer and I was referred to an oncologist. He recommended that I have laser surgery to remove a lesion on my tongue, and surgery on my swollen lymph nodes in my neck.

Five days before the surgery, the administrative staff at the hospital informed me that they had canceled all my appointments and procedures. They explained to me that my insurance company had told them I had reached the annual benefits maximum in my policy for the 2010 calendar year.

Of course, I was confused, devastated by the information they provided me. I knew I had a $20,000 annual cap on my policy, but I also knew that I had not been to the doctor for any medical care procedures that cost anywhere near $20,000. I thought I understood how the insurance policy worked. I paid bi-weekly premiums out of my paycheck, and it wasn't going to cover any of the treatments recommended.

I had just been diagnosed with cancer. I was trying to come to grips with this news, and no one ever wants to hear the dreaded words from their doctor, "You have cancer." I thought I was going to get surgery and start treatment but, instead, I was told that the hospital couldn't help me.

I immediately called the insurance company to find out why they told the hospital they would not cover my surgery. That's when I found out that, instead of a policy with a $20,000 annual limit for all services, the $20,000 limit was divided into benefit categories. My policy actually has a $2,000 annual limit on physician visits and outpatient treatments and a $20,000 annual limit on hospitalizations. Further, the hospitalization coverage does not cover payments for more than $2,000 in services for lab tests, surgical supplies, and medications. As I learned, cancer treatment, such as chemotherapy, and radiation, and surgery, are often done in doctors' offices or at an outpatient treatment center. So, my treatments would not be covered by my plan.

As an individual recently diagnosed with cancer, the $2,000 that my policy provides me annually for doctors' visits and outpatient treatment doesn't even begin to cover the costs of the lifesaving treatments that I need for my oral cancer.

Instead of receiving the treatments my doctor prescribed and beginning my recovery, I have spent the last few months struggling to piece together coverage to treat my cancer.

Recently, I was able to enroll in the Medically Indigent Services Program at Riverside County Regional Medical Center in Moreno Valley, California. Even though I finally have access to treatment, I do not feel that I am receiving the same treatment that I would if I had health insurance. Just last week, the doctors at the program informed me that they are now only planning to treat my cancer with chemotherapy and radiation, despite the earlier recommendations from my oncologist for a laser procedure and surgery.

It has now been months since my diagnosis, and I continue to experience significant discomfort on my tongue and neck due to the cancer.

The insurance I have has fallen far short of what I need to fight this chronic disease. I hope my testimony today will make a difference. I don't want anyone else to have to go through what I'm going through. I hope that you will continue to support the full implementation of the Affordable Care Act so employees like me can have access to comprehensive healthcare coverage that is transparent and presented to people in terms that they understand.

Thank you.

[The prepared statement of Mr. Melville follows:]

PREPARED STATEMENT OF EUGENE MELVILLE, CANCER PATIENT, RIVERSIDE, CA

Good afternoon, Chairman Rockefeller, Ranking Member Hutchison and distinguished members of the Committee. I would like to thank you for the opportunity to share my story with you. My name is Eugene Melville. I am from Riverside, California, and was recently diagnosed with oral cancer. I was asked to attend today's hearing to discuss the difficulties I am currently having with getting the treatment I need because of limitations of my current health insurance coverage. The American Cancer Society Cancer Action Network (ACS CAN) was able to make the Committee aware of my story because I called the American Cancer Society's Health Information Assistance Service for help with trying to get access to the medical services I need to fight this disease. I am hopeful that my story will demonstrate why the adequacy of health insurance coverage is so important. The last thing anyone wants to be told when they are diagnosed with cancer is that their health insurance provides inadequate coverage to fully address the treatment they need. However, that is what has happened to me—and is the reason I traveled here today to tell my story.

I have worked for a big-box retail chain for several years. I do not plan to identify my employer during my testimony today, as I am not here to drag their name through the mud. The problem is that bad health insurance is offered in the marketplace. The health insurance I currently have is a policy my company offers to part-time employees through Aetna. When I purchased the insurance, my understanding at the time was that the policy had a $20,000 annual limit on all benefits. I knew my policy had limitations. However, I thought the policy would at least provide some financial buffer if something catastrophic happened to me.

I went to the doctor for what I thought was an injury from a car accident in July of this year. However, during his examination, my doctor became concerned about a lump in my neck. The doctor referred me for diagnostic screening and a biopsy. The biopsy showed that it was cancer. My oncologist recommended that I have laser surgery to remove swollen lymph nodes in my neck, as well as a lesion on my tongue.

Five days before my scheduled surgery, the administrative staff at the hospital informed me that they had canceled my appointments and procedures. They explained to me that my insurance company had told them I had reached the annual benefits maximum on my policy for the 2010 calendar year. Of course I was confused and devastated by the information they provided me. I knew I had a $20,000 annual cap on my policy, but I also knew I had not been to the doctor for any medical care or procedures that cost anywhere near $20,000 this year. I didn't understand how the insurance policy I paid bi-weekly premiums for out of my paycheck wasn't going to cover any of the treatments recommended.

I had just been diagnosed with cancer, and was trying to come to grips with this news. No one ever wants to hear the dreaded words from their doctor—"You have cancer." I thought I was going to get surgery and start treatment, but instead I was told that the hospital couldn't help me.

I immediately called my insurance company to find out why they told the hospital they would not cover my surgery. That is when I found out that instead of what I thought was a policy with a $20,000 annual limit for all services, the $20,000 limit was divided into benefit categories. My policy actually has a $2,000 annual limit on physician visits and out-patient treatments, and an $18,000 annual limit on hospitalizations. Further, the hospitalization coverage does not cover payment for physicians or medications—only room and board. As I learned, cancer treatments such as chemotherapy, radiation and surgery are done in doctor's offices or at an out-patient treatment center so my treatments would not be covered by my plan.

As an individual recently diagnosed with cancer, the $2,000 that my policy provides me annually for doctor's visits and out-patient treatment doesn't even begin to cover the cost of the life-saving treatments I need for my oral cancer. Instead of receiving the treatments my doctor prescribed and beginning my recovery, I have spent the last few months struggling to piece together coverage to treat my cancer.

Recently, I was able to enroll in the Medically Indigent Services Program at Riverside County Regional Medical Center in Moreno Valley, California. Even though I finally have access to treatment, I do not feel that I am receiving the same treatment that I would have if I had health insurance. Just last week, the doctors at the program informed me that they are now only planning to treat my cancer with chemotherapy and radiation, despite the earlier recommendation from my oncologist for a laser procedure and surgery. It has now been months since my diagnosis and I continue to experience significant discomfort on my tongue and neck due to the cancer, and swollen lymph nodes in my neck.

The insurance that I have has fallen far short of what I need to fight a chronic disease such as cancer. I hope my testimony today will make a difference. I don't want anyone else to have to go through what I am going through. I hope that you will continue to support the full implementation of the Affordable Care Act so that employees like me can have access to comprehensive health care coverage that is transparent, and presented to people in terms that they understand.

The CHAIRMAN. Thank you, Mr. Melville, very much.

And now, Mr. Aaron Smith is Co-Founder—and I guess if you co-found, you get to be Executive Director, it's part of the deal—of a very impressive group called Young Invincibles——

Mr. SMITH. Chairman Rockefeller——

The CHAIRMAN.—a misleading name.

Mr. SMITH. Thank you.

STATEMENT OF AARON SMITH, CO-FOUNDER AND EXECUTIVE DIRECTOR, YOUNG INVINCIBLES

Mr. SMITH. Chairman Rockefeller, Ranking Member Hutchison, and other members of the Senate Commerce Committee, thank you for having me here today.

My name is Aaron Smith, and I am the Co-Founder and Executive Director of Young Invincibles. Young Invincibles is a nonprofit, nonpartisan organization that advocates on behalf of young adults, ages 18 to 34. Founded by a group of students and young workers during the healthcare reform debate, Young Invincibles sought to provide a voice for young adults in Washington on an issue that directly affects millions of young Americans.

We have continued that work since the passage of the Affordable Care Act. We recently submitted two amicus briefs in support of the law in federal district courts in Virginia and Florida. And this fall, we coordinated a national education campaign on the dependent coverage provision, a benefit that will allow over 2 million young adults to get covered on their parents' plan up to age 26.

The healthcare needs of young adults are rarely discussed, yet about 21 million young adults are currently uninsured—the largest group in the country. The term "young invincible" is based on the false idea that young adults do not want to buy insurance because they think they do not need it. In reality, young adults want insurance, but numerous factors act as barriers, such as low wages and jobs without benefits. The problem is compounded by an extremely high youth unemployment rate, now over 18 percent for 16- to 24-year-olds.

Mini-med plans disproportionately impact young adults, in part because we make up a large percentage of the restaurant, retail, and temporary staffing industries that use these plans. A look at Aetna mini-med data underscores the impact on young adults. Almost 40 percent of enrollees on Aetna mini-meds are under the age of 30.

Why are mini-meds a problem for young workers? After all, something is better than nothing, right? This is the argument that you will hear in support of mini-med plans. But, mini-med plans are a problem for young adults, as the following story, one of several we have received on the topic, makes clear.

A 24-year-old man lives in Michigan. He has autism. For the past few years, he was fortunate to have a job with a retail chain

store, making $8 an hour and working 20 to 30 hours per week. When he took the job, the young man was told about a health insurance option for employees that would cost only $100 a month. It was a significant part of his paycheck, but he and his parents knew that having insurance was important. They assumed it would cover his basic needs, so he signed up.

Unfortunately, last year the young man had a seizure as a result of his condition. He and his parents expected his insurance to cover him. They were wrong. His insurance plan did not cover the ambulance ride, the CAT scan, the emergency room visit, or the prescriptions to treat him, following his emergency. He did not have the money to pay for all of his care, so his family was forced to pay over $3,000 out-of-pocket for this one incident.

The young man and his mother now say that if they had known his insurance covered so little, then they would have at least tried to buy private insurance to protect themselves.

Fortunately, this young man was able to get back on his father's plan this year, due to the new provision allowing young adults to stay on their parents' insurance up to age 26. While he will still struggle with his condition for the rest of his life, at least he and his family can worry less about his medical needs being covered.

This story illustrates some key problems with mini-med plans. First, with benefit caps often as low as $5,000, young adults on mini-meds often face thousands of dollars in medical bills should they get sick or injured. And, despite the myths, young adults have significant medical needs. Nearly one in young ten adults have between $5,000 and $50,000 in medical bills each year. And young adults 19 to 29 go to the emergency room more than any other age group under the age of 75. One emergency room visit can easily cost thousands of dollars, and on a mini-med plan, many of these costs are paid out of pocket and, at times, can go uncompensated. It can even mean bankruptcy for a young adult making $8 an hour with no savings.

Second, mini-med plans are often deceptively advertised to young workers as full coverage, when, in fact, they are not comprehensive at all. For first-time health insurance consumers new to the system and the terminology, this can be particularly problematic. A recent survey of college students found that only 29 percent understood the meaning of a premium, and only 30 percent knew what a lifetime coverage limit meant. Insurance plans and their maze of deductibles, benefit caps, co-insurance, et cetera are complicated enough for even experienced consumers. For young people completely new to the insurance system, distinguishing types and quality of insurance is that much more difficult. As a result, they are even more susceptible to the economic allure of mini-meds and their apparent affordability.

Of course, primary and preventive care are good things in and of themselves. If employers want to offer workers and inexpensive preventive care package or discounted access to a clinic, we would welcome that. But, that is not what's happening here. Instead, many employers advertise these mini plans—mini-med plans—as real insurance, because it attracts workers who desperately want to be covered, when, in fact, these plans will not cover you when

you need it the most. Mini-med plans are simply not adequate coverage.

Young Invincibles will be paying close attention as insurers report more information on their mini-med plans. Our goal is to move as quickly and smoothly as possible toward full implementation in 2014, a time when young adults should have a variety of affordable quality options for insurance. By that point, mini-med plans should be a thing of the past. Yet, employers can, and should, help now to transition to a system where all Americans have a decent standard of coverage. It is in all of our best interests to bring young workers into the health insurance system to pay their fair share for affordable medical care that will keep them healthy, productive, and ready for the future. Surely, that is a goal we can all get behind.

Thank you.

[The prepared statement of Mr. Smith follows:]

PREPARED STATEMENT OF AARON SMITH, CO-FOUNDER AND EXECUTIVE DIRECTOR, YOUNG INVINCIBLES

Chairman Rockefeller, Ranking Member Hutchinson, and other members of the Senate Commerce Committee: thank you for having me here today. My name is Aaron Smith and I am the Co-Founder and Executive Director of Young Invincibles.

I. Young Invincibles

Young Invincibles is a non-profit, non-partisan organization that advocates on behalf of young adults, ages 18 to 34. Founded by a group of students and young professionals during the health care reform debate, Young Invincibles sought to provide a voice for young adults in a process that too-often excluded young people.

Our name, "Young Invincibles," comes from an insurance industry term illustrating a belief that so many young adults are uninsured because they perceive themselves as "invincible." Our research and our own experiences tell us that, in fact, the opposite is true. Young people want and need coverage but are confronted by a broken system filled with obstacles to quality, affordable insurance. As we got involved in the fight for health care reform, we added a slogan to our name: "because no one is invincible without health care."

During the health care reform debate, Young Invincibles joined in coalition with over twenty national youth-focused organizations, such as Rock the Vote and U.S. PIRG, with a combined membership of more than 1.5 million young adults. The coalition adopted a policy platform that sought to provide comprehensive, affordable coverage for young adults and to fix the broken system for all Americans. Those policies included staying on a parent's plan up to age 26, a key provision that has already begun to help young people and families, and could provide coverage for over 2 million young adults.

Young Invincibles chose to support the Patient Protection and Affordable Care Act ("ACA") because it would help provide coverage to the vast majority of uninsured young adults in the country, and provide both improved consumer protections and more affordable, better quality health for the millions who already have coverage.[1] The ACA provides insurance tax credits to individuals making up to 400 percent of FPL, thus making health care more affordable for millions of young Americans. Almost 9 million young adults ages 18 to 34 are limited-income, earning between 133 percent and 400 percent of FPL, and will qualify for tax credits.[2] The ACA also requires states to expand Medicaid coverage to all individuals making less than 133 percent of FPL, regardless of whether the individual has a child or a disability. Before the ACA, states generally only covered young adults with children. The expansion of Medicaid could cover nearly 7 million currently uninsured young adults.[3] Access to this coverage will allow young adults with chronic conditions to find treatment, give healthy young adults an option to maintain their health, and generally

[1] *See* YI Want Change, *Comprehensive Insurance: Not Insurance In Name Only: YIWC Analysis of Catastrophic Plan and Dependent Coverage*, (December 2009).

[2] U.S. Census. (2009–2010). *Current Population Survey: Annual Social and Economic Supplement*.

[3] *Id.*

provide a health care backstop for a generation that is struggling in a tough economic recession.

Young Invincibles has continued its work to give young adults a voice in the legislative, regulatory and legal process by informing lawmakers, courts and relevant organizations about the unique needs of young adults , and by organizing grassroots campaigns to educate our generation. We strive to give young adults all the information and tools they need to get covered, get care, and get involved. The focus of this work is formed through interaction with thousands of young adult members around the country and extensive research on young adults and the health care system.

This summer, Young Invincibles launched *Getting Covered*, a national campaign promoting the dependent coverage provision in ACA that took effect on September 23, 2010. YI worked with over 20 national organizations, ranging from AARP to Small Business Majority, to provide information to young adults and parents. We developed a website, GettingCovered.org, that acts as a central hub where young adults, parents and employers can get comprehensive information about how dependent coverage works, personalized information about their coverage options and the capacity to easily share coverage information with family and friends. The site includes an "Employer Answer Center" to respond to questions from small businesses and local Chambers of Commerce. To spread the word about the dependent coverage provision, Young Invincibles co-hosted a webcast tele-town hall with AARP in California that drew over 11,500 participants. To mark the occasion of the provision taking effect in law on September 23, we helped coordinate more than 80 events in 25 states around the country.

Young Invincibles has also weighed in on the debate over health care reform now taking place in our federal courts. We submitted amicus briefs in the cases currently underway in the Eastern District of Virginia and the Northern District of Florida, offering a policy argument on behalf of our generation in defense of the law's constitutionality. Additionally, Young Invincibles is an active participant in the ongoing process of implementation. We have submitted comments about dependent coverage and the insurance exchanges to Health and Human Services (HHS). At the state level, we have been asked to sit on the New York State Health Care Reform Advisory Committee. And we are hard at work developing a state implementation "blueprint" that will help all states implement reform in a way that best meets the needs of young adults.

II. The Challenges of Young Adults in the Health Care System

About 21 million young adults are currently uninsured, the largest age group of uninsured in the country. Young adults make up 26 percent of the population under the age of 65, but account for 42 percent of the uninsured in that demographic.[4] Millions more remain underinsured, enrolling in barebones coverage that leaves them without access to everyday care.[5] The high rate of uninsured young adults does not reflect a free choice by young Americans to go without insurance, but rather the lack of affordable, worthwhile coverage options. Polling shows that majority of young Americans favor the ACA, in part because of the pervasiveness of coverage barriers for our generation and the possibility of new insurance options.[6]

A. The Myth of the Young Invincible

The term "young invincible" is based on the false premise that young adults simply do not want to buy insurance coverage because they think that they do not need it. The reality is much more complicated. Numerous factors act as barriers to coverage for young adults, from low-incomes to the scarcity of entry-level jobs with benefits. In fact, evidence shows that young adults want and need health insurance and will buy it readily when given the opportunity.[7]

A major reason behind the high uninsurance rate for young adults is that they more often lack access to employer-sponsored health insurance, which is the source

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[4] *Id.*

[5] Families USA, *Barebones Insurance Would Do Little to Help Uninsured Working Families*, May 4, 1999, available at *http://www.familiesusa.org/resources/newsroom/statements/1999-statements/press-statementbarebones-insurance-would-do-little-to-help-uninsured-working-families.html*.

[6] *Gallup*, June 22, 2010, available at *http://www.gallup.com/poll/140981/Verdict-Healthcare-Reform-BillDivided.aspx*.

[7] *See* Jennifer Nicholson, *et al.*, Commonwealth Fund, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help*, 2009 Update, 2009, at 6, available at *http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/Aug/1310_Nicholson_rite_of_passage_2009.pdf* ("Rite of Passage? 2009"); *see also* Gallup, *Income Trumps Health in Young Adults' Coverage*, February 26, 2010, available at *http://www.gallup.com/poll/126203/income-trumps-health-status-young-adults-coverage. aspx*.

of insurance for the vast majority of Americans. Only 53 percent of young adults ages 19 to 29 have access to employer-sponsored insurance, as compared to 76 percent of adults over 30.[8] The lack of employer-sponsored insurance is partly due to the staggeringly high unemployment rate for young adults. For 16 to 24 year-olds, the unemployment rate is currently about 18 percent, nearly twice the national average.[9] Another factor is that many young adults take low-paying entry-level jobs that do not offer benefits, particularly in the retail and restaurant industries. Finally, the current job market often requires young adults to seek internships and apprenticeships to gain experience and advancement, positions that rarely offer benefits.

For young adults who do not have access to employer-sponsored insurance, purchasing individual market insurance can be an option, but, given the cost, it is usually not tenable. The average young adult with no access to employer-sponsored insurance earns $14,746 per year.[10] The average annual cost of an individual plan offered to a relatively healthy 27-year-old is $1,723.[11] In other words, an individual insurance plan would be well over 10 percent of the young adult's income, a significant burden for a low-income individual already struggling to make ends meet.

Premiums for those young adults with a pre-existing medical condition are even higher.[12] The "offer rate" on the individual market for a young adult between 18 and 34 with a pre-existing condition (the frequency with which the consumer is offered coverage by an individual market insurer) is roughly equal to someone with a preexisting condition between the ages of 35 and 49.[13] But the 35 to 49 year-old is 15 percent more likely to have employer-sponsored coverage, meaning that young adults with pre-existing conditions have fewer options than their older counterparts.[14] Given the average wages of young adults without employer-sponsored coverage, these individuals, who need care, will be among the least able to afford it.

By contrast, studies show that when health insurance is made affordable and available, young adults eagerly enroll. When young adults between the ages of 19 to 29 are offered affordable health insurance through their employers, 78 percent enroll, compared to 84 percent of adults over age thirty.[15] These similar enrollment rates demonstrate that uninsurance among young adults reflects the lack of affordable options, not a cultural opposition to coverage.

Moreover, young adults with higher income levels are far more likely to have insurance. The uninsured rate is just 14 percent for young adults living over 400 percent of the federal poverty line ("FPL"), but rises to 46 percent for young adults making less than 200 percent of the FPL.[16] With about 37 percent of young adults living below 200 percent of the FPL, it is no surprise that young adults have the highest uninsurance rate of any age group.[17]

The simple facts show that when insurance is made available to young adults, either by providing it through employers or by providing an individual option within their economic means, they get covered. With ACA promising to cover millions more uninsured young Americans and improve options for the already insured, it is therefore not surprising that young adults are the age group most supportive of the health care reform law.[18]

III. Mini-Med Plans and Young Adults

Estimates of the number of enrollees in mini-meds vary, but insurers state that it could be over 2 million consumers. It is difficult to determine exactly how many of those enrollees are young adults, but a basic understanding of the industries using mini-meds make it clear that young adults are disproportionately impacted. Mini-meds are typical of the restaurant industry, and in particular fast food chains, as well as temporary staffing agencies. Young adults under 30 make up over half

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[8] Nicholson, *supra* note 7.

[9] Rory O'Sullivan and Barbara Ray, *Economy Hammers Already Vulnerable Young Adults*, Young Invincibles, 2010 available at *http://www.younginvincibles.org/News/Releases/2010 1105__Unemployment__Issue__Brief.pdf*.

[10] U.S. Census.

[11] AHIP Center for Policy Research, *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability and Benefits* (October 2009).

[12] *Id.*

[13] *Id.*

[14] *Id.*; U.S. Census, *supra* note 2.

[15] Nicholson, *supra* note 7.

[16] U.S. Census, *supra* note 2; *see also* Gallup, *Income Trumps Health in Young Adults' Coverage*, February 26, 2010, available at *http://www.gallup.com/poll/126203/income-trumps-health-status-young-adults-coverage.aspx*.

[17] U.S. Census, *supra* note 2.

[18] *Gallup*, June 22, 2010, available at *http://www.gallup.com/poll/140981/Verdict-Health care-ReformBill-Divided.aspx*.

of restaurant industry employees.[19] More broadly, young adults under age 35 make up 41 percent of the employment services industry, but only 35 percent of workers as a whole.[20]

A quick look at Aetna mini-med plans underscores this point. About 39 percent of enrollees on Aetna mini-meds are under age 30, though young adults under age 30 make up only about 25 percent of the labor market as a whole.[21] While mini-meds do affect Americans of all ages, the impact is particularly great for young workers.

A. A Young Adult on a Mini-Med Plan

Young Invincibles often receives stories from young adults and families around the country who have had troubles with the current health care system, including with mini-med plans. Here is one (names removed at request of the person):

A 24-year-old young man lives in Michigan. He has autism. For the past few years, he was fortunate to have a job with a big-box retail chain store making $8/hr and working 20–30 hours per week. When he took the job, the young man was told about a inexpensive health insurance option for employees that would cost only $100/month. It was a significant part of his paycheck but he and his parents thought having insurance was worth it. The coverage was advertised as normal health insurance so the young man assumed it would cover his basic needs. He signed up for the option, and had the $100 taken out of his paycheck each month. Unfortunately, last year the young man had a seizure as a result of his condition. He and his parents expected his insurance to cover his condition. They were wrong. His insurance plan did not cover the ambulance ride, the CT scan, an EEG and other tests, the emergency room visit or the prescriptions to treat the young man following his emergency. He did not have the money to pay for all his care so his family was forced to pay over $3,000 out-of-pocket for this one incident, despite the fact that he was supposed to have coverage. The young man and his mother feel that if they had known that his insurance covered so little, then they would have at least tried to buy private insurance to protect themselves.

Fortunately, the young man was able to go back on his father's plan this year due to the provision in the Affordable Care Act that allows young adults to stay on their parent's insurance up to age 26. While he will still struggle with his condition, at least he and his family can worry a little bit less about his insurance.

A. The Problem with Mini-Med Plans for Young Adults

The current recession has exacerbated long-term labor market trends impacting young adults. Over the past 30 years, jobs for young adults have become more unstable, and wages have stagnated. The types of jobs and benefits available to young adults have also changed. Many entry-level positions, the kind available to most young adults after high school or college do not provide comprehensive insurance coverage. This type of low-wage, low-benefit labor market in part has led to the rise of mini-meds, which are advertised by insurance companies as an inexpensive way to retain and attract low-wage employees. In many of these plans, the employer provides no contribution, as they typically do for more comprehensive employer-based insurance. Employees can only afford mini-med plans because the coverage is so minimal, with benefit caps often below $10,000.[22] As a result, workers who get sick or injured and truly need insurance may end up paying thousands of dollars out-of-pocket.

The problems associated with mini-meds, however, are compounded when marketed to consumers who are less experienced and less knowledgeable about health insurance and the health care system overall. Most young adults are completely new to insurance, and the choice of a mini-med plan may be their first insurance decision. Many struggle to understand the common industry terms used in mini-med promotional materials. For example, a recent survey of college students done by *eHealthInsurance.com,* one of the largest online brokers, found that less than half of young adults surveyed could confidently define basic health insurance terminology, only 29 percent understood the meaning of a "premium," and only 30 per-

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[19] Restaurant Industry, Small Business and Technology Development Center, 2005, available at *http://www.sbtdc.org/pdf/restaurant.pdf.*

[20] Career Guide to Industries, 2010–11 Edition, Bureau of Labor Statistics, available at *http://www.bls.gov/oco/cg/cgs039.htm.*

[21] Background Of Aetna Affordable Health Choices*Limited Benefit Plans, *Loss Of Health Coverage For Persons In Employer-Sponsored Group Limited Benefit Plans*, May 3, 2010; U.S. Census.

[22] Background Of Aetna Affordable Health Choices® Limited Benefit Plans, *Loss Of Health Coverage For Persons In Employer-Sponsored Group Limited Benefit Plans*, May 3, 2010; U.S. Census.

cent knew what a "life-time coverage limit" meant.[23] The problems are certainly not limited to college students. A recent survey of insured adults found that 52 percent thought that reading Shakespeare was easier than reading their health insurance policy.[24]

Yet, the fine print on mini-med insurance policies is particularly confusing. For example, a mini-med plan will often have a totally different benefit cap for annual expenses, inpatient services, outpatient services, emergency room visits, and preventive care.[25] With so many different benefit caps, it becomes increasingly difficult for even the most experienced consumer to judge how much coverage they are actually receiving, let alone a young adult who is new to the market. Even professionals in the health insurance industry acknowledge that these plans can be extremely confusing for workers.[26]

In sum, young adults are disproportionately likely to be on mini-med plans, but disproportionately likely to be less informed about how insurance operates or how mini-meds actually work. That makes young adults more susceptible to insurance plans that are sold as "real" coverage but are actually far from comprehensive.

It should not shock anyone that a $1,000, $5,000 or $50,000 cap on coverage does not provide adequate coverage to young adults. A biking accident, a kidney stone or a pregnancy all cost more than the $2,000 annual benefit cap in the basic McDonald's mini-med plan. While young adults are comparatively healthy, they still incur significant health costs each year. Approximately 8.6 percent of young adults between the ages of 18 and 30 had medical claims between $5,000 and $50,000 in 2010, or about 4.6 million young adults. In contrast, only .15 percent of that age cohort had annual costs between $50,000 and $100,000.[27] This data shows first that the current benefit caps found in many mini-med plans are not sufficient to meet the health needs of young people who can easily have thousands of dollars in medical costs. Second, the data suggests that the hundred thousand dollar accidents and illnesses that drive up premiums and spur employers to avoid more comprehensive coverage is not typical of this population and therefore is less of a financial risk for insurers. This is also in line with what we have found in other types of limited benefit plans offered to young adults, where raising or eliminating benefit caps has a relatively small impact on premiums. In other words, providing comprehensive insurance that covers the health needs of young workers is both necessary and affordable.

This niche of the health insurance market has exploded in large part because young adults—and low and moderate income adults—want some form of coverage. Many young adults understand that it is their responsibility to themselves and to society as a whole to get covered. The danger of mini-med plans is that they take advantage of consumers who want to do the right thing, but may not have enough knowledge or experience to know that the coverage they are getting can be, in practice, barely more than no coverage at all.

B. The Impact of Not Having Decent Insurance

Having a mini-med plan or any substandard insurance policy can have negative health and financial consequences for young adults. Young adults do suffer from chronic illnesses, catastrophic accidents and more unpredictable health crises: they are not invincible. They also need preventive care. And given their lower incomes, young adults often face serious financial troubles when forced to pay out-of-pocket for health expenses. In short, a lack of quality, affordable insurance has long-lasting consequences to the health and economic opportunity of young adults.

a. The Need for Care

Young adults need medical care to treat chronic conditions, care for sudden accidents or illnesses, and provide critical preventive services. Approximately 15 percent

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[23] eHealth, *eHealthInsurance 2010 College Graduates Survey: No Work, No Health Insurance, No Clue*, Marketwire, May 19, 2010, available at *http://www.marketwire.com/press-release/eHealthInsurance-2010-College-Graduates-Survey-No-Work-No-Health-Insurance-No-Clue-NASDAQ-EHTH-1263012.htm*.

[24] Business Wire, Inc., *New Consumer Education Website Helps Simplify Health Benefits Decisions in Era of Health Care Reform*, Insurancenewsnet.com, Oct. 13, 2010, available at *http://insurancenewsnet.com/article.aspx?id=230225&type=newswires*.

[25] Background Of Aetna Affordable Health Choices® Limited Benefit Plans, *Loss Of Health Coverage For Persons In Employer-Sponsored Group Limited Benefit Plans*, May 3, 2010; U.S. Census.

[26] HR.BLR.com, *Can't Afford Insurance? Try a Mini-Med Plan*, May 9, 2007, available at *http://hr.blr.com/whitepapers/Benefits-Leave/Healthcare-Insurance/Cant-Afford-Insurance-Try-a-MiniMed-Plan/*.

[27] Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), available at *http://www.meps.ahrq.gov/mepsweb/*.

of young adults live with a chronic health condition such as asthma, diabetes, or cancer that requires ongoing care.[28] Another 9 percent grapple with depression or anxiety disorders.[29] These conditions worsen without treatment, resulting in higher health care costs later. Moreover, almost 16 percent of young adults, ages 18 to 24, and 21 percent of young adults, ages 25 to 34, have what is classified as a "pre-existing condition" and are often excluded from the individual market altogether.[30]

Preventive care is critical to protect the future health of both the healthy and chronically ill. While some mini-med plans may cover basic vaccines or primary care visits, they often do not cover the full range of preventive care that even young adults need, particularly if they have a chronic condition that needs ongoing care.

Additionally, young adults often experience accidents or unexpected illnesses. Rates of motor vehicle accidents, sexually transmitted diseases, and substance abuse are at their highest in young adulthood.[31] As a result of the higher accident rate, young adults ages 19 to 29 find themselves in the emergency room more than any other age group under the age of 75.[32] Even the healthiest young adult, then, is never more than an instant away from entering the health care market where they will need insurance to afford proper care. Unfortunately, the low benefit caps on mini-med plans mean that a trip to the emergency room can quickly equal thousands of dollars in out-of-pocket expenses for a young adult.

b. Medical Bankruptcies

Young adults generally find it more difficult to pay medical costs when they do access care. Of those uninsured young adults who sought medical attention, 60 percent reported difficulty paying for their treatment, compared to just 27 percent of insured young adults.[33] About two-thirds of young adults earn below 400 percent of the FPL, or approximately $43,320.[34] This limited-income population has little opportunity to buildup savings. As a result, when they do face a medical crisis, they often face medical bankruptcies at much higher rates than their older counterparts.[35] While data is limited as far as the number of mini-med enrollees who enter bankruptcy due to medical bills, we expect that given the low benefit caps in mini-med plans, young adults on these plans would be more susceptible to medical bankruptcy than young adults with comprehensive insurance.

IV. Conclusion

Despite the myths, young adults have serious health needs and require quality, affordable health insurance to pay for medical care. They are also a population that *wants* to enroll in the kind of comprehensive coverage that provides such care. Because of their relative lack of economic power and options and because they are typically less sophisticated consumers, young adults too often find themselves with substandard insurance products they do not understand. Mini-med plans are a prime example of this problem. The low benefit caps means that many—perhaps even most—young adults on these plans face significant financial risk should a medical emergency arise, defeating the whole purpose of insurance. Moreover, these plans are too often marketed in a deceptive way that gives less experienced consumers of health insurance the false impression that they have a decent level of coverage.

The reality for a young person on a mini-med plan who has to go to the emergency room or who has a more sustained health condition is that they do not have adequate coverage. Sadly, many of these young workers find themselves saddled with medical debt and simultaneously become a burden on their families and the rest of the health care system. Young adults need quality, affordable insurance to maintain good health and encourage earlier, more consistent treatment that is both more effective and better for the health insurance system overall.

Despite the obvious flaws in mini-med plans, it is an encouraging sign that employers see providing insurance as a valuable and necessary benefit for their em-

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[28] Nicholson, *supra* note 7.

[29] *Id.*

[30] Families USA, *Health Reform: Help for Americans with Preexisting Conditions*, at 3, available at *http://www.familiesusa.org/assets/pdfs/health-reform/preexisting-conditions.pdf*.

[31] Robert Fortuna and Brett Robbins, *Dependence on Emergency Contracts among Young Adults in the United States*, (2010), available at *http://resources.metapress.com/pdf-preview.axd?code=wv5 8867474626077&size=largest*.

[32] M. Jane Park, *et al., The Health Status of Young Adults in the United States*, Journal of Adolescent Health, 39, (2006), available at *http://download.journals.elsevierhealth.com/pdfs/journals/*.

[33] *Id.*

[34] U.S. Census.

[35] Michelle Doty, *et al.,* Commonwealth Fund, *Seeing Red: Americans Driven Into Debt By Medical Bills*, August 2005 Issue Brief (2005), at 2, available at *http://www.commonwealthfund.org/usr__doc/837__Doty__seeing__red__medical__debt.pdf*.

ployees. Young Invincibles would gladly work with employers transitioning from mini-med plans to more quality, affordable health insurance. The profits made by insurance companies on mini-med plans suggest that a transition toward better value is both realistic and desirable. Such a move will not only be welcomed by workers, young and old, but could have positive effects on productivity and worker satisfaction. Thankfully, young adults will have many more options in 2014 with the full implementation of ACA, with millions likely to get affordable, comprehensive insurance through subsidies in the exchange or Medicaid. That is a very good thing. Mini-med plans by that point should be a thing of the past. Yet, employers can help now to transition to a system where all Americans have a decent standard of coverage. Bringing young workers into the health insurance system, to pay their fair share for affordable medical care that will keep them healthy and ready for the future, should be a goal that we can all get behind.

The CHAIRMAN. Thank you very much, Aaron Smith.

And now, Mr. Richard Floersch, who is the Executive Vice President and Chief Human Resources Officer of the McDonald's Corporation.

We welcome you.

STATEMENT OF RICH FLOERSCH, EXECUTIVE VICE PRESIDENT FOR HUMAN RESOURCES, MCDONALD'S CORPORATION

Mr. FLOERSCH. Thank you.

Chairman Rockefeller and members of the Committee, I am Rich Floersch, Executive Vice President for Human Resources at McDonald's Corporation.

More than 3,100 independent small business owners, or franchisees, own and operate nearly 12,500 McDonald's restaurants throughout the United States. McDonald's USA owns and operates approximately 1,500 additional restaurants.

For many of our employees, McDonald's is their first job. Our goal is to provide those employees with competitive compensation and benefits. Health insurance is, of course, but one of a suite of benefits, such as dental, vision, and retirement savings, provided to our employees. We have sought to match the health insurance options we make available to the needs, desires, and capabilities of our employees.

To understand the options we provide to our employees, it is important to understand a little bit about our employees. At restaurants owned by the company, over three-quarters of our crew employees work part-time, averaging slightly less than 18 hours per week. There is considerable turnover, and the tenure of crew employees tends to be rather short, lasting about 17 months. Most often, by 18 months the employee has either left McDonald's, perhaps to return to school, or been promoted to a more senior position.

At McDonald's, we are proud of our long tradition of promoting from within. Today, 70 percent of our restaurant managers, 50 percent of our corporate staff, and, indeed, 40 percent of our top 50 executives are remarkable individuals who started their career in an entry-level position at a McDonald's restaurant.

For the crew at company-owned restaurants, nearly 80 percent of which are hourly part-time employees, we offer four choices for health insurance. Three are low-cost limited-benefit plans and one is a higher-cost comprehensive medical option. The comprehensive plan provides significantly higher benefit levels, but, naturally, at

a higher premium. If the employee elects any one of these plans, McDonald's contributes $10 a month during their first year of employment, and $20 a month thereafter, until such time as the individual is promoted to a longer-term, full-time position with eligibility for our core benefit plans.

The three limited-benefit plans have different annual benefit limits—$2,000, $5,000, or $10,000—and correspondingly higher premiums. McDonald's works hard to make sure that its employees understand the coverage limitations, as well as the benefits provided by these plans. All of the documentation provided to employees details the limited nature of the coverage.

Whether or not an employee has reached their annual insurer-paid benefit limit—and very few do—they continue to benefit from their participation in the plans. They receive significantly reduced prices for prescription drugs and healthcare services through negotiated discounts.

Given the high and continually increasing cost of healthcare, those annual insurer-paid benefit limits may appear low. Yet, it is important to note that, even though the lowest annual benefit plan is overwhelmingly the most popular choice amongst our hourly employees, approximately 90 percent of covered employees do not reach the annual limit for these benefits.

Although we do not have the ability to direct franchisees on the wages and benefits they provide to their employees, we did insist that our insurance carrier make available the same plans to our franchisees. We are pleased that, over the past 5 years, participation in these health plans has increased over threefold, and now nearly 80 percent of franchisees offer these plans.

For those employees who are making McDonald's a career, including all restaurant managers, assistant managers, certified swing managers, primary maintenance employees, and corporate staff, we offer several comprehensive plans. These plans are designed so that higher-compensated employees are required to pay significantly more in premiums than lower-compensated employees.

With respect to our limited-benefit plans, based on numbers provided by our carrier, the loss ratio for these plans apparently has ranged from a low of 78 percent to a high of 91 percent over the past 5 years, with the most recent year being 86 percent.

In closing, earlier this fall, the Department of Health and Human Services granted over 100 temporary waivers from certain statutory benefit targets. Those waivers specifically exempted plans made available to employees by many businesses and unions. At the time, there were press reports that speculated on what McDonald's would do if our current health insurance carriers stopped offering limited-benefit plans. The removal of these options only weeks before our next open enrollment period would have been highly disruptive to the company and our employees. We would have been forced to go back into the insurance marketplace and obtain the best available affordable options to offer our employees. We feared those options would not measure up to those we currently offer. But, we would have taken action to make sure that our employees were provided the best health insurance options available.

At McDonald's, we are proud of the benefits that we offer to our employees. We cannot control the rising cost of healthcare. We cannot dictate what insurance products health insurers are willing to offer. But, what we can do, and what we are committed to continue doing, is to strive to make available to our employees, and those of our participating franchisees, benefit options that fit their needs.

Thank you.

[The prepared statement of Mr. Floersch follows:]

PREPARED STATEMENT OF RICH FLOERSCH, EXECUTIVE VICE PRESIDENT FOR HUMAN RESOURCES, MCDONALD'S CORPORATION

Chairman Rockefeller and members of the Committee, I am Rich Floersch, the Executive Vice President for Human Resources of McDonald's Corporation. My team's responsibilities include determining the various benefit programs that are available to the employees of McDonald's and, in some cases, the employees of the thousands of small businesses that own and operate the nearly 12,500 franchised McDonald's restaurants around the nation.

I am here today to continue the informative discussion we have been having with various policymakers concerning the health insurance challenges facing organizations such as McDonald's and our employees as well as our franchisees and their employees, given the ever increasing cost of health care in America.

Let me start by describing our organizational structure. McDonald's and its franchisees operate approximately 14,000 restaurants in the United States. Nearly 12,500 of those restaurants are owned and operated by more than 3,100 independent small business owners—franchisees—throughout the United States. McDonald's USA owns and operates approximately 1,500 restaurants in the United States. Individuals working at those McDonald's-owned stores, along with those of us who work for the corporation, are employees of McDonald's. Our franchisees, and the people who work in the nearly 12,500 franchise-owned restaurants, are employees of these individual small businesses.

For many of our employees, McDonald's is their first job. Our goal is to provide those employees with competitive compensation and benefits. Health insurance is, of course, but one of a suite of benefits, such as dental, vision and retirement savings, provided to our employees. We have sought to match the health insurance options we make available to the needs, desires, and capabilities of our employees. Indeed, to understand the options we provide to our employees, it is important to understand a little bit about our employees.

At restaurants owned by the company, over three-quarters of our crew employees work part-time, averaging slightly less than 18 hours per week. There is considerable turnover and the tenure of crew employees tends to be rather short—lasting about 17 months. Most often by 18 months the employee has either left McDonald's, perhaps to return to school or take another job, or been promoted to a more senior position. At McDonald's we are proud of our long tradition of promoting from within. Many employees who started out as members of a restaurant crew have moved on to supervisory or management positions. Today 70 percent of restaurant managers, 50 percent of corporate staff and indeed, 40 percent of our top 50 executives are remarkable individuals who started their career in an entry-level position at a McDonald's restaurant.

We have worked hard to find affordable health insurance plans that meet the needs of our restaurant employees. We utilized the services of noted experts in this field. We believe that we have achieved the best result that the marketplace allows. When we surveyed our crew employees about their health care needs, they told us: 16 percent would not pay for any health insurance; 18 percent were covered under another plan; 35 percent would be willing to pay $5–$10 per week for health insurance; 20 percent would pay $11–$20 per week while 7 percent said they would pay $21–$35. Only 3 percent of our crew indicated they would pay more than $35 per week for health insurance.

For the crew at company-owned restaurants, nearly 80 percent of which are hourly part-time employees, we offer four choices for health insurance. Three are low cost limited benefit plans and one is a higher cost comprehensive medical option. The comprehensive plan provides significantly higher benefit levels, but naturally at a higher premium. If the employee elects any one of these plans, McDonald's contributes $10 a month during their first year of employment and $20 per month thereafter until such time as the individual is promoted to a longer term, full-time position with eligibility for our core benefit plans.

The three limited benefit plans have different annual benefit limits—$2,000, $5,000 or $10,000—and correspondingly higher premiums. McDonald's works hard to make sure that its employees understand the coverage limitations as well as the benefits provided by these plans. All of the documentation provided to employees details the limited nature of the coverage.

Whether or not an employee has reached their annual insurer paid benefit limit, and very few do, they continue to benefit from their participation in the plans. They receive significantly reduced prices for prescription drugs and health care services through negotiated discounts with providers, as well as access to a 24/7 nurse care phone line.

Given the high, and continually increasing, cost of health care, those annual insurer paid benefit limits may appear low. Yet it is important to note that, even though the lowest annual benefit plan is overwhelmingly the most popular choice amongst our hourly employees, approximately 90 percent of covered employees do *not* reach the annual limit for these benefits. And again, even for those employees who reach the benefit limit of the plan they chose, they continue to receive the additional benefit of the substantial negotiated discounts on health care services and prescriptions.

Although we do not have the ability to direct franchisees on the wages and benefits they provide to their employees, we did insist that our insurance carrier make available the same plans to our franchisees. We have actively and successfully promoted participation at the franchisee level, indeed, over the past 5 years, participation in these health plans has increased over threefold and now nearly 80 percent of franchisees offer these plans.

For those employees who are making McDonald's a career, including all restaurant managers, assistant managers, certified swing managers, primary maintenance employees and corporate staff, we offer several comprehensive plans. These plans are designed so that higher compensated employees are required to pay significantly more in premiums than lower compensated employees.

I know that some criticize limited benefit plans not only for their limits but also with respect to the ratio of benefits paid out compared to premiums received. These are largely questions for insurance carriers and were the subject of the regulations recently issued by HHS—but I would offer the following observation regarding our experience. Based on numbers provided by our carrier, the loss ratio for the limited benefit plans offered to McDonald's hourly employees apparently has ranged from a low of 78 percent to a high of 91 percent over the past 5 years, with the most recent year being 86 percent, and would appear to be comparable to the goals established in the recent legislation.

Earlier this fall, the Department of Health and Human Services granted over 100 "temporary waivers" from certain statutory benefit targets. Those waivers specifically exempted plans made available to employees by many businesses and unions. At the time there were press reports that speculated on what McDonald's would do if our current health insurance carrier stopped offering limited benefit plans. The removal of these options only weeks before our next open enrollment period for employees would have been highly disruptive to the Company and our employees. We would have been forced to go back into the insurance marketplace and obtain the best available affordable options to offer our employees. We feared those options would not measure up to those we currently offer. But we would have taken action to make sure that our employees were provided the best health insurance options available.

At McDonald's we are proud of the benefits that we offer to our employees. We cannot control the rising cost of health care, we cannot dictate what insurance products health insurers are willing to offer—but what we can do, and what we are committed to continue doing, is to strive to make available to our employees, and those of our participating franchisees, benefit options that fit their needs. Thank you.

The CHAIRMAN. All right, thank you.

Mr. Timothy Jost, who is Professor of Law, Washington and Lee University School of Law.

Please.

STATEMENT OF TIMOTHY S. JOST, ROBERT WILLETT FAMILY PROFESSOR, WASHINGTON AND LEE UNIVERSITY SCHOOL OF LAW

Mr. JOST. Thank you, Senator.

Good afternoon, Senator Rockefeller, Senator Hutchison, and members of the Committee.

Once fully implemented in 2014, the Affordable Care Act will dramatically reduce the number of uninsured Americans. Equally important is the assistance that the legislation will provide to underinsured Americans. It is estimated that 25 million Americans under the age of 65, 20 percent of all insured American adults, are underinsured. Over half of them report problems gaining access to care. Sixty-two percent of bankruptcies in 2007 had a medical cause, and almost 70 percent of those bankrupts were insured. $2.6 billion of their debt was owed to healthcare providers, which is only a small part of the $43 billion that healthcare providers lose every year because of uncompensated care. Underinsurance is a serious problem for American consumers and for American healthcare providers.

Between 1 and 2 million Americans have limited-benefit, or mini-med, policies. These persons are often not fully aware of how inadequate their coverage is. Two-hundred and fifty dollars a day, for example, for hospital care, which is a reported benefit for one such policy, does not cover 10 percent of the average cost of hospitalization per day in the United States.

Once the Affordable Care Act, which, I'd like to mention, was held constitutional again yesterday in a federal court—since I'm a law professor—once it is fully implemented, underinsurance will be largely eliminated. All health plans in the individual and small group markets will be required to cover federally-defined essential benefits, and caps will be placed on out-of-pocket healthcare costs for all plans. Annual dollar limits on essential health coverage will disappear. Most importantly, premium tax credits and Medicaid expansions will make it possible for Americans with poorly paid jobs to get access to real comprehensive insurance. And many Americans currently insured through mini-meds will probably be eligible for Medicaid, once the Medicaid expansions go into place.

In the interim, however, significant protections are being put in place for plan years beginning September 23, 2010. Lifetime limits on coverage are banned, and annual coverage limits go to $750,000 for 2011, and disappear by 2014.

Beginning next year, insurers in the individual and small group market will also need to spend 80 percent of their premium revenues on healthcare or quality improvement. Beginning in 2012, all health plans will need to disclose their plan benefits and limitations on coverage in a standard, easily readable format. Limited-benefit plans will no longer be able the hide the limits of their benefits.

Unfortunately, two of the most important September 23 reforms will not be applied immediately to limited-benefit plans, as has been mentioned several times today. HHS has waived the annual limits requirements for 1 year for plans covering 1.175 million Americans. HHS has also announced that health plans with annual limits of $250,000 or less will be allowed to lower their minimum medical loss ratios from 80 percent to 40 percent.

I'd like to point out that both of these waivers are in compliance with the law. Section 2711 authorizes HHS to waive the annual limit requirement. Section 2718 allows it to adjust the minimum

medical loss ratio. So, HHS's actions here are legal. They're also understandable. Prior to 2014, there may be few affordable alternatives available that would benefit enrollees. And for some—I don't believe all—but, for some enrollees in mini-meds, they are better than nothing.

I'd like to also point out, at least, that I've heard from HHS that the benefits in the plans for which it has allowed waivers vary very significantly. The annual limits all under $750,000 a year, but limits in some of the plans are much higher than in other plans. And I understand that HHS is planning to post on its website the actual amount of the annual benefits of plans with waivers so that they can be seen.

The one requirement that HHS has imposed through its waiver guidance, which I think is very important, is a requirement of disclosure. Disclosure is very important, because, in some instances, the premiums for limited-benefit plans are not significantly different than those for comprehensive plans, including higher-deductible plans. Alternative coverage may also be available to some people who are on mini-meds through a high-risk pool or through a state Medicaid program or a CHIP program for their children. Moreover, enrollees who receive limited-benefit plans through their employers may be able to demand better coverage, or find an employer that offers better coverage, if they fully understand how limited their benefits are. There's no requirement, which I think is unfortunate, in the HHS medical loss ratio rule that mini-meds give notice to their enrollees of their lower target, but there should be, for the same reason.

Limited-benefit plans leave Americans exposed to far too great a level of financial and health risk. Until they disappear, it is essential that these plans fully comply with the requirements of the law, and that consumers be fully informed of any waivers or adjustments granted to their plans, and also that consumers truly understand how limited their coverage is.

Thank you.

[The prepared statement of Mr. Jost follows:]

PREPARED STATEMENT OF TIMOTHY S. JOST, ROBERT WILLETT FAMILY PROFESSOR, WASHINGTON AND LEE UNIVERSITY SCHOOL OF LAW

My name is Timothy Stoltzfus Jost. I hold the Robert Willett Family Professorship at the Washington and Lee University School of Law. I have taught and written about health law, and in particular health insurance law, for thirty years. I am a consumer representative to the National Association of Insurance Commissioners and have been heavily involved in the implementation of the Affordable Care Act. Thank you for the opportunity to speak to you today about limited-benefit health insurance policies, also known as mini-medical plans.

Much has been made of the impact that the Affordable Care Act will have on the uninsured once it is fully implemented, and rightly so. The CBO estimates that the Affordable Care Act will reduce the number of uninsured Americans by 32 million.

But equally important is the assistance that that the legislation will provide to the underinsured. It is estimated that 25 million insured adults under age 65, 20 percent insured American adults, were underinsured in 2007.[1] Seventy-one percent of Americans who are among the top 25 percent of spenders on health care services

[1] Persons are underinsured if they must spend at least 10 percent of their income for out-of-pocket medical expenses, or at least 5 percent if their income is below 200 percent of the federal poverty level, or if their deductibles equal or exceed 5 percent of their income. Cathy Schoen, *et al.,* How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007, Health Affairs, June 10, 2008, w298 to w309, w300.

and whose income is at or below 200 percent of poverty were underinsured.[2] Over half of underinsured Americans report problems gaining access to care, including over 40 percent who report not filling a prescription and 30 percent who report skipping a test or treatment or not following up on a recommendation from a doctor because of the cost the care.[3] Forty-five percent of underinsured Americans report problems with medical bills.[4] Sixty-two percent of bankruptcies in 2007 had a medical cause, but almost 70 percent of those bankrupt were insured at the time of the bankruptcy.[5] Obviously, their insurance was not adequate to provide financial security. $2.6 billion of the debt involved in those bankruptcy proceedings was owed directly to health care providers, which in all likelihood lost billions more to unpaid bills owed by underinsured Americans who did not go bankrupt.[6]

Many of the underinsured have health insurance coverage with high cost sharing obligations, including high deductibles. But over a million of the underinsured have limited benefit, or mini-med, policies. High cost sharing policies expose lower-income Americans to immediate, sometimes unsustainable, costs when they seek medical care. Limited benefit policies, on the other hand, are more insidious, as the persons whom they cover often are not fully aware of how inadequate their coverage is compared to the medical costs they are likely to incur. An individual whose coverage excludes the first day of a hospital stay may not realize that most, often virtually all, of the costs of a hospital stay may be incurred during the first day, when a surgery is most likely to occur. A family whose policy limits coverage to $250 a day for hospital care may not realize that this would not cover 10 percent of the average per diem cost of hospitalization in the United States.

When the Affordable Care Act is fully implemented in 2014, it should dramatically reduce the level of underinsurance in the United States. All health plans in the individual and small group market will be required to cover a federally defined essential benefits package and caps will be placed on deductibles for small group plans and for out-of-pocket costs for all health policies.[7] Employees who are offered plans at work with an actuarial value below 60 percent of covered benefits or who are required to pay more than 9.5 percent of their income for the employee share of insurance premiums will be eligible for federal premium tax credits, and their employers will have to pay a penalty.[8] Annual dollar limits on health coverage will disappear.[9] Most importantly, premium tax credits and Medicaid expansions will make it possible for Americans with low income jobs to get access to real comprehensive insurance coverage.[10]

In the interim, however, significant protections are being put in place for plan years beginning after September 23, 2010 to shield insured Americans from financial disaster. For most Americans, these requirements go into place on January 1, 2011 when their new plan year will begin. First, lifetime limits on coverage are banned, and annual coverage limits will go up immediately to $750,000, increase further for 2012 and 2013, and then disappear by 2014.[11] Few insured persons ever encounter lifetime limits, but persons who do are very sick people who face financial devastation and the possibility of losing life-sustaining treatment. Annual limits are a more common problem. The law will ensure that annual limits are high enough to provide insured Americans with real protection. Insurers will also be barred from imposing higher cost sharing on enrollees who have to go out-of-network to get emergency care.[12] The September 23 reforms also ensure that enrollees in non-grandfathered plans will have access to preventive services without cost sharing.[13]

Beginning next year, insurers in the individual and small group market will also need to spend 80 percent (and insurers in the large group market, 85 percent) of

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[2] Jon R. Gable, *et al.,* Trends in Underinsurance and the Affordability of Employer Coverage, 2004–2007, Health Affairs, June 2, 2009, W595–w606, w604.
[3] Schoen, *et al.,* at w304.
[4] Ibid.
[5] David Himmelstein, *et al.,* Medical Bankruptcy in the United States: Results of a National Study, The American Journal of Medicine, available at *http://www.pnhp.org/new__bankruptcy__study/Bankruptcy-2009.pdf.*
[6] Melissa Jacoby & Mirya Holman, Medical Providers as Lenders: A National Study (working paper).
[7] Pub. L. No. 111–148, § 1302(a)
[8] 26 U.S.C. § 4980H(b), added by Pub. L. No. 111–148, § 1513.
[9] 42 U.S.C. § 2711(a)(1)(B), added by Pub. L. No. 111–148, § 10101(a).
[10] Pub. L. No. 111–148, §§ 1401, 1402, 2001.
[11] 42 U.S.C. § 2711(a)(2), added by Pub. L. No. 111–148, § 10101(a); 45 C.F.R. § 147.126
[12] 42 U.S.C. § 2719A(b), added by Pub. L. No. 111–148, § 10101(h).
[13] 42 U.S.C. § 2713, added by Pub. L. No. 111–148, § 1001.

their premium revenue on health claims or expenses that improve quality of care.[14] Effective March, 2012, all health plans will need to disclose their plan benefits and limitations on coverage in a standard, easily-readable, format so that all enrollees will be able to clearly see the limits their coverage imposes.[15] Limited benefit plans will no longer be able to hide their limitations.

Unfortunately, two of the most important September 23 reforms will not be applied immediately to limited benefit plans. Exercising authority granted by the Affordable Care Act to "ensure that access to needed services is made available with a minimal impact on premiums,"[16] HHS has, to date, waived the annual limits requirement for 1 year for 111 plans covering 1.175 million Americans.[17] Under a Guidance issued September 3, 2010[18] and a Supplemental Guidance issued November 5, 2010, plans can apply for and be granted a waiver if full compliance with the annual limit requirement, "would result in a 'significant decrease in access to benefits' or a 'significant increase in premiums.'"

HHS also announced in its medical loss ratio rule, released on November 22, that limited benefit plans with annual limits of $250,000 or less will be allowed to double the amount that they spend on medical claims and quality improvement activities for calculating their medical loss ratios (effectively lowering the target percentage of their premium revenues that they must spend on medical care and quality improvement from 80 percent to 40 percent in the small group and individual market and to 42.5 percent in the large group market).[19] This dispensation will only apply for 2011, and during 2011 limited benefit insurers are required to submit quarterly reports of their experience so that HHS can determine if further adjustments will be permitted. HHS took this step under the authority it has under the medical loss ratio provision to take into account the special circumstances of "different types" of plans in establishing the medical loss ratio calculation methodology.[20]

It is unfortunate that enrollees in limited benefit plans will not get immediate relief from the highly restricted annual dollar limits imposed by those plans. On the other hand, prior to 2014 when tax credits become available, there may be few affordable alternatives available for limited benefit plan enrollees. An important protection in the November 5 HHS Guidance is a requirement that enrollees in a limited benefit plan receive a notice informing each participant or subscriber that the plan or policy does not meet the restricted annual limits for essential benefits set forth in the IFR because it has received a waiver of the requirement. The notice will be required to include the dollar amount of the annual limit along with a description of the plan benefits to which it applies, and will be required to be prominently displayed in clear, conspicuous 14-point bold type. In addition, the notice will be required to state that the waiver was granted for only 1 year. HHS will establish model notice language for issuers which will be posted at the HHS website.

Disclosure that a plan does not comply with the requirements of the Affordable Care Act is very important because in some instances the premiums for limited benefit plans are not significantly different from those charged for more comprehensive plans (including higher deductible plans). An enrollee in or applicant for a limited benefit plan may be able to find alternative coverage. Alternative coverage may also be available through a high-risk pool or state assistance plan. Moreover, enrollees who receive limited benefit plans through their employers may be able to request more comprehensive coverage or find an employer that offers better coverage if they understand how limited their coverage is.

The annual waiver Guidance does not state when this notice should be given. This question is addressed by a model law recently approved by the health insurance committee of the National Association of Insurance Commissioners.[21] HHS should

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[14] 42 U.S.C. § 2718, added by Pub. L. No. 111–148, § 10101(f).
[15] 42 U.S.C. § 2715, added by Pub. L. No. 111–148, § 1001.
[16] 42 U.S.C. § 2711(a)(2), added by Pub. L. No. 111–148, § 10101(a);
[17] *http://www.hhs.gov/ociio/regulations/approved_applications_for_waiver.html*.
[18] *http://www.hhs.gov/ociio/regulations/patient/ociio_2010-1_20100903_508.pdf*.
[19] See Interim Final Rule, Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act, §§ 158.120(d)(3), 158.221(b)(3). *http://www.ofr.gov/OFRUpload/OFRData/2010–29596_PI.pdf*.
[20] 42 U.S.C. § 2718(c), added by Pub. L. No. 111–148, § 10101(f).
[21] The National Association of Insurance Commissioners' Proposed Model Law for Lifetime and Annual Limits requires:

Sec. 4(C)(2)(a) At the time a health benefit plan receives a waiver from the U.S. Department of Health and Human Services, the health benefit plan shall notify prospective applicants and affected policyholders and the commissioner in each state where prospective applicants and any affected insured are known to reside.

require notice to be given at the time the waiver is granted and to prospective applicants and enrollees during any open or special enrollment period. Notice should also be given to the state insurance commissioner in the state where the waiver is granted and be posted on the *healthreform.gov* web portal if any limited benefit plan is identified on the web portal. Notice should also when a waiver expires.

The HHS medical loss ratio rule does not require that plans give a special notice to enrollees that the plan is excused from the rebate requirement. HHS should also require notice to be given of loss ratio waivers. Presumably only plans that receive the annual limits waiver will qualify for the medical loss ratio waiver, and the notice of the loss ratio waiver should be given at the same time that an annual limit waiver notice is given. HHS should also carefully consider the quarterly data submitted by limited benefit plans this year and only extend the medical loss ratio adjustment beyond 2011 if it becomes indisputably clear that an extension of the adjustment is necessary to assure continued availability of coverage. Even then, the required target should be raised to a level closer to the statutory requirement of 80 or 85 percent. While it may not be possible to eliminate limited benefit plans immediately, they should be required to operate as efficiently as possible.

Limited benefit plans leave Americans exposed to far too great a level of financial and health risk. They should disappear as soon as possible. As a practical matter, however, they may be the only coverage available to some Americans until the premium tax credit and Medicaid expansions take place in 2014. In the interim, it is essential that these plans comply with the requirements of the law to the maximum extent possible and that consumers be fully informed of any waivers or adjustments granted to these plans and of how limited their coverage under these plans truly is.

The CHAIRMAN. Thank you very much.

And finally, Dr. Devon Herrick, Ph.D., Senior Fellow, National Center for Policy Analysis.

STATEMENT OF DEVON M. HERRICK, PH.D., SENIOR FELLOW, NATIONAL CENTER FOR POLICY ANALYSIS

Dr. HERRICK. Mr. Chairman, Ranking Member Hutchison, and members of the Committee, I am Devon Herrick, Senior Fellow with the National Center for Policy Analysis. I welcome the opportunity to share my views and look forward to your questions.

Between one and two million Americans currently have a health plan that features limited benefits, sometimes called "mini-med plans." Mini-med plans are increasingly popular among low-income workers, seasonal and part-time employees, and firms too small to be able to afford generous health plans.

The typical design of a mini-med plan includes coverage for a select number of physician visits, ancillary tests, a limited number of inpatient hospital days, and prescription drugs. The deductibles and copayments tend to be pretty low. And the maximum amount of medical benefits that can be claimed in any given year is capped anywhere from a few thousand dollars, in some cases, to $25,000, maybe even $50,000, annually.

Mini-med plans are affordable. Premiums for single coverage can start out as low as $250 per year for single coverage, or for family coverage, in some cases, as low as $1,000 a year. But, one reason that mini-med plans are affordable is because of the amount of risk that the insurance company is underwriting is lower than for a comprehensive plan and is capped at a predetermined level. However, the Affordable Care Act, the new healthcare reform law, pre-

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(b) At the time the waiver expires or is otherwise no longer in effect, the health benefit plan shall notify affected policyholders and the commissioner in each state where any affected insured is known to reside.

Available at *http://www.naic.org/documents/committees_b_101122_materials.pdf*.

vents insurers from capping annual limits at less than $750,000 this year, and that phases out completely in 2014. By design, a limited-benefit plan cannot meet these requirements and remain affordable. Without waivers, mini-med plans would essentially be banned from the marketplace.

Another threat to the existence of mini-med plans is the medical loss ratio regulations requiring insurers to spend 80 percent of insurance premiums on medical care. The nature of mini-med plans is such that, with the marketing and the administrative cost of plans, especially in industries that have a higher worker turnover, it's hard to meet these regulations.

Public health advocates often deride mini-med plans as inadequate, but I believe this is misguided. In any given year, most people who are covered by health insurance experience very low claims. For example, per capita annual medical expenditure does not surpass $3,000 a year until you approach age 50, on average. About half the population spends less than $1,000 a year on medical care. In fact, about 80 percent of the population will have annual medical expenditures of less than $4,000 in a given year. High medical spending tends to be concentrated among older individuals.

Some critics of mini-med plans assume that mini-meds are really the result of stingy employers, but this is really not the case. Economists all agree that it's workers themselves who bear the cost of employee health coverage. Workers bear the cost through reduced wages. They bear the cost through indirect contributions. Health benefits are really just a form of noncash compensation that's part of the workers' total compensation package. If the minimum compensation required is higher than workers are able to produce, they will be priced out of the market for labor. Thus, to deprive workers of these low-cost limited-benefit plans also means that many workers will lose coverage. In the long run, many could lose their jobs. For example, by 2014, we estimate, using CBO data, that the minimum benefit level required for workers in medium to large firms will approach $5,000 per individual or a little over $12,000 per family. If you break this down, this equals about $2 per hour for single coverage and nearly $6 an hour for family coverage. Add to that the required federal minimum wage of $7.25 in 2014, and employers will face a minimum cost to employee workers in medium to large firms at around $13 per hour or $27,000 per year. Workers who cannot produce that much in value are at risk of finding themselves out of work. And besides, it would be a hardship to really expect workers with modest means to contribute sums of money equivalent to half their wages.

The Affordable Care Act provides no new subsidies for low income workers at large firms. A better way would be to have a uniform tax credit, as has been proposed by Senators Coburn and McCain.

Let me conclude by saying, plans that feature limited benefits in return for a lower monthly premium are not for everyone. Indeed, these plans cap benefits at a level that was never intended to provide protection in the event of a catastrophic medical illness. However, during the healthcare reform debate the President told the American people, and I quote, "And if you like your insurance plan, you will keep it. No one will be able to take that away from you,"

unquote. Mini-med plans provide a level of benefits that many Americans come to rely upon, and the loss of this coverage will make them worse off.

Thank you.

[The prepared statement of Mr. Herrick follows:]

PREPARED STATEMENT OF DEVON M. HERRICK, PH.D., SENIOR FELLOW, NATIONAL CENTER FOR POLICY ANALYSIS

Limited Benefit Plans Serve a Need

Mr. Chairman and members of the Committee, I am Devon Herrick, a Senior Fellow at the National Center for Policy Analysis, a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control and solving problems by relying on the strength of the competitive, entrepreneurial private sector. I welcome the opportunity to share my views and look forward to your questions.

Beginning in 2014, most U.S. residents will be required to have health insurance coverage. This provision of the Patient Protection and Affordable Care Act (ACA) is often referred to as an *individual mandate*. In addition to this requirement, new ACA provisions will limit the choice of health plans offered in the future and reduce Americans' ability to enroll in plans that meet their needs and fit their budget.

Costly Coverage. On September 23, 2010, a wide array of ACA provisions went into effect, creating new regulations on existing health insurance plans and phasing in new requirements for health plans offered in the future. Annual and lifetime caps on benefits will not be allowed by 2014. Beginning next year, insurers will be required to spend 80 percent to 85 percent of premium dollars on medical costs, referred to as the Medical Loss Ratio (MLR), or refund the excess to policy holders.

Once the individual mandate becomes effective on January 1, 2014, the ACA requires most policies sold to provide an *essential benefit package* that covers preventive services with no cost sharing. For most plans the least comprehensive benefit plan allowed must cover 60 percent of medical costs—the so-called *Bronze Plan*. Insurers selling coverage in the individual market will not be allowed to deny coverage to applicants with pre-existing conditions or to charge them more than healthy applicants. In addition, insurers will only be allowed a 3-to-1 ratio for older applicants compared to premiums for younger applicants. Regulations requiring an essential benefit package, and a minimum MLR, largely preclude the sale of health insurance other than comprehensive coverage that more closely resembles pre-paid medical care than pure insurance.

Limited Benefit Plans.[1] Between one and two million Americans currently have a health insurance plan that features "limited benefits," sometimes called "mini-med" plans. Mini-med plans are increasingly popular among moderate income workers, seasonal and part-time employees, as well as small firms that cannot afford comprehensive health benefits. A typical design for a limited benefit plan includes coverage for a number of physician visits, ancillary tests, limited hospital inpatient days and negotiated discounts on prescription drugs. The deductibles and copayments are relatively low. Depending on plan design, some mini-meds provide first-dollar coverage for some services. However, the maximum amount of medical benefits that can be claimed in a given year is capped, providing maximum benefits of anywhere from a few thousand dollars to $25,000 to $50,000 or more annually.

Mini-med plans are affordable. Premiums for family coverage can vary from $1,000 to $6,000 a year, or as little as $250 to $2,500 annually for single coverage. Plans like these can provide access to basic medical care after a copayment, such as physician visits, prescription drugs and hospital inpatient services.

Insurance involves the transfer of risk from the insured to the insurer. One reason mini-med plans cost less than comprehensive health insurance is because the risk underwritten by the insurer is lower than comprehensive coverage and capped at a predetermined level.

Mini-Med Plans Under the Affordable Care Act. The ACA prevents health insurers from capping annual limits on coverage at more than $750,000 in 2010, $1.25 million in 2011 and $2 million the following year. Most annual dollar limits on health coverage will be phased out by 2014. By design, a limited benefit plan cannot meet these requirements and remain affordable. Without waivers allowing enrollees to retain their plans, mini-med plans will essentially be banned from the marketplace.

[1] David R. Henderson, "Mini-Med Plans," Brief Analyses No. 727, National Center for Policy Analysis, October 21, 2010.

As a result, many people who rely on these plans will lose coverage and join the ranks of the 50.7 million people who are uninsured at any given time.[2]

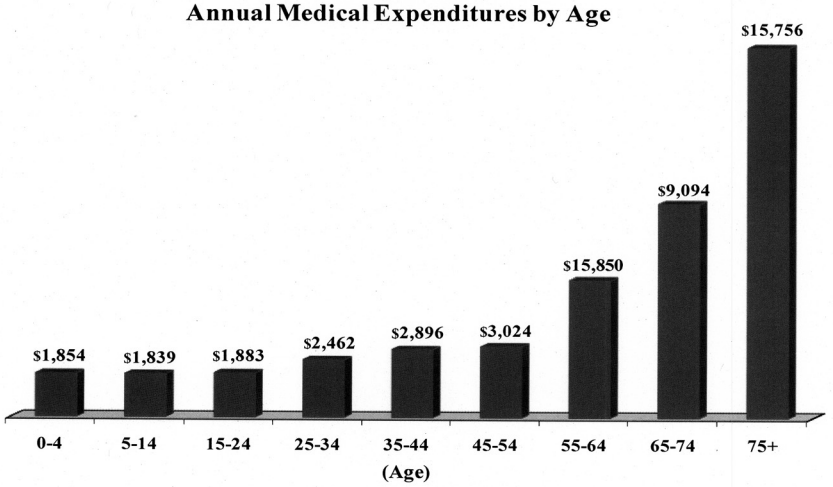
In the short run, the only other option for affordable coverage is a high-deductible plan that provides little in the way of access to a doctor or prescription drugs without significant cost sharing. High-deductible plans have a place in the market and provide a level of protection against catastrophic health conditions. But they are not popular among many moderate income families precisely because they do not provide benefits below a high threshold in a manner that limited benefit plans do.

Another threat to the continued existence of limited benefit plans is the Medical Loss Ratio regulations requiring medical expenditures to be 80 percent to 85 percent of premiums. These regulations favor comprehensive, pre-paid medical plans, where a significant share of premiums dollars represents care the enrollee expects to receive in a given year. Health plans with limited benefits are more likely to run afoul of MLR requirements given that less of the premium represents pre-paid medical spending. By contrast, the owners of mini-med plans expect a lower level of medical spending. The overhead cost to market and administer a mini-med policy is likely to be a larger proportion of the premium dollars than is currently allowed by law. This is especially true of industries with high turnover of workers.

An unintended consequence of efforts to require a MLR of 80 percent for individual and small group plans is that mini-med plans will cease to be an affordable option for moderate income Americans. Public health advocates often deride limited benefit plans as inadequate to protect Americans against the most serious health problems and view the demise of mini-meds as necessary and in the interest of public health. However, in any given year most people covered by health insurance experience very low claims. Especially for young people just starting out, a plan providing a less comprehensive package of benefits is often sufficient to meet all their medical needs. For instance, per capita annual medical expenditures do not approach $3,000 per year until around 50 years of age [see Figure I].[3] Moreover, for most people age 40 years and under, the percent of U.S. health care expenditure consumed by the sickest 5 percent of the group does not exceed 10 percent of medical costs for that cohort.[4]

Figure I

Annual Medical Expenditures by Age



Source: Calculations based on Ellen Meara, Chapin White and David M. Cutler, "Trends in Medical Spending by Age, 1963–2000," *Health Affairs*, Vol. 24, No. 4, July/August 2004, p. 179.

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[2] Carmen DeNavas-Walt, Bernadette D. Proctor and Jessica C. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2009," P60–238, U.S. Census Bureau, United States Department of Commerce, September 2010.

[3] Ellen Meara, Chapin White and David M. Cutler, "Trends in medical Spending by Age, 1963–2000," Health Affairs, Vol. 23, No. 4, July/August, p. 179.

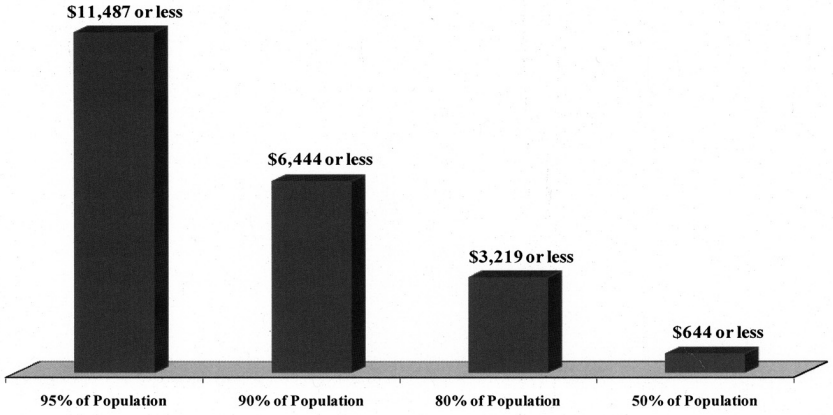
[4] Leslie J. Conwell and Joel W. Cohen, "Characteristics of People with High Medical Expense in the U.S. Civilian Noninstitutionalized Population, 2002," Statistical Brief No. 73, Agency of Healthcare Research and Quality, March 2005.

In fact, 80 percent of the population consumes less than $3,220 annually in medical care [See Figure II]. High medical spenders tend to be concentrated among older individuals.[5] McDonalds has reported that 85 percent of its enrollees spend less than $5,000 annually.[6]

Figure II

Annual Per Capita Medical Expenditures

(% of Population Spending ≤)



Note: Figures are expenses per person.

Source: Leslie J. Conwell and Joel W. Cohen, "Characteristics of People with High Medical Expense in the U.S. Civilian Noninstitutionalized Population, 2002," Statistical Brief No. 73, Agency of Healthcare Research and Quality, March 2005.

For example, in 2006 the state of Tennessee created *CoverTN* for families with incomes too high for Medicaid and too low to afford private coverage. *CoverTN* is a low-cost option that features limited benefit health plans, with benefits capped at $25,000—only $15,000 of which can be put toward hospital bills. Benefits consultant Milliman estimated about 98 percent of enrollees would not exceed their annual benefit cap in a given year.[7]

For moderate income Americans, an insurance plan providing a lower level of benefits fills a need. For most of these, insuring against the risk of medical expenses—that could reach a few thousand dollars—is worth insuring against.[8]

Other Advantages. Our health care system is not set up for cash paying patients. When a patient enters their doctor's office third-party insurers pay about 90 cents on the dollar toward the cost, on average. For the health care system as a whole the proportion of third-party payment is about 88 percent.[9] Cash-paying patients who inquire about the price of a medical procedure are likely to be disappointed. Typically, neither the hospital nor the doctor will know the cost until the procedure is completed.[10] Indeed, the same procedure may have many different prices, because each health insurer may have negotiated a different discount. In fact, the cash price is often the highest. A cash-paying patient is often charged exorbitant "list prices" because they are receiving care without a health plan. Instead of paying cash, mini-

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[5] Mark W. Stanton, "The High Concentration of U.S. Health Care Expenditures," Issue No. 19, Agency of Healthcare Research and Quality, June 2006.

[6] Janet Adamy, "McDonald's May Drop Health Plan," *Wall Street Journal*, September 30, 2010.

[7] Chad Terhune, "Covering the Uninsured, But only up to $25,000," *Wall Street Journal,* April 18, 2007.

[8] David R. Henderson, "Mini-Med Plans," Brief Analyses No. 727, National Center for Policy Analysis, October 21, 2010.

[9] Centers for Medicare and Medicaid Services, "National Health Expenditures by Type of Service and Source of Funds: Calendar Years 2006–1960," U.S. Department of Health and Human Services, 2008.

[10] Devon M. Herrick and John C. Goodman, "The Market for Medical Care: Why You Don't Know the Price; Why You Don't Know about Quality; And What Can Be Done about It," National Center for Policy Analysis, NCPA Policy Report No. 296, February 2007.

med patients are able to benefit from negotiated, in-network discounts and discount drug cards.

Burden on Workers. Health benefits are a non-cash portion of workers' total compensation package. We estimate the cost of the minimum benefit package that everyone will be required to have under the ACA at about $4,750 for individuals and $12,250 for families. That translates into a minimum health benefit of $2.28 an hour for full-time workers (individual coverage) and $5.89 an hour (family coverage) for full-time employees. In 4 years' time, the minimum cost of labor will be a $7.25 cash minimum wage and a $5.89 health minimum wage (family), for a total of $13.14 an hour or about $27,331 a year.

Economists agree that workers themselves ultimately bear the cost of their own health coverage through direct contributions and wage reductions in lieu of take-home pay.[11] When the cost of health benefits rise, employers tend to pass on the costs or constrain wage increases.[12] In addition, total employee compensation tends to equal the value of what workers produce—that is what they add to overall output, at the margin. If the minimum compensation required is higher than what workers are able to produce, they will be priced out of the labor market. Thus, to deprive workers access to these low-cost limited benefit plans ultimately means many workers will lose coverage—or lose their jobs.

The real purpose of insurance is asset protection for people who anticipate needing medical care and have assets to protect or income to protect. Moderate income people and those who are young have few accumulated assets and many don't expect to experience costly medical bills. It is a hardship to ask them to spend sums that could amount to one-half their annual income on health insurance and then fine them or their employer when they cannot afford to do so.

Individuals who purchase health insurance in the exchange beginning in 2014 can expect to receive subsidies that in some cases will be worth about $19,400 annually. However, the ACA provides no new subsidies to low-income employees of large firms. A moderate income family earning $30,000 per year could expect to only receive about $2,800 in federal subsidies for a comprehensive health plan purchased through their employer.[13] This is too little to make comprehensive health coverage affordable. It is a hardship to deprive moderate income workers access to a health plan that meets their needs and fits their budget.

How Government Can Help. A better way to help moderate income workers afford health coverage would be to provide a uniform tax credit as Senator McCain, Senator Coburn and Representative Ryan have all proposed. This would provide the same subsidy to all families regardless of their tax bracket or where they receive their coverage. This would allow them to set some of the tax credit aside in a Health Savings Account for later use or purchase whatever coverage meets their need and fits their budget.

Conclusion. Plans that feature limited benefits in return for a lower insurance premium are not for everybody. Indeed, these plans cap benefits at a predetermined level and are not intended to provide protection in the event of a catastrophic illness. However, they are an affordable choice for many Americans. During the health reform debate, the President told the American people "And if you like your insurance plan, you will keep it. No one will be able to take that away from you. It hasn't happened yet. It won't happen in the future."[14] Limited benefit plans provide a level of benefits many Americans rely on and the loss of coverage would make them worse off.

The CHAIRMAN. All right, I thank you.

The—philosophically, Dr. Herrick, when you say that it covers—that most people don't reach that—90 percent of people don't reach beyond the $2,000, first—I mean, you have to consider, what is health insurance? Health insurance assumes risk. And most people aren't going to have to use a lot of health insurance, particularly when they're young. Although, as Mr. Smith knows, the largest

[11] David M. Cutler, "The Cost and Financing of Health Care," Vol. 84, No. 2, Papers and Proceedings of the Hundredth and Seventh Annual Meeting of the American Economic Association Washington, D.C., January 6–8, 1995, *American Economic Review*, May 1995, p. 35.

[12] For instance, see "Employer-Based Health Insurance: High Costs, Wide Variation Threaten System," Government Accountability Office, HRD–92–125, September 22, 1992.

[13] Stephen Entin, "Health Insurance Exchange Subsidies Create Inequities," Brief Analyses No. 696, National Center for Policy Analysis, March 3, 2010.

[14] Office of the Press Secretary, "Remarks by the President on Health Insurance Reform in Portland, Maine," The White House, April 1, 2010.

users of emergency medical services are, in fact, people between the ages of 17 and 29. And, you know, mental health and all kinds of other things—chronic diseases—they have these things but then sometimes, because they're young, don't think they need to take care of them. But, then they do. They run into a crisis and then they're—then they want health insurance. But, it's a matter of risk.

Nobody implies that—you know, that 80 percent of all Americans are going to have—are going to come up to the requirements of what their plan might be. But, the comparison I would make—if you're serious about health insurance, then you have to—you would probably be comfortable with the fact that your—the car that you're driving, the brakes on it work 90 percent of the time; 10 percent, they don't. That describes health insurance.

You can't just say, "Oh, but, you see, lots and lots of people are really only using it up to $2,000," as Mr. Floersch did. But, you have to also be able to look at those who don't, because that's what health insurance is about. You make money on some, you lose money on others, but it has to be there. And for those for whom it has to be there, like Mr. Melville, the answer, which has been bandied about quite a bit here, that it's better than nothing—I would say it's worse than nothing because of the false expectations and false hope that it raises, and the fact that people don't—I mean, that little brochure I held up—you know, how many people are actually going to read that? I tried to, last night. It's actually half in Spanish and half in English, and it—they're turned upside down. So, I mean, it's actually—it's a work of art. But, the 10 percent that need it need it. And if you're a corporation and you're providing health insurance, then you cannot treat the 90 percent—or, the 10 percent different than the 90 percent, or the 90 percent different from the 10 percent. Your brakes have to work all the time or else you're not going to drive your car.

We had—we went through this in sudden speed acceleration with Toyota and other vehicles, here. All of a sudden, the car just speeds up. Well, most of the time, it doesn't. I went through this myself with two American cars. But, when it does speed up, you can't control it, and you run into what Mr. Melville has run into. In this case, it would be the car in front of you. And you can't control the speed at all.

So, I really want to put to rest the idea that Mr. Melville doesn't count, because he's part of only the 10 percent, rather than 90 percent. If McDonald's and other corporations are serious about health insurance—and which is why the health insurance bill passed, and which—why it would be useful if HHS were here, but I've talked at length with them about this, as my staff has, and what they're simply waiting for is the—as you pointed out, Mr. Jost—is they're waiting for the state exchanges, which, incidentally, are not federally run, but which are state-run and state-regulated. So, that's—and so, there's a little period of a couple of years here where HHS had to kick the can down the road. As you indicated, Mr. Floersch, the—you're just going into your open enrollment period. They understand that. They know that the state exchanges are coming up. It's going to be a full concentration effort to get those working right. But, when they do come up, there will be, as you indicated, Mr. Jost, no more mini-medical plans. They will not exist. They

will not be allowed to exist. And that's, I think, a very important aspect.

I've already gone over my—no I haven't. I have 30 seconds more. I won't use it. I'll wait until the next question.

Senator Hutchison.

Senator HUTCHISON. Thank you, Mr. Chairman.

Mr. Floersch, McDonald's, as we have said, is one of the businesses that has received mini-med waivers from HHS. And, according to your testimony, in response to company surveys, only 3 percent of your crew employees have said they would be willing to pay more than $35 per week for health insurance. The Chairman said that you have a cap, on your mini-meds, of $2,000 in benefits, per year. I'd like to ask, is that true? And, if so, do you think that McDonald's has found the best plan possible for this $35-per-week health coverage for your employees?

Mr. FLOERSCH. Yes, I—actually, when we did—we did survey our employees to find out what they'd be willing to pay, and—our hourly employees—and the majority said that they would be willing to pay anywhere from $5 to $20 a week for insurance. We factored that in when we went out to the marketplace. We worked with outside experts and said, "Who are the organizations out there that we should take a look at to construct this insurance program?" We came up with a group of companies. We had a strong internal team that looked at these proposals. We actually have a more customized plan with the insurance carrier that we have, BCS, than what exists elsewhere in the marketplace, that meets our needs—and the fact that we've seen a tripling of our enrollment over the last 3 to 4 years, in terms of hourly employees enrolling in the program, and more franchisees offering it. We also stay very close to what other companies are offering. We feel very positive that our plan is actually one of the best.

Senator HUTCHISON. It is, in fact, a $2,000-a-year limit. What is the amount that an employee would pay per week for a policy with that kind of annual limit?

Mr. FLOERSCH. Eleven dollars for $2,000. And there's a $5,000 option, then there's $10,000. And then we do offer a comprehensive option for hourly employees, as well.

Senator HUTCHISON. And for the $5,000 limit, what would that weekly fee be for the employee?

Mr. FLOERSCH. It's more like around $15 or, you know $20. We've tried to stay within this—after we surveyed our employees, we tried to stay within this range of what we consider to be affordable for them. Because they told us——

Senator HUTCHISON. So, a $15-a-week amount, by the employee, could provide a $5,000——

Mr. FLOERSCH. Right.

Senator HUTCHISON.—maximum coverage.

And so, from what you're saying, I understand you start at a low level, and then move to a higher level; and the premium goes up some, but the coverage goes up to higher maximums. You have a range of options, apparently, for your employees. Is that correct?

Mr. FLOERSCH. That is correct, yes.

Senator HUTCHISON. And let me ask you this. According to what I understood your testimony to be, 90 percent of your covered em-

ployees, even at the lowest maximum level, don't reach the annual limit. Is that correct?

Mr. FLOERSCH. If you take all of the $2,000, $5,000, and $10,000, the majority of people are in the $2,000, and 90 percent of that total population of $2,000, $5,000, and $10,000 do not hit their limits.

Senator HUTCHISON. Let me go to Dr. Herrick. You mentioned in your testimony—or in your written testimony—that Tennessee has a program called "CoverTN" for families with incomes in between Medicaid eligibility and private coverage affordability, as a gap filler. And it provides a low-cost health insurance option with benefits capped at $25,000. And, in that program, you said that 98 percent of those employees don't reach that cap, which certainly is believable. Do you think that that is an affordable option? And, would it meet the requirements of the new federal reform law, or would they have to significantly change their policies?

Dr. HERRICK. Oh, no, that would not meet the new requirements of the Affordable Care Act. The particular plan had a maximum benefit of $25,000, of which no more than $15,000 could be used toward hospital care. And, at the time, which was, I think, 2007, it was widely reported that Milliman, the actuarial and consulting firm, reported that probably 98 percent of the enrollees would never reach their caps.

High healthcare costs and high spenders tend to be concentrated among older individuals and people on Medicare. And, by and large, most of us don't really experience anything that's of a catastrophic nature in any given year. Of course, it is very tragic when it does occur, but I'm not convinced if any health plan could affordably cover all the risks.

Senator HUTCHISON. The Chairman mentioned that the state plans, or the state options, when they come into effect, are going to be run by the states and regulated by the states. But, they do have the federal requirements, which is going to mean that they have to meet certain standards. I mean, even companies that provide, say, 35 percent of the premiums are not going to meet the federal standards. So, doesn't that cut off a lot of plans that now give a level of coverage, maybe even a $25,000-limit coverage, but are not going to meet the federal plan, and so, might be out of range for people who are now on these policies?

Dr. HERRICK. Oh, absolutely, especially if you work for a medium-size firm with—which employs more than 50 people. You will get no additional subsidy from the Affordable Care Act. And, as I said, economists agree that workers themselves bear the cost of coverage in reduced wages. So, a lot of people will be priced out of the market when their employer is required to provide a much higher level of coverage and then, of course, pass on the costs to them.

Senator HUTCHISON. Thank you.

My time is up. Thank you.

The CHAIRMAN. I'll go on, but I just want to make one correction. You are aware, are you not, Dr. Herrick, that—in the healthcare plan, that starting next year 35 percent of healthcare premiums will be subsidized for small businesses?

And then by 2014, up to 50 percent will be subsidized by federal premiums?

Dr. HERRICK. Yes, I am aware of that. That's for very small firms, and it phases out as the average wage rises to $50,000. it phases out as the average number of employees reaches 25. And I can't recall the exact statistic, but it has been estimated that, really, a rather small proportion of small firms will, in fact, qualify for that program.

The CHAIRMAN. Well, I think you're wrong on that, but I'm speaking out of turn.

Everybody left.

Senator BOXER. I'm still here.

The CHAIRMAN. You're here.

Senator BOXER. Yes.

The CHAIRMAN. Barbara Boxer.

STATEMENT OF HON. BARBARA BOXER,
U.S. SENATOR FROM CALIFORNIA

Senator BOXER. Thank you.

I am somebody from a state of 38 million people, but it's OK.

Mr. Melville, thank you for coming to share your story, because what you have done by your presence is, you have put a human face on a healthcare system that was in desperate need of reform. And don't think Dr. Herrick totally gets it, either, so—I mean, I'll get to that later. But, no one will be forced to pay more than 8 percent of their income. And tax credits will kick in. And I would just say this to you. You don't choose, nor do any of us, the time at which we're going to get sick. Right?

Mr. MELVILLE. That's correct.

Senator BOXER. And a lot of the things we did, you know, won't be corrected until 2014. They're starting to kick in slowly. So, I want you to know, I apologize to you, that you have not been protected from what has happened to you.

And I want to just explore this with you. Because, from what I understand, you believed you had a $20,000 cap on your policy every year. Is that correct?

Mr. MELVILLE. I felt there was a buffer.

Senator BOXER. Right. And who led you to believe that there was a $20,000 cap on your policy, as opposed to a $2,000 cap, on paying the bills for your illness? Who led you—you don't have to give me a name of an individual.

Mr. MELVILLE. It wasn't an individual.

Senator BOXER. Was it an insurance company not disclosing this in proper way? Was it an employer who didn't disclose it in the proper way? How did you come to the conclusion that you had a $20,000 cap for your illness, when, in fact, you had a $2,000 cap and called Mr. Finan or called the Cancer Society—thank God you're there, sir, doing what you do to help people—what—was it just sold as $20,000 cap? Was that your understanding?

Mr. MELVILLE. I believe the company is at fault for lack of disclosure.

Senator BOXER. OK.

Mr. MELVILLE. And I was under a false impression. And then, when I did get diagnosed for cancer, I said, "Well, OK, I've got a

little buffer here," and then I would be willing to get three jobs to pay whatever would come up that I would owe. Unfortunately, I would owe pretty much everything, minus——

Senator BOXER. Well——

Mr. MELVILLE.—$2,000, which is——

Senator BOXER.—let me just say, you would join a lot of other folks, because one of the reasons we acted on health reform is that, if you look at all the bankruptcies, more than 60 percent of them were related to a healthcare crisis. And people say, "Well, these mini-med policies are better than nothing." Barely. If you don't get sick, hey, you're fine. But, I could say, just my own limited experience with the healthcare system, $2,000 is a blink of an eye and a few pills at the hospital. So, let's get real.

And you're paying—not you, sir, but the average person at McDonald's is paying hundreds of dollars a year, $700 or $800, for that minimum policy. Maybe they'd be better off saving that money. So, in some cases, I'm not so sure that it's better than nothing. But, I could be wrong on that.

But, let me just get to you, sir. I believe that the insurance company and your company should make things right for you, because I believe you were misled. And I don't know who did it, but you're a smart man. I listened to—I don't know what your work is, I don't know what your education is, I just know you're smart. I could hear——

Mr. MELVILLE. Thank you.

Senator BOXER.—and I've got to tell you, you were fooled into thinking this policy covered $20,000 worth, and it didn't. I would call on Aetna Insurance and your company to make it up to you. Why on earth should you be subjected to less than top-tier treatment? You're a hardworking person who has played by the rules. You said here you'd be willing to get three jobs, and I believe you.

Mr. MELVILLE. I think Senator Rockefeller said it, in kind of a nutshell, regarding gambles. The insurance company has all the variables, and they know what the variables are, according to statistics, as, you know, Mr. Floersch said, with McDonald's and working with insurance companies. The insurance companies, they take a—it's—insurance is a gamble. They're betting that you're not going to get sick. However, nondisclosure, being naive, whatever it is—not being informed—I couldn't make an intelligent and informed decision, simply because this is what my company offered me——

Senator BOXER. Absolutely.

Mr. MELVILLE.—and I assumed it had a little oomph. Unfortunately, to my dismay, it had nothing, in my opinion.

Senator BOXER. When you buy a policy that has a $20,000 cap, and it turns out that's divided into different categories, to me that's a sham. So, I'm calling on Aetna——

Mr. MELVILLE. There's $18,000 that I—that's sitting there in——

Senator BOXER. Exactly.

Mr. MELVILLE.—my supposed account—$18,000——

Senator BOXER. Exactly.

Mr. MELVILLE.—that's sitting right there that I can't touch.

Senator BOXER. Well, I'm just trying to make a point here. I am going to work with Aetna, and—I don't know who your employer

is, because you have not said, and I'm not asking you. But, I'm going to start with Aetna, and I'm going to take a look at the way this policy was sold to you. They ought to make it up. Because, right now, as I understand it, you're not getting the treatment that you were told was the most effective treatment at the beginning of this battle that you're facing.

Mr. MELVILLE. That's correct.

Senator BOXER. Is that true?

Mr. MELVILLE. That's correct. I—they wanted to do laser surgery on my tongue and some surgery on my lymph nodes in my neck. And when the $2,000 limit came about, I got a call from the hospital saying that, "Please, you can't come here anymore. Your limit has been exhausted."

Senator BOXER. And now, you have to plead—you have to go to a place for indigent care, which I know didn't—isn't a pleasant experience.

I just want to say, Mr. Chairman, I would like to get a second round after the two of you do some more questions. I have some more questions for the rest of the panel, but I'll hold until I get a second round. Is that OK?

The CHAIRMAN. OK.

Mr. Melville. Yes, sir.

The CHAIRMAN. I think Senator Boxer and a number of the panelists and I disagree very strongly with this, but a few of the panelists appear to think, "Oh, it's OK. You know, 90 percent don't require more than a few thousand dollars." And—but, 10 percent do. And so, that makes you think, "Well, what is the obligation to the 10 percent who do?" We understand that insurance is about risk. When people do get sick, you'd—I don't think it's enough to say, "I'm really happy and really applaud McDonald's, or others, for having 90 percent if that's what it says, or is, who don't have to use more than $2,000." I think the more basic question is, like, would a car that the brakes only worked 90 percent of the time, but didn't work 10 percent of the time, would that get approved? Would that get on the market? Would that be in any car sales shop in the country or the world? The answer is, no. And if we ran into problems, they would be fined, penalized, all kinds of things. And it's—to me, it's outrageous.

But, you did your best to try and figure out what you were going to get. And we looked very carefully at your policy, and here's what we found. The policy's limit on all doctor's office visits and outpatient tests is only $2,000, not the $20,000 to which you understandably gravitated because it was a higher number and you—you know, for $20,000, you can get quite a lot done. But, you gravitate toward that. But, no, it wasn't. It was only $2,000. And the policy's limit on emergency room services is only $600. OK? So, if you're desperate, and you—some things aren't working out, you go to the emergency room, which is one of the reasons we passed that bill, so we could insure 32 million uninsured Americans, which would reduce the need for uncompensated care, which would allow premiums for other people to go down.

But, here's the really tricky thing about this policy, the hospital coverage. Your policy covers up to $20,000 of room-and-board costs at a hospital.

Mr. MELVILLE. That's correct. You—it's not any outpatient services.

The CHAIRMAN. That's what I'm——

Mr. MELVILLE. You need to be——

The CHAIRMAN. I don't want you to rob me of my——

Mr. MELVILLE. You need to be admitted into the hospital.

The CHAIRMAN. Yes. I mean, it's nice to have a room and a bed. Let's agree on that.

Mr. MELVILLE. Yes, I concur wholeheartedly.

The CHAIRMAN. Yes. But, it only covers up to $2,000 of most other goods and services you receive—and tests—in a hospital.

For example, under this $2,000 limit—this is Aetna we're talking about—medical/surgical supplies, syringes, bandages, surgical instruments, IVs, catheters, blood tests, X-ray, CAT scans, MRIs, all operating room and recovery room expenses—you're probably not going to be able to afford them. So, you've got a nice bed, you've got a nice room, but you got snookered. And they were banking that you wouldn't get sick—on the hope that you wouldn't get sick—the insurance company certainly was, because that's what they do. I mean, we had to actually, in the law, outlaw recisions. Most people don't know what a recision is. A recision is when you have an insurance policy, but the insurance company decides that they don't want to cover you, because you may be at risk. Now, you can be at risk. A preexisting condition includes a C-section. It includes being pregnant. It does, in fact, and can, include having acne. It can include all kinds of things where insurance companies, because nobody is watching any of this, nobody understands this, it's not being reported on, that—you know, that when you get sick, you have to get help. And there's no way around that. So that McDonald's and other companies, Dr. Herrick to the contrary—seems to me, you can't just be happy about the 90 percent, you've got to take full responsibility for the 10 percent, or else you're saying, "Well, they don't matter, because they're not"—I mean——

Mr. MELVILLE. There's your gamble on—there's their gamble for the insurance company.

The CHAIRMAN. Yes.

Mr. MELVILLE. That—it's just like, Senator Rockefeller, you explained earlier.

And I just want to add, though, that I did get a letter in the mail from my insurance company. I had just been diagnosed for cancer about 30 days prior, and I got a letter in the mail saying that "You need to fill out this form, because we feel that it's a preexisting"——

The CHAIRMAN. Yes.

Mr. MELVILLE. And I almost—well, I——

The CHAIRMAN. Yes, but that's——

Mr. MELVILLE.—felt pretty terrible, and I called them——

The CHAIRMAN. That's the way that——

Mr. MELVILLE.—and she said, "If you don't send it in, then we're going to really take a look at you." I said, "I'm going to just write whatever I want, because it doesn't really matter." I—it wasn't preexisting; I know that. I mean, they had just diagnosed it. If it was preexistent, I never knew.

So, anyway, I'd——

The CHAIRMAN. No, I——

Mr. MELVILLE.—I just wanted to put that in there.

The CHAIRMAN. We're—I understand you.

So, let me ask Mr. Floersch. Are the 90 percent who don't come up to $2,000—are they more important to you, in your policy-making about health insurance, than the 10 percent who have major medical, or at least more than $2,000 of medical requirements? How do you separate, in your mind, the human being factor of the 90 percent that you get—or, the insurance company gets away with, and therefore, you can apply their coverage? But, it isn't—again, the brakes that don't work. You don't drive the car at all, that the point—the principle is sacrosanct there. Why are the 10 percent different, in your mind? Why can you let them go, let them suffer, let them suddenly go into, you know, bankruptcy or whatever, because, 90 percent aren't a challenge to you? How do you make that distinction?

Mr. FLOERSCH. Well, I—Mr. Chairman, we don't look at the 90 percent differently than the 10 percent.

The CHAIRMAN. Well, you do.

Mr. FLOERSCH. No, because we do offer a comprehensive option for hourly employees. So, they do have the opportunity to be able to see three limited-benefit plan options—the $2,000, the $5,000, and the $10,000—and a comprehensive option. So, we do offer that comprehensive option for our hourly employees.

And the other thing I would say is, we're very clear in our materials. I know you talked about the brochure, here. But, you know, within the first 2 pages, we've got eight references to the fact that this is a limited benefit. We're very clear. We have a definition of what is outpatient services, what are—we have—this is—we have a video that we show to our employees. It's very clear about how this is broken down.

I agree completely with what everybody has said, including Mr. Melville. We need to be very transparent about this, and we take this very seriously. So, I just wanted to make sure that you——

The CHAIRMAN. No, but you're—you see, what you're saying is, "If we're transparent in saying that if you're—if you get sick—I mean, cancer being sort of the most extreme example of that, most scary example of that—we understand that, but we've got something which will handle that." Well, in fact, you don't, because the premiums won't cover what—the kind of healthcare that Mr. Melville's going to need.

So, you say, "Well we can take care of you." But, in fact, you don't. Now, you do take care of yourselves. The corporate healthcare plan is absolutely magnificent—top-of-the-line, gold-plated. And that, again, is why it confuses me, from a humanistic point of view, how you can so comfortably do that, and then, because somebody shows they're particularly good, and so you take them up into the corporate ranks, and all of a sudden their insurance covers virtually everything. It's a gold-plated insurance plan. But, in the meantime, the 10 percent. Why is it wrong for me to be worried more about the 10 percent who get snookered than the 90 percent who, by good fortune, particularly yours, don't get sick up beyond $2,000 a year.

Mr. FLOERSCH. Well, I think, Mr. Chairman, the fact that we do offer the comprehensive option for the same group of employees, and the fact that we're very clear in our communication about what the plans are, that's how I feel, you know, comfortable with what we've done.

The CHAIRMAN. All right. I would say to my staff, have we passed this around? Does everybody—press, do you have this? This is what he's talking about. You don't have it. Can you get it to them?

[The information referred to follows:]

	McDonald's "Mini-Med" Plans (available to McDonald's restaurant hourly employees)	McDonald's "Corporation Health Plan" (available to McDonald's corporate staff and certain McDonald's restaurant management)
Employee's 2011 annual premium	$710 ("Basic" plan) $1,332 ("Mid 5" plan) $1,947 ("Mid 10" plan)	$682–$920 ("Health Account PPO") $704–$951 ("Deductible PPO") $1,063–$1,435 ("No Deductible PPO")
Employee's overall annual maximum health care benefit	$2,000 (Basic plan) $5,000 (Mid 5 plan) $10,000 (Mid 10 plan)	Unlimited
Employee's annual limit for outpatient services (*e.g.,* doctor's visits, tests, prescriptions)	$2,000 (Basic plan) $1,500 (Mid 5 plan) $2,000 (Mid 10 plan)	Unlimited
Employee's out-of-pocket maximum for covered medical expenses	Unlimited	$4,000
Employee's out-of-pocket maximum for prescriptions	Unlimited	$2,000
McDonald's annual contribution per covered employee	$0–$120	$6,894

Sources: Employee benefit materials provided by McDonald's; Annual Return/Report of Employee Benefit Plan, Form 5500 for the McDonald's Corp. Health Plan for the calendar plan year ending Nov. 30, 2008 (filed with U.S. Department of Labor, 2009).

My time is way over, and so I go to Senator Hutchison.

Senator HUTCHISON. Mr. Chairman, I've asked my questions. Let me look at this. Let Senator Boxer go. I might have something——

Senator BOXER. Thank you so much.

Mr. Floersch, what percentage of these low-income people's healthcare plans do you pick up? What percentage do you pay?

Mr. FLOERSCH. On this—the $10 and $20.

Senator BOXER. Or——

Mr. FLOERSCH. Ten dollars for the——

Senator BOXER. Or the——

Mr. FLOERSCH. Ten dollars per month for a first-tier——

Senator BOXER. The range. No, the range. What do you pay for your employees, on average, from—what do you pick up? What percentage do you pick up?

Mr. FLOERSCH. Oh, what percentage of a subsidy?

Senator BOXER. Yes. Of the healthcare premium do you pick up? If it's $40 a month, do you pick up $20? Do you pick up $10? What's the percentage you pick up——

Mr. FLOERSCH. Anywhere from——

Senator BOXER.—for your employees?

Mr. FLOERSCH. Anywhere from 10 to 20 percent.

Senator BOXER. Ten to twenty percent?

Mr. FLOERSCH. For the hourly employees that we're talking about.

Senator BOXER. OK. And what do you pick up for your corporate people?

Mr. FLOERSCH. We pick up 80 percent for our corporate people. We pick up 80 percent for our restaurant mangers. We pick up 80 percent for our certified swings. We pick up——

Senator BOXER. So, explain that.

Mr. FLOERSCH.—70—I'm sorry; I want to—70 percent for our executives.

Senator BOXER. So——

Mr. FLOERSCH. We subsidize our——

Senator BOXER. So, explain that to me. So, the people who earn the least, you pick up the least of their premium. Is that what you're saying?

Mr. FLOERSCH. I'm saying that, when we have comprehensive options—and the first promotion that a person gets at McDonald's, to floor supervisor after 6 months of being in the job—and that only takes a couple years to get to that role—you get a——

Senator BOXER. OK.

Mr. FLOERSCH.—70-percent subsidy.

Senator BOXER. No, no, no. I get it. I get it. You are telling me, with a straight face, that an hourly employee could afford the same level of coverage that you get? No. And what you do is, you pick up hardly anything of the lowest-income people. And if you look at—do you know what, for example, Starbucks pays for its workers? Seventy-five percent. So, I'm just saying to you, just as a human being—and I think that you posted a $4.5 billion profit in 2009, and that's great, and I want everyone to be really successful—but, I am saying to you, just on—as a moral issue that—I can't legislate morality, but I'm just saying to you, the fact that, essentially, you pick up 70 or 80 percent for your higher-income workers, and 10 to 20 percent for your lowest workers, I think you ought to take a look at that. That just makes my heart beat fast, and not in a good way. I don't really get it.

Now, what steps do you plan to take, if any, to offer more comprehensive healthcare than these mini-med plans? Do you have anything in mind?

Mr. FLOERSCH. Well, we have the comprehensive option that we offer to hourly employees.

Senator BOXER. Yes, but they can't afford it. So, are you thinking about paying, perhaps, more of the premium for your hourly workers?

Mr. FLOERSCH. We—a couple years ago, we moved from the $10 subsidy to the $20 subsidy, so we have increased that subsidy over the last couple of years.

Senator BOXER. OK. Well, could I just suggest to you—it might be really a wonderful thing, might make you feel really good—if you paid the same percentage of those people's costs as you do the higher-end people, I think it would be really important.

Now, I want to ask Mr. Jost—Mr. Jost, in 2009, Consumer Reports ran a story about Susan Braig, of Altadena, California, who

bought what she thought was a hospital-only catastrophic insurance plan when she turned 50, only to find out it covered almost nothing when she got breast cancer and needed help. To what extent do plans that only cover hospital services—so-called "hospital-only" plans—present the same hazards for consumers as mini-med plans?

I think Senator Rockefeller pointed it out—our Chairman—when he said to Mr. Melville, looking at his policy, it covered hospital, but only the room, not anything—not any of the treatment.

So, do you see a problem, now? Because, by 2014, we have taken steps to cure a lot of these problems. And we face—actual repeal of what we've done, and I hope we'll be able to hold it off, because stories like this help us make our case. But, do you see those hospital-only plans presenting similar hazards for consumers as these mini-med plans? And do you recommend a way we could address them in the interim, before 2014, when we solve some of these problems?

Mr. JOST. Well, I think that there are a number of kinds of plans out there—there are also disease-only plans—that offer very limited coverage. There are catastrophic benefit plans with very high deductibles that offer very little coverage. And there are quite a few plans out there, of various sorts, that really do not cover what people will get in 2014, which is essential benefit coverage.

The problem between now and then is how to pay for those plans. Because, if you have very low income, but not low enough to qualify for Medicaid, which, in states like Virginia means, if you're still alive and you obviously have enough income not to qualify for Medicaid, if you're an adult, how do you pay for that? And that's why it's so important that we get the tax credit——

Senator BOXER. OK.

Mr. JOST.—system online.

Senator BOXER. Well, let me just say this, and I'll stop. I think what Chairman Rockefeller was getting to, and Mr. Melville addressed, in terms of the risk—we all know the point of insurance. You get a huge pool of people together. The bigger the better. And, you know, you hope, and you look at the different tables—actuarial tables—who's going to get sick, who isn't? How do you price these plans? Et cetera, et cetera. So that when someone does get sick, they're not shunted aside or told, "Oh, guess what? We don't cover this." To me, what's going on out there, these are sham policies. They're shams. And, as Dr. Herrick said, if people don't get sick, they never know it. They say, "I love my insurance." They never get sick. Maybe they get a scratch. Maybe they go once a year. But, these stories, as we heard from Mr. Melville, who could barely tell it, you know, are running rampant through the countryside.

So, my point is that if you're saying the hospital-only might be a problem, the disease-only might be a problem—what I think we need to do in the interim, Mr. Chairman, is make sure that the Secretary of HHS is shining a bright light on these shams and scams that are out there. Because, they're just figuring, "Most people won't get sick and they'll never know." And the fact that Mr. Melville would now get a letter saying, "We think you had a preexisting condition and didn't tell us," adds—it just adds another dimension to the tragedy he's facing, a man who's a hardworking

man losing his dignity, thinking he has a policy that's capped at $20,000, finding out it isn't, and then getting a letter in essence saying, "Did you deceive us? You may have had this preexisting condition." We know that this is going on.

So, I want to just thank the Chairman, because, you know, we passed a very important bill. We're going to revisit it and revise it and make it better. But, this is very important because we have to keep shining a light on what's happening to the American people, to a lot of us, in this interim period.

And I want to thank you. It has been a terrific panel.

Thank you.

The CHAIRMAN. Thank you, Senator.

I return to Senator Hutchison.

Senator HUTCHISON. No further questions.

Senator Nelson?

STATEMENT OF HON. BILL NELSON,
U.S. SENATOR FROM FLORIDA

Senator NELSON. Mr. Chairman, I want to——

The CHAIRMAN. You can ask a question. You can make a statement. You can talk about NASA. You can do whatever you want. But——

[Laughter.]

Senator NELSON. No, we did that in this room, this morning, all morning.

The CHAIRMAN. Oh, you did. OK.

Senator NELSON. We did.

The CHAIRMAN. So, let's concentrate on these folks.

Senator HUTCHISON. Our Chair is——

Senator NELSON. I can—and—yes, and so did Senator Hutchison. This is our day for the——

Senator HUTCHISON. Commerce Committee.

Senator NELSON.—for the Commerce Committee, Russell Room, beautiful hearing room.

I'd like to make a statement, that I thank you for having this hearing.

And I think what it is exposing, since I had the privilege of sitting with you in the Finance Committee as we crafted this legislation of trying to have reform of healthcare in America and health insurance. And I think what we're seeing today is another reason why—why should there be a country as advanced as ours that, of the 300 million people, 45 million people do not have health insurance but still get healthcare when they get sick, and everybody else pays for them, because when they get sick, they get health care, they just go to the most expensive place, which is the emergency room, at the most expensive time, since they didn't have any preventive health care, then when the sniffles turn into pneumonia, then you have to treat the emergency?

Now, I think what we're talking about here today is a lot of these mini-med plans are like that, with these high deductibles. So, in effect, if you are a mom and a dad, maybe you can get your—and you have modest income—maybe you can get your children insured by virtue of the fact that Senator Rockefeller upped the levels of the children's health insurance plan; but for the mom and dad, the

only thing you can afford is this high-deductible medical plan. And so, what does the mom and dad do? If everything—let's say it's a $5,000 deductible or a $10,000 deductible. What they do is, they don't go to the doctor, because they don't want to afford the out-of-pocket cost, or they can't afford it.

And so, a system that is operative, that we have exposed here today, is one of the very reasons why we need comprehensive health insurance overhaul to make insurance companies give 85 cents of every premium dollar that will actually go into healthcare, and, for smaller group policies, a lower percentage, but, nevertheless, a—an increase over what it is now, and to make health insurance available and affordable to people otherwise. Otherwise, we have this bifurcated system, where the haves have health insurance and get healthcare, and the have-nots do not, unless you're really a have-not and you qualify under Medicaid.

Now, that's just—in a country that values the Golden Rule, "Do unto others as you would have them do unto you," in a country that is a moral country, we just have an obligation to try to help people. And here's another example of why we needed health reform.

Now, a lot of these things don't take effect until 2014. And there's a part that will affect these folks that doesn't take effect, and that's the—imposing the annual limits on essential health benefits. That doesn't take effect until 2014.

But, it's good that you get this out here for discussion, Mr. Chairman. And I thank you.

The CHAIRMAN. Thank you, Senator Nelson.

I'd just like to ask a question. I might ask this to Mr. Smith. Again, we have the principle of health insurance, that some people are going to be sick and some people aren't going to be sick, and nobody knows what the measurement's going to be. But, the American Health Insurance folks, AHIP—the American Health Insurance Plans—they published a Consumer's Guide to Health Insurance. And the very first question—and they were the ones who fought the hardest to defeat the health reform bill. They spent more money, more time, more advertising than anybody else in trying to defeat it. Now, they represent the health insurance industry. On this committee, that is no surprise, because we've had many hearings on the health insurance industry—and the way they get away with things and the use of fine print and smiling faces, so that—because—knowing that a lot of people just—don't have the time. They're afraid. They're not going to look into it very carefully. However, these folks, who tried to do everything they could to defeat the health bill—the reform bill—the very first question answered in the guide is, why do you need health insurance? Now, this is not me talking; this is them talking. And here's what they said: "The purpose of health insurance is to help you pay for care. It protects you and your family financially in the event of an unexpectedly serious illness or injury that could be very expensive." To wit, Mr. Melville. Now, what—this just reeks with hypocrisy, based upon what they tried to do during a year and a half of debate, and what we've uncovered here in this committee in previous hearings about a variety of health insurance companies' practices.

I'm wondering if Mr. Floersch doesn't have the comfort of knowing that, when the 10 percent have their problems, like Mr. Melville, and he has to scramble to anyplace he can get, that Mr. Floersch knows that the American taxpayer is going to pay for what he isn't, because they will be going into emergency rooms, they'll be going anyplace they can, and that takes him off the hook, which is why we passed health reform, so people wouldn't have to do that, so they wouldn't have to go to the emergency room and—because they might have to go, but they'd have health insurance—so that the taxpayers—other taxpayers, who aren't Mr. Melville, who aren't any of you sitting up there or anybody in this room, don't have to pay for his health insurance, because the health reform bill will do that.

So, I'm actually wondering if the 10-percent factor—10 percent of the time that the brakes don't work—doesn't weigh heavily on McDonald's, or other corporations that do similar type things as this, with mini-med, because they know that the taxpayers will make up for what they refuse to do, because they don't want to spend a lot of money on temporary employees.

Mr. SMITH. I think you're right, Senator, that there's a powerful, and I think it's probably unintentional, consequence of these sorts of mini-med plans, is that there is a burden transferred from the company to the public system and to taxpayers. I think, from my vantage point, the fundamental question is, Do we actually think that mini-meds are adequate insurance? Or do we think that it's the best we can do for an $8-an-hour low-wage worker? And I think if we all around this table and, you know, any American asked themselves, I think that most of us would say that a $2,000 annual benefit cap is not going to be adequate. It's not going to cover you when you actually need it.

So, we—if we don't really think it's adequate, then the question is, is this really the best we can do? I don't think we should accept that. And I think that the Affordable Care Act sets up a system that is going to fix that problem with the status quo. It's going to provide a—more affordable, more comprehensive options for young adults. And—you know, but there is a transition period. And one thing I would like to hear from the employers, particularly these employers who have mini-med plans, is, what are you going to do, as Senator Boxer said, to improve the quality of your plans before 2014? How can we work together to either make a bigger contribution or to figure out ways to make those plans more comprehensive and actually meet the needs of your workers?

The CHAIRMAN. So, you could be working at McDonald's, yourself. Right?

Mr. SMITH. Absolutely.

The CHAIRMAN. I mean, not all of their employees are co-founders, you see, so——

[Laughter.]

The CHAIRMAN.—but, you could be doing that. And so, I have to look at you as the 10 percent. Number one, young people tend to think they're not going to get sick. They don't know, as I said, that they are, far and away, the largest users of emergency rooms of any age group in the country, and have been for years. They don't know that 10 percent of them have depression, mental illness prob-

lems, as is the case across America. But, they don't know that, because young people aren't meant to be that way, except when we read, dramatically, in newspapers, things that they have to do. They don't know that they have chronic illnesses, and that those are debilitating and expensive. Or they are—they don't want to be bothered with the healthcare system.

I started out my life, so to speak—public life, my reasonable life—as a VISTA volunteer in southern West Virginia, where nobody had health insurance, where nobody had heard of health insurance, where there had never been a doctor. You know, the schoolbus didn't even come there, because they said, "Ah, you're too far away," so nobody went to school. Well, you get the picture. But, the county board of health was willing to send a van for PAP smears. Now, that's all they were willing to send, but they did do that. And I worked very hard, in the community, to get people to show up. Very sensitive, you know, somebody my age, and it was a sensitive subject for me; I wasn't very good at it. First time the van came, nobody showed up. I worked another month or so. They came again. Nobody showed up. And then the third time, two people showed up but wouldn't go in. What was the lesson learned? There's so much bad news in people's lives as they are—were then and are now—young people, all people—that they don't want to go in and take a test which might show them that they have what Mr. Melville has. They don't want to know that. So, it's the keep-that-possibility-away-from-me factor.

Well, that can be a human reaction, but that cannot be a public policy answer. Public policy has to come aggressively to the rescue, to encourage people through—that's why all of the prevention in the healthcare reform bill is all free—for seniors, for anybody else. It's free. Wellness. All kinds of things. That's why people of your age, when you go into the exchange, you'll have hundreds and hundreds of millions of dollars of financial help, because—maybe you see something you want, but you can't quite afford it. Everything will be out there in print, the cost of everything. It'll—it won't—you know, Mr. Floersch said that it's all in the brochure. I—that wasn't my opinion as I read it. But, it will—that will surely be the case—transparency, total and full knowledge.

So, I just think that you can't say that 10 percent of the people don't count. I don't think you can. I don't think that's right.

I sort of want to end the hearing on that, but I'd like to hear—some people will have opinions or have things they haven't said that they wanted to say.

Start with you, sir.

Mr. JOST. Yes. An important point has been touched on a couple of times, but not really emphasized. And that is, another group that we don't have the table here today are healthcare providers, because Mr. Melville's story illustrates that, when the insurance runs out, it's the provider who continues to care for you. And someone pays that cost. Who pays that cost? Some of it's passed on to the taxpayers. Much of it's passed on to other employers, who are providing comprehensive health insurance and who bear the cost of paying for uncompensated care.

So, in this country, we have very cheap hamburgers that are provided by very low-wage workers with very little health insurance.

But, we pay a lot more for other goods and services, because the employers who provide those goods and services are providing comprehensive health insurance that is paying providers for $43 billion of uncompensated care.

One of the things that the Affordable Care Act does is ends this very inefficient system—or, I think will end this very inefficient system of cross subsidization, so that all employers will hopefully provide health insurance. If they don't provide health insurance, there will be tax credits available to middle-class and lower-income people who need health insurance. And that will be paid for more directly, rather than just passing all these subsidies around underneath the table. And, as Senator Nelson said, people will get healthcare when they need it, and it's going to be less expensive in the long run.

So, I think this is a very positive step that we're taking. It's very unfortunate we have to wait another 4—3 years before it's fully in place.

Thank you.

The CHAIRMAN. That's correct. But, remember that—I think it was Teddy Roosevelt that started trying to reform the healthcare system. So——

Mr. JOST. We're almost there.

The CHAIRMAN. Yes, the 3—I'm not scared of 2014. To me, it's just 3 years away. To others, it may be a long time. But, it will take that kind of time to get the state exchanges working. And they will be the—they'll be the folks that handle all of this.

Mr. Finan, I think you have to have something to say.

Mr. FINAN. I do. And thank you very much, Mr. Chairman. Just a couple of comments.

I really appreciate the dialogue you had about the 90/10. And I just wanted to point out, among that 10 percent, there's probably a very high percentage of cancer patients. As you've said, the real purpose of insurance—any kind of insurance, not just health insurance—is to protect people against a catastrophic loss. And mini-meds clearly don't do that.

We've had a lot of discussion today about transparency, and that's critical. The insurance system we have, or we've had up until now, is largely dysfunctional. It's not competitive. In large—and one of the main reasons is the total lack of transparency. Consumers don't have information. They don't know what they're buying. They're only buying by price. And all too often we've seen many, many stories, like Mr. Melville's, of cancer patients who get into treatment only then to discover what the real limits of their plans are.

And we—that's one of the many reasons why we're supportive of the Affordable Care Act. We need to move away from that system. We need much more transparency and accountability, sure, as we've discussed, but also we need the essential benefits package, because we need to provide adequate healthcare, one that fully provides all the necessary services to treat a serious medical condition like cancer. Clearly, mini-meds can't do that, and won't be able to do that.

We also have to recognize the economic competitive pressures that exist today that result in consumers and employers and insur-

ers providing mini-meds. We have to move away from that. And fortunately, the Affordable Care Act does—takes a huge step in doing that. It begins to provide an alternative mechanism for providing insurance, meaning the health exchange. It's defining adequate healthcare for the first time ever in this country. And we're providing subsidies that are necessary to help people, like Mr. Melville and others who work at McDonald's, who don't have the means to buy—pay the full cost of what is fully affordable.

Clearly, health insurance is, first and foremost, important to us as individuals, but it is also very important to us as a society. If we want to continue to grow and be productive in—we need good health. And we, in the United States, have some of the finest medical facilities, finest providers, finest scientists in the world, but we do a terrible job of providing that—translating that care to real service for all Americans like Mr. Melville. It's got to stop. And fortunately, the Affordable Care Act takes a lot of huge steps to restructuring the system so that the—people like Mr. Melville, in the future, won't have the problems that he faces.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you.

Aaron Smith, I just wanted to add one thing. I do a lot of talking, in West Virginia, to youth groups, and—at universities, colleges, et cetera—and I always come right at them at what they least like about healthcare reform, and that is that we say that it's mandatory that people have health insurance. And if you don't do it, we're going to fine you. Well, that goes against the spirit of everything.

But, having said that, there's an enormously powerful reason for that, because if young people and people who don't have health insurance, just as people who buy automobiles pay automobile insurance and never complain a whit—health insurance—they haven't had to, therefore they complain about it. But, why do we do that? We do that so we can enlarge the risk pool so that more people are paying into the health insurance market and, therefore, premiums for individuals who do have health insurance won't go up to the extent—forget medical loss ratio for the moment, but they won't go up to the extent that they are now, because so many—fewer people are paying for so many who don't have health insurance and go to the emergency room and, therefore, they do that.

And it's interesting. Young people, more so than others, tend to understand that, because they tend to understand that their sense of, sort of, sickness invincibility really isn't there, and that their chances are better than others, but that doesn't mean if they—that they get in trouble—they're not going to get into real trouble.

Mr. SMITH. You're right, Senator. In fact, most of the polls show that young people support healthcare reform, and even support the mandate, more than almost any other age group.

And one thing I would just add to your statement is that the problems that young people have in the healthcare system are pervasive. I was uninsured after I graduated from college. Many—so many young people are. It's incredible. And so, when you talk about the challenges that we face in an economy where it's hard to find a job and where it's hard to get—certainly find a job with benefits—I think it's very easy for young people to understand that moving to a system where I might have to buy insurance, but I'm

also going to have more options—I'm going to have subsidies to buy insurance; I'm going to have an expanded Medicaid program and an exchange that makes things more competitive—I think it's a good sell. And young people get it.

The CHAIRMAN. Thank you.

Anybody else? Final thoughts.

Yes, sir.

Mr. FLOERSCH. You know, I think part of what, you know, we also see is just a couple decades of inflation, healthcare inflation, that have been at, you know, very high levels—you know, 6, 10 percent. You know, we've seen it at McDonald's, as well. And our hope is that—with the healthcare reform, that there'll be as much attention on trying to bring down some of the costs. Because I do believe that when the costs start to come down, or flatten out, I think some of these affordability issues, and access, will actually work hand-in-hand, Mr. Chairman.

The CHAIRMAN. I thank you all for coming.

I haven't looked at the clock, because, to me, this has been very interesting, very compelling. And this is a very American kind of hearing, where you have differences of view.

Mr. Melville, get well.

Mr. MELVILLE. Thank you, Senator. I really appreciate your holding this hearing. And I really like Washington, D.C. I——

[Laughter.]

The CHAIRMAN. Don't stay on the Hill long. You'll change your view.

[Laughter.]

Mr. MELVILLE.—I'm going back to Bunk Hill.

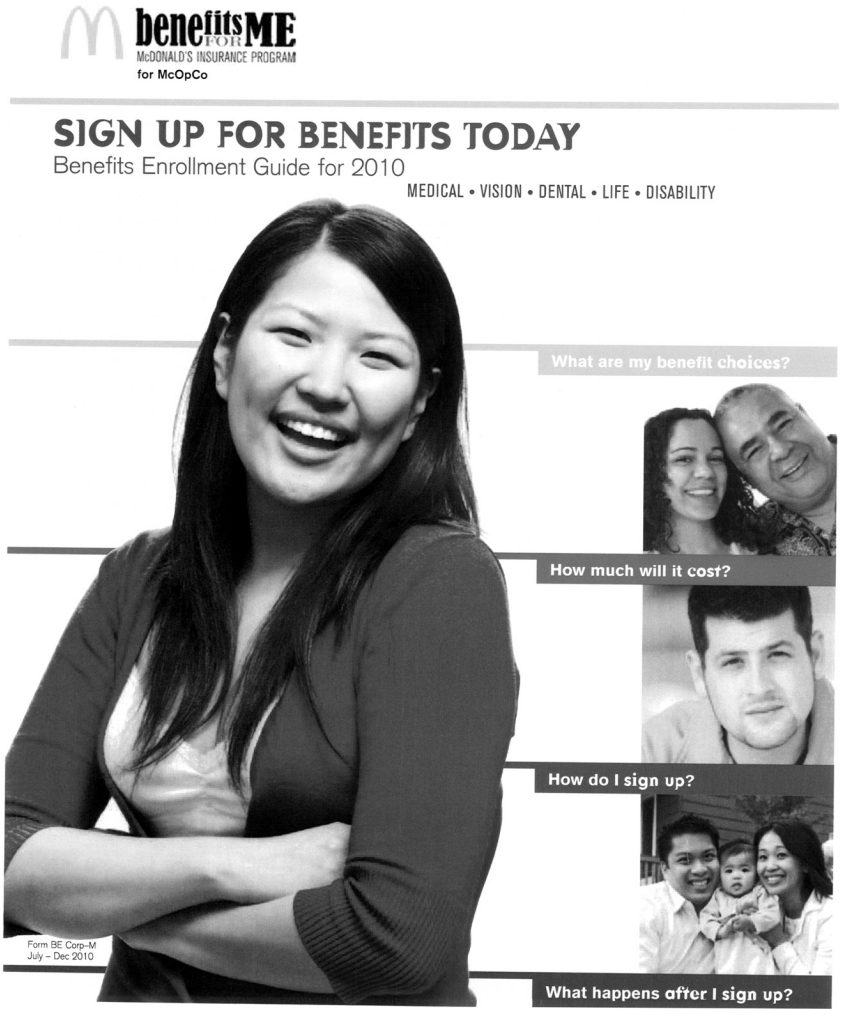
The CHAIRMAN. Yes. You're right. You're right.

This hearing is adjourned.

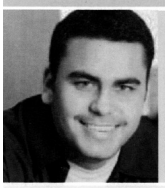
I thank you.

[Whereupon, at 4:30 p.m., the hearing was adjourned.]

A P P E N D I X


benefits FOR ME
McDONALD'S INSURANCE PROGRAM
for McOpCo
SIGN UP FOR BENEFITS TODAY
Benefits Enrollment Guide for 2010
MEDICAL • VISION • DENTAL • LIFE • DISABILITY
What are my benefit choices?
How much will it cost?
How do I sign up?
What happens after I sign up?
Form BE Corp-M
July – Dec 2010

What are my choices?



THE McDONALD'S INSURANCE PROGRAM (MIP) FOR McOpCo INCLUDES MEDICAL, VISION, DENTAL, TERM LIFE, SHORT-TERM DISABILITY...

Pick one or more of the benefit plans you see in this guide, whatever is right for you.

Why have insurance? Because it...

Helpful Terms to Know

Throughout this guide, important words will be shown in ***bold italic text*** when they first appear. Definitions and descriptions of these words can be found in the Terms to Know box on page 7.

What You Need to Know About the Plan Year

The ***plan year*** for your insurance will be shorter than usual this year. **After the end of this year (December 31, 2010), all plan limits and deductibles will be reset.** Beginning next year, the plan year will be January 1 through December 31.

Can help pay for care when you need it: If you are sick or injured, or have a cavity, medical and dental insurance can help you pay for treatment from a doctor or dentist, which saves you money.

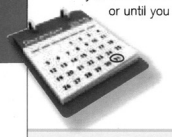
Protects the health of you and your family: A yearly medical, dental or vision checkup can help you stay healthy by catching minor problems before they become more serious or prevent them from occurring in the first place.

Supports you and your family: If you can't work due to an off-the-job accident or illness, insurance can provide you access to the care you need to recover as well as provide some income for you and your family while you are out of work. You can also provide your family a benefit in the event of your death.

Saves you money: Using doctors, hospitals and other providers in the network can save you as much as 30% on the cost of your care.

Who is eligible?

If you are an **hourly paid employee of a McDonald's McOpCo restaurant, you are eligible to sign up for one or more of the benefits described in this guide.** For employees new to McDonald's, after you meet the **30-day** new hire waiting period, you have 45 days to choose your benefits. If you don't enroll within 45 days, you will have to wait until the next enrollment period or until you have a qualifying life event.



What is a qualifying life event?

A qualifying life event is defined as a change in your statu due to one of the following:

- Marriage*
- Loss or gain of insurance coverage by your spouse*
- Birth or adoption of a child(ren)*
- Divorce*
- Loss of Medicaid coverage**
- Eligibility for premium assistance under a Medicaid or SCHIP plan**

*You have 30 days from the date of the qualifying life event to enroll

**You have 60 days from the date of the qualifying life event to enroll

This limited health benefits plan does not provide comprehensive medical coverage. It is a basic or limited benefits policy and is not intended to cover all medical expenses.

MEDICAL BENEFITS

Do you take any medication that requires a prescription? Do you need to see a doctor about a health concern? Want to know if you're actually healthy?

Medical insurance helps pay for the care you need when you're sick, injured or have an ongoing medical condition. And if you're not sick, medical insurance can help you stay healthy by offering checkups through the wellness benefit.

What You Get in the Basic, Mid 5 and Mid 10 Plans

Each plan offers a different level of coverage — so the higher the maximum benefit, the more the plan will pay when you need medical care.

Basic Plan	Mid 5 Plan	Mid 10 Plan
$2,000 maximum benefit	$5,000 maximum benefit	$10,000 maximum benefit

Less coverage ● ——— ● More coverage

Here's how medical insurance works:

1 **You pay the co-pay** for a doctor's office visit, convenient and urgent care clinic visits and prescriptions. Once you pay the ***co-pay***, the insurance will pay the rest of the expenses up to the plan year maximum benefit.

OR

You pay the ***deductible*** for the plan year before the medical plan begins to pay for many services. Each dependent you sign up will have his or her own deductible. Deductible amounts will start over at the beginning of each plan year.

2 **Once your deductible is met,** the insurance begins to pay a portion of the total costs (***co-insurance***) for those services that required a deductible up to the ***plan year maximum benefit***.

3 **Benefits stop when the plan year maximum benefit is reached.** Every time you get some kind of medical care, the insurance company keeps track of the actual cost of that service. For example, if you go to the doctor, you may only pay $20, but the real cost could be $150. So the difference between these amounts ($130) is the benefit you received from the plan; it's the amount the insurance company pays.

These costs add up to a plan year maximum benefit (the most the plan will pay for services during the plan year). Once you reach your plan year maximum benefit, your insurance will not pay any additional charges for the remainder of that plan year. However, you will still receive network discounts even after you've reached your maximum plan year benefit. Each covered dependent will have his or her own maximum to reach.

The Mid 5 and Mid 10 Plans have an outpatient plan year maximum where your ***outpatient expenses***, like a doctor's office visit or filling a prescription, count toward your outpatient plan year maximum benefit.

Basic, Mid 5 and Mid 10 Plans

These three plans differ in the plan year maximum benefit and the plan year deductible to help you make the best choice.

	Basic	Mid 5	Mid 10
Plan Year Maximum Benefit	$2,000 per person	$5,000 per person (up to $1,500 for outpatient services)	$10,000 per person (up to $2,000 for outpatient services)
Plan Year Deductible (you pay this once each plan year)	$150 per person	Inpatient: $150 per person Outpatient: $150 per person	Inpatient: $150 per person Outpatient: $150 per person

Get Your Checkup and Stay Healthy!*

The key to staying healthy is stopping health problems from getting too serious or preventing them from occurring in the first place. Conditions like diabetes and high cholesterol can lead to more serious illnesses like heart disease, so it's important to look for signs early on.

Here are some easy ways you can stay healthy and save money by having medical insurance:

For **$20**...	For **$10**...	For **$5**...	For **$0**...
you can go to the doctor and receive a checkup*	visit a Convenience Care Clinic*	fill your prescription with a generic drug*	speak to a nurse about a health concern

* Subject to policy benefit limits.

	You Pay	Plan Pays (up to the plan year maximum benefit)
Primary Care Office Visits (doctor charges, labs and diagnostics are included in your co-pay)	$20 co-pay	100% of the remaining balance
Specialist Office Visits (doctor charges are included in your co-pay)	$20 co-pay	100% of the remaining balance
Convenience Care Clinic Visits (Minute Clinic, Redi Clinic, The Little Clinic, Take Care Health and Fast Care Clinic)	$10 co-pay	100% of the remaining balance
Wellness Benefit (checkup)	$20 co-pay	100%, up to $250
Diagnostic and Surgical Services (including labs and diagnostics done in a Specialty Provider's Office)	30% after deductible	70%
Emergency Room (for Emergencies)	30% after deductible	70%
Emergency Room (for Non-Emergencies)	$250 deductible per visit and 50% of charges	50%
Inpatient Hospital Services	30% after deductible	70%
Prescription Drugs	Generic drugs: $5 co-pay Brand-name drugs: $50 co-pay	100% of the remaining balance

Some important things to know about your deductibles and maximums:

Basic Plan: Your plan year deductible applies to all inpatient and some outpatient services. Where a co-pay applies, you do not need to meet a deductible. For all other services, you need to meet the $150 deductible first and then the plan pays a percentage of remaining allowable charges up to the plan year maximum benefit.

Mid 5 and Mid 10 Plans: You have separate $150 deductibles for inpatient and outpatient services. Certain outpatient services like doctor visits require a co-pay but no deductible. For all other outpatient services, and for all inpatient hospital services, you must first pay the plan year deductible, and then the plan will pay 70%, up to the plan year maximum benefit.

High Plan

The High Plan is a self-insured plan administered by BlueCross BlueShield of Illinois (BCBSIL). Unlike the Basic, Mid 5 and Mid 10 Plans, the High Plan does not have a plan year maximum benefit, so there's no limit on how much the plan will pay. BCBSIL will provide enrollees with a High Plan ID card.

Plan Year Maximum Benefit	No maximum
Plan Year Deductible	$500 per person / $1,000 family maximum
Out-of-Pocket Maximum	$4,000 per person / $8,000 per family
Eligible Dependents	In addition to your family members, you may also be able to sign up an eligible Domestic Partner* in this plan. Contact the McDonald's Insurance Program Support Center for more information.

	You Pay	Plan Pays
Doctor Office Visits	20% after deductible	80%
Diagnostic and Surgical Services	20% after deductible	80%
Emergency Room (for Emergency and Non-Emergency)	20% after deductible	80%
Inpatient Hospital Services	20% after deductible	80%
Prescription Drugs	25% of cost	75% of cost

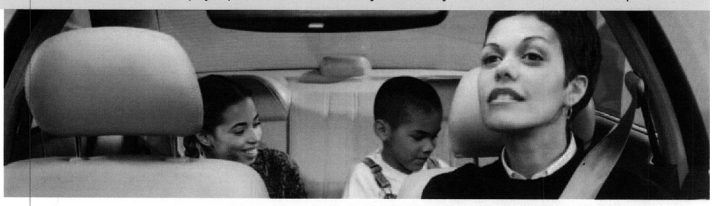
* If you work in Connecticut, Massachusetts or Missouri, due to federal tax rules the portion of your premium that covers your Domestic Partner must be made on an after-tax basis and you will have imputed income on the amount that McDonald's pays toward your premium.

For more information about the High Plan, you can request a Summary Plan Description (SPD) through the McDonald's Insurance Program Support Center or contact BCBSIL at 1-800-734-8254 or visit www.bcbsil.com/med.

VISION BENEFITS

Do you need new glasses? Want to switch to contact lenses? Do you or a family member need to get your eyes checked?

The vision plan, through EyeMed Vision, helps you get an eye exam for just a small fee — especially if you go to an in-network provider. If you or a family member needs new glasses, your vision insurance will pay a portion of the cost so you can buy them at a more affordable price.



What You Get	In-Network		Out-of-Network	
	You Pay	Plan Pays	You Pay	Plan Pays
Eye Exam Including Dilation (once every 12 months)	$10 co-pay	100%	100% of cost, less $35 discount	$35
Standard Contact Lens Fit and Follow-up (once every 12 months)	$55 or the actual cost of lens fit and follow-up, whichever is less	$0	100% of cost	$0
Frames (once every 24 months)	80% of the cost after $110 allowance from the plan	$110 plus 20% of the remaining cost	100% of cost, less $55 discount	$55
Standard Plastic Lenses (once every 12 months)*				
Single Vision	$25 co-pay	100%	100% of cost, less $25 discount	$25
Bifocal Vision	$25 co-pay	100%	100% of cost, less $40 discount	$40
Trifocal Vision	$25 co-pay	100%	100% of cost, less $55 discount	$55
Contact Lenses (materials only)*				
Conventional Lenses	85% of the cost after $110 allowance from the plan	$110 plus 15% of the remaining cost	100% of cost, less $88 discount	$88
Disposable Lenses	100% of the cost after $110 allowance from the plan	$110	100% of cost, less $88 discount	$88
Medically Necessary	$0	100%	100% of cost, less $200 discount	$200

*This benefit applies to either contact lenses or a pair of glasses

To find an in-network eye doctor near you contact EyeMed at 1-866-723-0513 or visit www.eyemedvisioncare.com.

DENTAL BENEFITS

Do you need to have a dental procedure? How do you know your teeth are healthy? Have you had your teeth cleaned lately?

The dental plan lets you see any licensed dentist of your choice and pays a portion of the cost for exams, cleanings, X-rays and dental procedures (like crowns and bridges).

What You Get

Plan Year Maximum	$750 per person
Plan Year Deductible	$50 per person (you pay this once during the plan year)

	You Pay	Plan Pays
Class A (Preventive Care) — exams, cleanings and X-rays	20% (no waiting period)	80% (after deductible and up to plan year maximum)
Class B (Minor Procedures) — fillings, oral surgery, repair of crowns, repair of bridges and repair of dentures	40% (after three-month waiting period)	60% (after deductible and up to plan year maximum)
Class C (Major Procedures) — crowns, bridges and dentures	50% (after six-month waiting period)	50% (after deductible and up to plan year maximum)

TERM LIFE BENEFITS

Do you want your family to be taken care of in the event of your death?

With the life and accidental death benefit, you can provide your family with a benefit of up to $40,000.

What You Get

With the term life benefit, you are covered for any cause of death.* You can sign up for yourself or yourself and your eligible dependents.

Coverage for You	Coverage for Your Dependents
Your beneficiary would receive: • **$40,000** if you die in an accident covered by the plan • **$20,000** if your death is not because of a covered accident	You would receive: • **$2,500** if your spouse dies • **$2,500** if your child age 6 months to 24 years dies • **$500** if your child under 6 months dies

* See Exclusions and Limitations on pages 12 and 13.

SHORT-TERM DISABILITY BENEFITS*

Do you want to be able to provide for your family when you can't work?

If you become sick or injured in an off-the-job accident, this benefit provides some income while you are disabled.

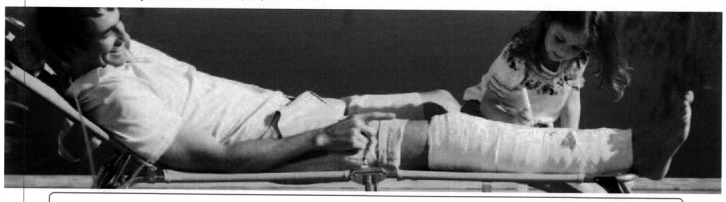
What You Get

You can receive 50% of your base pay — up to $150 a week — for 26 weeks when you are disabled.

You must meet certain requirements for disability in order to receive benefits. Here's a look at what's covered and what's not covered.

You can get disability benefits:	You will not be eligible for disability benefits:
• When you have been unable to work for 14 days in a row • If you are hospitalized, beginning the first day you are admitted to the hospital • For pre-existing conditions if you are enrolled in this benefit for at least 12 consecutive months • If you become pregnant after enrolling in this benefit	• For a disability related to a pre-existing condition (an illness that you were treated for within six months prior to your enrollment date) • If you were being treated for pregnancy at the time you enrolled in this benefit Please see pages 12 and 13 for a list of all Exclusions and Limitations.

* Short-term disability is not available in CA, NJ, NY and RI.



Terms to Know

Co-pay – The amount you pay for each doctor office visit or for each prescription filled at a pharmacy (except in the High Plan).

Co-insurance – The percent you pay for medical services after you have paid the deductible.

Deductible – The amount you pay each plan year before the plan pays for medical services when a co-pay doesn't apply.

Doctor Visit – Services provided in a doctor's office for an injury, illness or wellness visit.

Inpatient Expenses – Services that result from a hospital stay of at least one day of room and board charges. These expenses count toward your plan year maximum benefit in the Basic, Mid 5 and Mid 10 Plans.

Outpatient Expenses – Services you receive without being admitted to a hospital, like a doctor's office visit or filling a prescription. These expenses count toward your outpatient plan year maximum benefit in the Mid 5 and Mid 10 Plans.

Out-of-Pocket Maximum – In the High Plan, this is the most you will have to pay in the plan year for covered health care services, other than your premiums.

Plan Year – The six-month period from July 1, 2010 – December 31, 2010, and each following 12-month period in which you are signed up for the plan.

Plan Year Maximum Benefit – The most you can receive in benefits from the Basic, Mid 5 and Mid 10 Plans during the plan year.

How much will it cost?

Each plan has a different price tag. The charts in this section show how much will come out of your paycheck for the benefit(s) you pick.

Medical

Basic, Mid 5 and Mid 10 Plans

		Weekly Paycheck			Bi-Weekly Paycheck			Semi-Monthly Paycheck		
		Employee only	Employee +1	Family	Employee only	Employee +1	Family	Employee only	Employee +1	Family
Basic	Employees with less than 1 year of service	$13.09	$30.07	$47.01	$26.18	$60.14	$94.02	$28.35	$65.14	$101.84
	Employees with at least 1 year of service	$10.79	$27.77	$44.71	$21.58	$55.54	$89.42	$23.35	$60.14	$96.84
Mid 5	Employees with less than 1 year of service	$24.43	$54.97	$85.49	$48.86	$109.94	$170.98	$52.92	$119.09	$185.21
	Employees with at least 1 year of service	$22.13	$52.67	$83.19	$44.26	$105.34	$166.38	$47.92	$114.09	$180.21
Mid 10	Employees with less than 1 year of service	$35.76	$79.96	$124.13	$71.52	$159.92	$248.26	$77.46	$173.23	$268.93
	Employees with at least 1 year of service	$33.46	$77.66	$121.83	$66.92	$155.32	$243.66	$72.46	$168.23	$263.93

High Plan

Crew employees with less than 1 year of service	$115.44	$221.59	$304.19	$230.88	$443.19	$608.39	$250.11	$480.10	$659.07
Crew employees with at least 1 year of service	$113.14	$219.29	$301.89	$226.28	$438.59	$603.79	$245.11	$475.10	$654.07
Floor supervisors with less than 6 months in the role and less than 1 year of service	$115.44	$221.59	$304.19	$230.88	$443.19	$608.39	$250.11	$480.10	$659.07
Floor supervisors with less than 6 months in the role but at least 1 year of service	$113.14	$219.29	$301.89	$226.28	$438.59	$603.79	$245.11	$475.10	$654.07
Floor supervisors with at least 6 months in the role	$39.28	$145.43	$228.03	$78.56	$290.87	$456.07	$85.11	$315.10	$494.07

Vision

$1.91	$3.30	$4.62	$3.82	$6.60	$9.24	$4.14	$7.15	$10.01

Dental

$5.26	$10.52	$17.35	$10.52	$21.04	$34.70	$11.40	$22.79	$37.59

Term Life

$1.93	$2.37	$2.37	$3.86	$4.74	$4.74	$4.18	$5.14	$5.14

Short-Term Disability

Weekly Paycheck		Bi-Weekly Paycheck		Semi-Monthly Paycheck	
Under Age 65	Age 65 and older	Under Age 65	Age 65 and older	Under Age 65	Age 65 and older
$5.15	$10.30	$10.30	$20.60	$11.16	$22.32

How do I sign up?

When you know what plans you want, follow the easy steps described here to sign up for your benefits.

Now it's time to make your choices.

Using the price tag charts on page 8 as a guide, write down the cost of your benefit choices here:

Benefit Plan I Want	Coverage Level* (Who I Want to Sign Up)			Cost (What Will Come Out of My Paycheck Each Pay Period)
Medical				
☐ **Basic**	☐ Employee only	☐ Employee +1	☐ Family	$☐☐☐.☐☐
☐ **Mid 5**				
☐ **Mid 10**				
☐ **High Plan**				
☐ **Vision**	☐ Employee only	☐ Employee +1	☐ Family	$ ☐☐.☐☐
☐ **Dental**	☐ Employee only	☐ Employee +1	☐ Family	$ ☐☐.☐☐
☐ **Term Life**	☐ Employee only	☐ Employee +1	☐ Family	$ ☐.☐☐
☐ **Short-Term Disability**	☐ Under Age 65		☐ Age 65 and older	$ ☐☐.☐☐
			My Total Cost:	$☐☐☐.☐☐

*If you sign up your dependent(s) for any benefit, you must sign them up for all benefits you choose for yourself.

Who Can I Cover Under My Insurance?

You can cover eligible family members in the medical, vision, dental and/or term life plans. Your eligible family members (dependents) are:

- Your spouse
- Your domestic partner (medical High Plan only)
- Your unmarried children
  - Under age 26* (all plans except medical High Plan)
  - Under age 19 or under age 26 and a full-time student at an accredited school or college** (medical High Plan only)

*Under age 30 for certain military veterans who are Illinois residents. Call the McDonald's Insurance Program Support Center at 1-888-645-6410 for details.

**Some states allow you to enroll your dependents over age 19 whether they are in school or not. Please contact the McDonald's Insurance Program Support Center at 1-888-645-6410 to see if this applies to you.

When you sign up, you will need some important information about yourself, your dependents and your store. Use this chart to write down these names and numbers.

Remember to be careful with this personal information. Please appropriately discard this sensitive material after you enroll.

Your Information

National Store Number — look for this on the Open Enrollment Poster in the crew room ☐☐☐☐☐

Personal PIN Code — the numbers 135 followed by your month and year of birth (for someone born in February 1980, this would be: 135021980) **135**☐☐☐☐☐☐

Social Security Number — leave out dashes ☐☐☐ ☐☐☐ ☐☐☐☐

Dependents (if you are enrolling any family members)

Full name_____ **Relationship**_____

Social Security Number ☐☐☐-☐☐-☐☐☐☐ **Date of Birth** ☐☐/☐☐/☐☐☐☐

Full name_____ **Relationship**_____

Social Security Number ☐☐☐-☐☐-☐☐☐☐ **Date of Birth** ☐☐/☐☐/☐☐☐☐

Full name_____ **Relationship**_____

Social Security Number ☐☐☐-☐☐-☐☐☐☐ **Date of Birth** ☐☐/☐☐/☐☐☐☐

Beneficiary (for Term Life only, this is the person who will get benefits if you die)

Full name_____ **Relationship**_____

Sign Up for Benefits

Sign Up Online

1. Complete your enrollment worksheet and have it with you before you log on.
2. **Log on to www.essentialcare.com/mcdonalds and enter your National Store Number. You can find this number on the Open Enrollment Poster that is in your crew room.**
3. **Click on the link to the McOpCo enrollment web site.**
4. **Enter your Personal PIN Code and Social Security Number.**
5. Follow the prompts on the screens to make your choices. When you finish, you can log back into the McOpCo enrollment web site to make sure you chose the right benefits.

OR

Sign Up By Phone

1. Complete your enrollment worksheet and have it with you before you call.
2. **Call 1-800-269-7783.**
3. **Listen to the instructions provided by the automated attendant and use your phone keypad to enter in your choices. If you are currently enrolled in MIP for McOpCo, you must re-select those same benefits in order to continue that coverage. If you do not re-select those same benefits they will be terminated.**
4. **Write down the Confirmation Number given to you at the end of the call.**

My Confirmation Number _____

What happens after I sign up?

You have made your benefit choices...now what?

Watch for More Information

Within two weeks of when you sign up, you will receive a packet at your restaurant, with information including:

- Your Benefits ID Card* with your name on it — you'll need this card when you go to the doctor or other providers
- A letter confirming that you have coverage under the insurance plans you chose
- A Summary Plan Description, which provides more detailed information about the benefit plans
- Some other helpful information about the program

If you need care after your benefits become effective, but before you receive your insurance ID card, contact the McDonald's Insurance Program Support Center toll free at 1-888-645-6410. Representatives (including bi-lingual representatives) are available Monday through Friday, from 8:30 a.m. to 8:00 p.m. ET.

If You Need to Cancel Your Insurance During the Year

If your payroll deductions are taken after-tax, you can cancel your benefits at any time. If your payroll deductions are taken before-tax, you will pay for benefits for the year and will only be able to cancel coverage during an enrollment period or when you have a qualifying life event, such as marriage, birth of a child or divorce.

When Your Coverage Ends

Your insurance coverage will continue unless you:

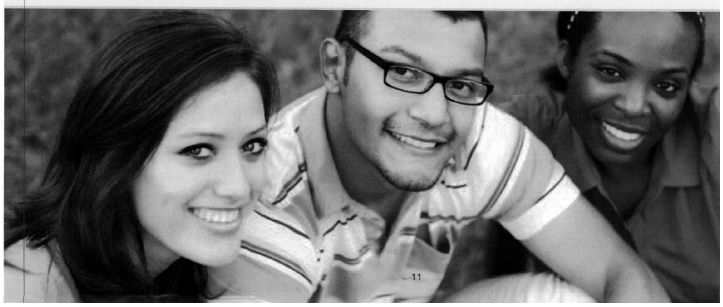
- Cancel your benefits, as described above
- Miss six weeks of payroll deductions in a row and you don't pay these missed premiums directly to the McDonald's Insurance Program Support Center
- If you cancel coverage or miss six weeks of deductions, you must wait for the next enrollment period or experience a qualifying life event to re-enroll

*If you sign up for the High Plan, you will receive your ID card directly from BCBSIL. If you enroll in another medical plan and/or the dental plan, you will receive an ID card with a confirmation letter and SPD. Enrollees in term life and short-term disability will receive a confirmation of coverage and an SPD. For vision coverage, enrollees will receive a separate ID card and information through EyeMed. If you do not receive these documents after three weeks, please contact EyeMed at 1-866-723-0513.

Wait for Your Insurance to Begin

If you are enrolling during the Spring Open Enrollment period: Your benefits will begin during the first pay period that includes July 1, 2010. You will not have coverage before this date unless you are already enrolled in MIP for McOpCo for the current plan year.

If you are a new hire or enrolling outside the Spring Open Enrollment period: Your benefits begin the first day of the payroll cycle for which you have a payroll deduction.



Your Contact List

Find out where to go with questions about...

	Resource	Telephone	Website
For general questions about MIP for McOpCo			
	McDonald's Insurance Program Support Center	1-888-645-6410 Monday through Friday 8:30 a.m. to 8:00 p.m. ET	www.essentialcare.com/mcdonalds
To find a doctor in the Basic, Mid 5 and Mid 10 Plans			
All states with the exception of those listed below	Beech Street Network	1-866-907-3619	www.beechstreet.com
New Hampshire	PHCS Network	1-866-680-7427	www.phcs.com
Delaware, Maine, Minnesota, Mississippi, Maryland, South Dakota, West Virginia	MultiPlan Network	1-888-342-7427	www.multiplan.com
To find a doctor or ask any questions about the High Plan			
	BCBSIL	1-800-734-8254	www.bcbsil.com/mcd
To speak to a nurse about a medical concern			
	Nurse Advisor Line — free service available 24 hours a day	1-866-645-0309	
To find an eye doctor			
	EyeMed Vision Care	1-866-723-0513	www.eyemedvisioncare.com

Exclusions and Limitations

Medical Benefits (Basic, Mid 5 and Mid 10 plans only)

Coverage is not provided for services, supplies or equipment for which a charge is not customarily made in the absence of insurance. No coverage is provided for:

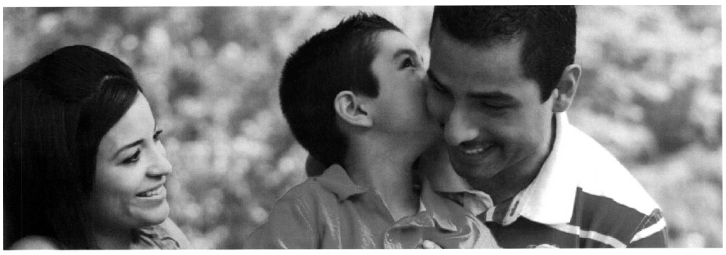
1. Mental or nervous disorders, except for serious mental illness;
2. Outpatient treatment of alcoholism;
3. Substance abuse treatment;
4. Intentionally self-inflicted injuries, suicide or any attempted threat while sane or insane;
5. Loss due to declared or undeclared war or any act thereof;
6. Loss due to a covered person's commission of a felony;
7. Work-related injury or sickness, whether or not benefits are payable under Workers' Compensation or similar law;
8. Eye examinations for glasses; any kind of eye glasses; or prescriptions therefore;
9. Ear examinations, or hearing aids;
10. Dental care or treatment other than the care of sound, natural teeth and gums required on account of injury resulting from an accident while the insured is covered under the Plan, and rendered within six (6) months of the accident;
11. Cosmetic surgery, except cosmetic surgery that a covered person needs for breast reconstruction following a mastectomy or as a result of an accident that happens while covered under the Plan. Cosmetic surgery for an accidental injury must be performed within ninety (90) days of the accident causing the injury and while the person's coverage is in force;
12. Expenses used to meet any deductible, or in excess of the percentages payable, or in excess of those expenses considered usual and customary;
13. Services provided by a member of the covered person's immediate family or services provided by the Employer.

Pre-Existing Information

Expenses for treatment of pre-existing conditions will not be covered under the McDonald's Insurance Program for McOpCo medical plans. The pre-existing condition exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period immediately preceding your enrollment date and shall not apply to any expenses incurred after twelve (12) months of continuous coverage under the policy. The pre-existing condition exclusion period will not apply to pregnancy (regardless of whether the woman had previous coverage) or to a newborn or adopted child under age eighteen (18), or child placed for adoption under age eighteen (18) provided the child became covered under the Plan or other creditable coverage within thirty-one (31) days of birth or adoption (or adoptive placement) and provided they have not incurred a subsequent break in coverage of sixty-three (63) consecutive days or more. The Plan's pre-existing condition exclusion period may be reduced by an equal period of any prior aggregate continuous health coverage (creditable coverage) as long as there is no break in coverage of sixty-three (63) consecutive days or more. Individuals have a right to demonstrate prior health coverage to reduce the Plan's pre-existing condition exclusion period by providing certificates of creditable coverage. You will need to contact your previous health coverage to obtain the appropriate letter of creditable coverage.

High Plan

See your Summary Plan Description for the High Plan, which you will receive after enrolling in the High Plan, for a complete listing of limitations and exclusions.



Vision Benefits

No coverage is provided for:

1. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing;
2. Medical and/or surgical treatment of the eye, eyes, or supporting structures;
3. Service provided as a result of any Worker's Compensation law;
4. Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy;
5. Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the plan;
6. Non-Prescription lenses and non-prescription sunglasses (except for a 20% discount);
7. Services or materials provided by any other group benefit providing for vision care;
8. Two pair of glasses in lieu of bifocals.

Dental Benefits

The exclusions and limitations may vary by state. See your Summary Plan Description, which you will receive after you enroll in benefits, for a complete listing of limitations and exclusions. Many procedures covered under the plan have waiting periods and limitations on how often the plan will pay for them within a certain time frame.

Term Life and Accidental Death Benefits

Term Life benefits are not payable for any loss during the first two years of coverage if death is caused by or results from suicide.

There is no Accidental Death coverage for loss caused by or resulting from:

1. Declared war or act of war;
2. Self-inflicted injury or suicide, while sane or insane; and
3. Loss due to covered person's commission of a felony.

Short-Term Disability Benefits

No benefits are payable under this coverage in the following instances:

1. Attempted suicide or intentionally self-inflicted injury, while sane or insane;
2. The intentional taking of poison; intentional inhalation of gas; intentional taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you or your spouse, your or your spouse's child, sibling or parent; or a person who resides in your home;
3. Declared or undeclared war or act of war;
4. Your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony;
5. Your participation in a riot;
6. If you engage in an illegal occupation;
7. Operating or riding in any aircraft. This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft; and
8. Work-related injury or sickness.

Pre-Existing Information

If the disability is related to a condition for which you received medical treatment, diagnosis, care or advice within 6 months prior to your enrollment date, you will not be eligible for benefits until after you are on the plan for 12 consecutive months.

For employees who live in Connecticut:

THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS FOR THE BASIC, MID 5 AND MID 10 PLANS ARE AS FOLLOWS: $2,000, $5,000, $10,000.

For employees who live in Massachusetts:

The Basic, Mid 5 and Mid 10 plans, alone, **do not meet Minimum Creditable Coverage standards** that are in effect January 1, 2009, as part of the Massachusetts Health Care Reform Law because the health plan imposes an overall annual maximum benefit for covered core services. If you purchase this health plan only, you will not satisfy the statutory requirement that you have health insurance meeting these standards. Contact your employer to determine if it offers other health plan options that meet Minimum Creditable Coverage standards.

If you want to learn about other health plan options available to individuals, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi, or the Connector by calling 1-877-MA-ENROLL or visiting its website at www.mahealthconnector.org. THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2009. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS. **If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.**

The McDonald's Insurance Program for McOpCo Basic, Mid 5 and Mid 10 Medical/Rx, Dental, Term Life, Accidental Death, Short-Term Disability and Vision plans are underwritten by BCS Insurance Company and BCS Life Insurance Company/Oakbrook Terrace, Illinois under Policy Form Numbers 24.220.14, 26.212, 62.200.14 and 62.213(IL). McDonald's Insurance Program is administered by PMI, Columbia, South Carolina.

This brochure is for illustrative purposes only. It is not a contract of insurance. It is intended to provide a general overview of the insurance coverages. Please remember only the insurance policy can give actual terms of coverage. All benefits payable are subject to the definitions, limits, maximums, deductibles, benefit periods and limitations and exclusions of the policy. McDonald's reserves the right to amend or terminate its policies, plans and programs, including the contents of this booklet, at any time without prior notice.

PREPARED STATEMENT OF JANET STOKES TRAUTWEIN, EXECUTIVE VICE PRESIDENT AND CEO, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

The National Association of Health Underwriters (NAHU) is a professional trade association representing more than 100,000 health insurance agents, brokers and employee benefit specialists from all across America. NAHU members help individuals and employers of all sizes purchase health insurance coverage. Every day, they work to obtain insurance for clients who are struggling to balance their desire to purchase high-quality and comprehensive health coverage with the reality of rapidly escalating medical treatment costs. As such, we recognize that limited medical benefit plans, or "mini-med" policies, serve as an important private coverage option in the current health insurance marketplace. I am pleased to submit the following comments for the record for your hearing today entitled, *Are Mini-Med Policies Really Health Insurance?*

It is estimated that more than 2 million Americans currently have coverage under limited medical benefit plans that are not considered to be excepted benefits under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). While the benefits offered by these plans are, by definition, limited, they do provide their beneficiaries with creditable coverage and access to medical services at an affordable price.

Most beneficiaries of limited medical benefit plans receive their coverage through their employers. Licensed health insurance agents and brokers, including NAHU members, help employers design these plans, educate employees about their coverage options under such policies and enroll eligible individuals. Many beneficiaries of group limited medical benefit policies are part-time, seasonal or temporary workers who may be ineligible for their employer's more comprehensive health plan options, or unable to afford such coverage. Others are in a waiting period for an employer's regular health plan. Sometimes an employer who is struggling with the cost of providing coverage to employees elects to offer a limited medical benefit plan as an alternative to dropping coverage altogether.

Limited medical benefit plans are also marketed to individual health insurance consumers by licensed health insurance agents and brokers, including many NAHU members. Individual health insurance consumers are naturally very price-sensitive and, while not the right choice for every customer, sometimes a limited benefit policy is the best match for an individual or family's budget and health insurance needs. Particularly in these trying economic times, a limited benefit policy may be the best and most affordable way for a consumer to ensure continuous and HIPAA-creditable coverage.

When marketing limited benefit policies to employers and individual consumers alike, it is both the role and professional obligation of licensed health insurance producers to explain in detail the scope of benefits covered under these plans. In addition, licensed health insurance agents and brokers must clearly explain any benefit limitations to those individual employees they help enroll in group limited medical benefit plans. NAHU members take their jobs most seriously. And it is the job of a licensed producer to ensure that every client selects the health benefit plan most appropriate for his or her budget and medical needs.

It has come to our attention that there is some concern about a rise in number of limited medical benefit plans being sold through association groups, in particular associations that may have been formed under dubious circumstances with loose membership criteria in order to offer health insurance benefits to "members." These association memberships and corresponding health benefit plans may also be marketed by unlicensed and unscrupulous actors.

NAHU believes that legitimate association plans that are subject to state-based regulation, offered by licensed health insurance carriers and sold by licensed health insurance agents and brokers have their place in today's private health insurance marketplace. However, NAHU has a long history of consumer-protection concern with associations that are formed purely for the purpose of providing health insurance coverage. Furthermore, we firmly believe that all individuals conducting insurance sales or advising consumers about their health insurance options should be licensed, carry errors and omissions insurance and be subject to all state-based insurance regulations, including continuing-education and consumer-protection requirements.

With regard to the Patient Protection and Affordable Care Act (PPACA), it is our understanding that limited medical benefit plans that are not considered to be excepted benefit policies under HIPAA will be subject to the same insurance market reform provisions of PPACA as other more robust individual and group health insurance policies.

Many limited benefit plans are able to be offered on an affordable basis due to their inclusion of annual limits on certain benefits. Due to the constraints PPACA imposes on annual benefit limits and medical loss ratios in all group and individual health plan contracts, NAHU had concerns about the ongoing viability of limited medical benefit plans. It was our fear that the imposition of these requirements, which were crafted for more comprehensive health insurance products, on limited medical benefit plans would unintentionally reduce the overall number of Americans who currently have health insurance coverage until the remainder of the PPACA market reforms and low-income subsidy provisions are fully implemented in 2014. Through recent interim final regulations, the Federal Department of Health and Human Services established a process for limited benefit plans to seek annual limit waivers if necessary and also established modified medical loss ratio calculation for the upcoming year, to preserve these product's place in the market. NAHU is supportive of these efforts to maintain limited benefit plans as a health insurance option for American health care consumers.

NAHU appreciates this opportunity to provide the Commerce, Science and Transportation Committee with comments on limited medical benefit plans. If you have any questions, or would like additional information, please do not hesitate to contact me at either (703) 276–3806 or *jtrautwein@nahu.org*.

PREPARED STATEMENT OF ANGELO I. AMADOR, VICE PRESIDENT—LABOR AND WORKFORCE POLICY, NATIONAL RESTAURANT ASSOCIATION

Chairman Rockefeller, Ranking Member Hutchison, and members of the Committee, on behalf of the National Restaurant Association, I appreciate the opportunity to be able to submit our statement for the record on limited benefit group healthcare policies, also known as "mini-med policies." In particular, I would like to expand on why they are prominent in the restaurant industry, who uses them, and why they should be protected. The National Restaurant Association is the leading business association for the restaurant and food service industry. Our mission is to help our members establish customer loyalty, build rewarding careers, and achieve financial success.

After delving into the main subject of this hearing, *i.e.,* the importance of mini-med policies, I would like to raise some broader issues related to the Patient Protection and Affordable Care Act of 2010 (PPACA) that should be taken into consideration in any health care discussion.

The Restaurant Industry Provides Healthcare Through Diverse Programs, Including Mini-Med Policies, and Needs this Flexibility to Cover a Larger Proportion of its Workforce

Our industry is comprised of 945,000 restaurant and foodservice outlets employing 12.7 million people—one of every 11 workers in the United States. Despite being an industry of predominately small businesses, the restaurant industry is the nation's second-largest private-sector employer. The restaurant and food service industry is unique for several reasons.

First and foremost, small businesses dominate the industry—with more than 7 out of 10 eating and drinking establishments being single-unit operators. Our workforce is also typically young, with nearly half under the age of 25, with a high average workforce turnover rate relative to other industries. In addition, the business model of the restaurant industry produces relatively low profit margins of 4 to 6 percent before taxes, with labor costs being one of the most significant line items for a restaurant.

Finally, restaurants employ a high proportion of part-time, seasonal, and temporary workers. Many of them, together with those workers that are in an eligibility waiting period, are part of the 1.4 million workers nationwide that have mini-med policies because they are ineligible for coverage under the employer's regular group healthcare plan.

In 2014, other options will become available. However, until 2014, these workers would not be able to either take advantage of federal subsidies found in the exchanges or have guaranteed issuance of coverage in the individual market. Thus, in the interim, it is important to continue to be able to offer mini-med policies to make sure a larger number of workers have at least some type of meaningful health insurance. Furthermore, for the many reasons outlined on the second half of my statement on PPACA in general, serious consideration should be given to preserving mini-med policies beyond 2014, in lieu of the mechanism currently established under PPACA.

For all practical purposes, mini-med policies are sometimes the only affordable option for a number of employees and their employers. For example, many low margin restaurants will not be able to remain profitable, if they were to expansively subsidize more generous coverage for large numbers of employees, particularly entry-level, part-time, and short-term employees. At the same time, lower income employees cannot afford—and will not purchase—more extensive and expensive coverage, even when offered by the employer. Mini-med policies help meet the needs of a segment of our workforce, who may not have coverage from other sources, by providing limited coverage and benefits at an affordable cost.

Section 2711(a)(2) of the Public Health Service Act ("PHSA"), as added by PPACA, calls on the Secretary to "ensure that access to needed services is made available with a minimal impact on premiums." The restrictions on annual limits and medical loss ratios being contemplated in some of the PPACA regulations, without a blanket waiver or other proper relief, would infringe both the spirit and the letter of the law. These restrictions would lead many of these mini-med policies to either no longer be offered or be offered with a significant increase in premiums.

Clearly, the regulations seem to acknowledge as much by providing for the Secretary of Health and Human Services (HHS) to establish a waiver program if compliance with the requirements would result in a significant decrease in access to benefits or significant increase in premiums. However, the waivers are not guaranteed.

We are pleased that some of our members have already been able to obtain such waivers on a case-by-case basis to continue offering mini-med policies. Although, it is unclear how many employers did not even attempt to avail themselves of the waiver process, particularly given the difference in the level of resources available to each employer to deal with this new complexity without a clear understanding on the likelihood of success.

The National Restaurant Association continues to believe that it is important to protect the healthcare coverage of workers in mini-med policies until other options become available in 2014. Thus, we continue to recommend that a blanket waiver on annual limit and medical loss ratio restrictions be given to mini-med policies.

Providing a blanket waiver for mini-med policies until 2014 would be in full harmony with both the spirit and the letter of the law by ensuring that access to needed services is made available and with a minimal impact on premiums. These plans currently serve many who do not have other options. If some of these plans were eliminated before 2014, they would leave some of the most vulnerable members of our workforce, and their dependents, with no healthcare coverage at all.

If the administration is unwilling to create a blanket waiver on annual limit and medical loss ratio restrictions for mini-med policies, as now seems likely, Congress may have to intervene. Staying competitive in recruiting and retaining employees is vital to the restaurant industry. Restaurateurs want to continue to provide healthcare coverage to their employees and flexibility is essential to design such coverage to meet the needs of their employees and the business. Current coverage offerings, including the availability of mini-med policies, have been crafted to strike and maintain that balance.

There Are Some More Important Fundamental Problems with PPACA from the Perspective of the Restaurant Industry

The early feedback from our industry on PPACA is not encouraging. So far, PPACA is failing to constrain rising health care and coverage costs, while imposing unsustainable costs and job burdens on the restaurant industry.

The National Restaurant Association actively participated in the Congressional health care reform debate. We, ultimately, opposed passage of PPACA because the law did not address the root of the problem—rising health care costs—while it added additional burdens on both employers and employees. PPACA will have an enormous impact on the U.S. restaurant industry. Employee demographics, distinctively labor intensive business models and a historically low voluntary enrollment rate in health insurance offerings will lead the U.S. restaurant industry to take the brunt of this act.

Our members will be predominantly affected by the burdens found in PPACA in a number of ways. First, the definition of full-time employee adopted by this law as an average of 30 hours per week is vastly different than current practice in the restaurant industry—generally 40 hours per week. This will create confusion and will mean workers' hours will be even more closely managed throughout the industry.

Due to the higher costs, it is entirely rational to expect some employees' work hours to be cut even further to be below the 30 hours per week threshold combined with less hiring of full time employees. Because the restaurant industry is distinc-

tively labor dependent and constrained by thin profit margins, these changes to the business model might be the only way to remain profitable. For front-of-the-house employees, the number of hours worked directly impacts their income. Thus, the changes businesses will make because of PPACA would have another unintended negative consequence that has not fully been taken into consideration. In addition, we fully expect less development and growth for existing restaurants and for some restaurants operating with marginal profits to have to close their doors altogether.

Second, the auto enrollment requirement poses further administrative burdens, due to the high turnover of employees in our industry. The industry has a high average turnover rate relative to other industries—a 75 percent average turnover rate in 2008. This means that employees could be auto-enrolled into a plans' pool and then taken out in a relatively short amount of time, increasing costs.

Finally, the employer-mandate and accompanying penalties effective in 2014 will impose a great burden on employers with 50 or more full-time employees or full-time equivalents who fail to offer qualifying coverage. The penalty is $2,000 per full-time employee (defined as 30 hours or more per week) after the first 30 employees.

Furthermore, a restaurant could provide qualifying coverage to full-time employees and still be penalized for any subsidy recipient full-time employees, if the cost to one full-time employee exceeds 9.5 percent of that employee's household income and the employee receives subsidized coverage. This penalty is $3,000 per subsidy-eligible employee up to a maximum of $2,000 times every full-time employee, after the first 30 employees.

The employment-based exemptions found in PPACA, in addition to placing direct pressure on employers to cut jobs to remain below the exemption level, does nothing to test whether the employer has the ability to absorb the additional costs. Thus, some in our industry are calling for an exemption based on a "profit-per-employee" (PPE) test. The PPE is calculated by dividing a business's net profit by its number of employees. A recent study from the University of Tennessee's Center for Business and Economic Research concluded that PPE would be better than total employment for exempting employers because it is a better proxy for ability to pay.[1] Most restaurants already offer health care options to their employees. However, a PPE based exemption would allow small and low-margin restaurants the flexibility to provide benefits at levels that allow them to remain profitable—helping preserve and create jobs, particularly important in this economic climate.

Since enactment of PPACA, the National Restaurant Association has been attempting to constructively shape the regulations—including those covering minimed policies. Nevertheless, there are limits to the scope of change we can achieve through regulations, particularly if those charged with their drafting choose to ignore the industry's comments. Ultimately, PPACA itself needs to be changed to mitigate the most harmful effects on the restaurant industry.

The National Restaurant Association will continue to be active in urging you to pass major legislative changes to PPACA because some of the fundamental problems cannot be fixed through regulations alone. Our highest priority will continue to be eliminating the employer-mandate penalties.

In the meantime, other important changes are needed to ease the administration of benefits without constraining benefit offerings, including the elimination of the auto-enrollment provision, the expansion of the limits on waiting periods, the modification in the definition of full-time employee, and others. We look forward to working with you on these and other important issues to improve health care for our workers without sacrificing their jobs in the process.

Conclusion

The National Restaurant Association supports the general principles of health reform and our recommendations would help prevent some meaningful coverage from disappearing, due to unintended consequences. We look forward to working with you and your staff as we move forward on our common goal of creating an affordable and reasonable health care system.

PREPARED STATEMENT OF JESSICA LYNN CARROLL, PROFESSIONAL STAGE ACTRESS AND MEMBER, ACTORS EQUITY ASSOCIATION

My name is Jessica Lynn Carroll, and I am a professional stage actress and member of the Actors Equity Association. I also tutor children and teens in math and

[1] Bruce, Donald (Ph.D.), "An Economic Analysis of Business Exemptions from Public Policies," Center for Business and Economic Research, The University of Tennessee, Knoxville, TN, August 2010.

SAT prep when I'm not on stage in order to earn a paycheck. I just turned thirty in August and was recently engaged to be married to a wonderful man. I live in the San Francisco Bay Area, where costs are high and performance opportunities aren't exactly plentiful, but I like to think that I've had a little success in my career, and that encourages me to continue to pursue it, although many of my peers have moved on to more lucrative professions. I am active and in great health. I am slowly but surely paying off my student loans, paying my bills, making ends meet. I feel like I'm a typical American following a dream of artistic and familial fulfillment.

Through a former tutoring job with a now defunct company, I qualified for a low-cost health insurance plan made available to part time workers. This plan, provided by the Strategic Resource Company (SRC), is called Aetna Affordable Health Choices. In exchange for $25 out of my small bi-weekly paycheck, I believed I had basic coverage for my rare visits to the doctor. After the company went out of business, I kept the insurance through COBRA, now paying $72 monthly.

At around 8 p.m. on September 24, 2010, I was sitting with my new fiance, Brandon, watching television and enjoying our time together. Suddenly, something felt dreadfully wrong with my left arm; it felt dead and heavy, as if I could no longer control it. Then the room began to spin, and I felt a wave of nausea wash over me. I was certain I was going to faint. After a few moments, the nausea vanished, but my arm still would not function properly. Earlier that day I had worked out and lifted my five pound weights with ease; now I couldn't even pick up the weight. Brandon was terrified, as was I. He wanted to take me to the emergency room immediately. He was convinced I was having a seizure, while I secretly worried that it was the onset of multiple sclerosis (for which I have no genetic predisposition, as far as I know, but it was truly a frightening feeling that made my crazy mind search for the most remote possibilities). We called an advice nurse, and she was concerned as well. She recommended that I see a doctor right away. I was nervous about going to the emergency room for two reasons. First, I like to stay as far away from needles as possible. Second, and most important, I was a little nervous about my insurance.

Every trip to the doctor for me is a roll of the dice, as far as my insurance coverage goes. Sometimes I have no co-pay. Sometimes it's $10; sometimes it's $15. Sometimes the labs cost nothing. Sometimes I have to pay a nominal amount. Sometimes I receive a bill from the lab only to be told later that I don't have to pay it. When I first paid for my coverage, I scheduled a gynecological appointment. A day later, I was told by my doctor's office that my insurance wouldn't cover it because it was a preventive service. I called SRC, outraged. I asked the representative, "How can you refuse to cover my yearly PAP? Does this mean that even though I pay you guys a premium, I have to go to Planned Parenthood just to get a regular exam?" The representative was a woman; she seemed to understand my feelings. She was helpful, too. She put me on hold, and when she returned, she told me about a website I should visit, making it very clear that she was not the one who had informed me about it. The website explained that because my plan is written in the state of New York, the law requires that my yearly gynecological exam be covered. I printed out the part of the New York law that says as much, and this now lives in my file at my doctor's office. It is incredibly confusing; although my insurance appears to cover preventive visits, I never receive those benefits because my doctor's office is told each time that they aren't covered. This means I have no idea what my cholesterol levels are, or my triglycerides, or all those other numbers I am supposed to know.

So, it is hopefully easy to understand that while I knew emergency room and hospital visits were covered by my plan, I was unsure about how much. Meanwhile, I still had an arm that refused my every command. Finally, my fiancé insisted that we go; to him, any cost was worth making sure that I was okay. How much could it really be, anyway? I finally caved in, and we headed to the emergency room at Good Samaritan Hospital. The emergency room doctor was concerned enough that she ordered a CT scan. Needles abounded. After the CT scan and some blood tests, I was given a clean bill of health, although it appeared that my already diagnosed hypothyroidism had gone haywire again. The doctor told me to schedule an appointment with my regular doctor to have those levels checked. At the end of a very long night, Brandon and I left the hospital at about 1 a.m., feeling confident that I was okay and that we had done the right thing. My regular doctor hypothesized that the episode was the neurological result of inhaling some aerosol bug spray I had used a couple of days prior. He, too, said that I did the right thing in going to the emergency room, as my symptoms had been odd and worrisome.

Flash forward to nearly a month later. I arrived home from tutoring to find Brandon standing in our living room, his face ashen. When I asked him what was wrong, he hugged me, said it was all worth it, and showed me a piece of paper. It was from

Aetna, and it outlined my explanation of benefits. The total charges amounted to $23,283.29. All told, my plan covered precisely $500 for the event, or $250 each day. After that and a PPO discount, my responsibility (with an included co-pay) was a total of $15,565.47. I nearly threw up. In the coming days, I received more explanations of benefits. One for the radiology department totaling $355.56 after a PPO discount. Another for the emergency room physician, costing $401.29 after a PPO discount. It appeared that I owed various medical bills for this one evening to the tune of $16,322.32.

This is money I simply do not have. I have paid every single bill in my life; I have never relied on charity or government support, even when I was eating chili beans because I couldn't afford food. This time, I knew I couldn't take care of this alone. I immediately began to search for help. First, I called Aetna to make sure that this was the correct information. I was assured by the representative that it was all incredibly accurate. She then advised me to go find better insurance. (Fantastic service, I must say.) Then, I contacted the kind people at Good Samaritan Hospital. With the help of Teresa, my financial counselor there, I thankfully qualified for an "underinsured" discount. That bill is now down to $4,358.33. (Funny how that looks like a paltry sum next to $16,000!) I have also applied for further financial aid through Good Samaritan. The physicians' billing company has offered me a 33 percent discount so far; I only hope that they will give me more assistance if I provide my financial hardship application to them, as well. The radiological bill has yet to appear. I fervently hope that it will go the way of the lab bills and magically disappear. As it is, I have no way to contact them, so I'll wait and see. Currently, I owe just under $5,000, which is much better by comparison; however, I still don't have that much money.

The effects of this situation are positive and negative. On the plus side, I'm glad that I contacted Mark Rukavina with The Access Project, who recommended that I tell my story in order to help others in the same situation. I want to help protect other people who purchase part time workers' insurance with the belief that it is full coverage. I feel more educated about my own plan, although there are still many things that I don't understand about it. I feel incredibly motivated to earn enough weeks of acting work to qualify for health insurance through my union. Also, I now know that I shouldn't use anything stronger than Windex as bug spray.

As for the negative consequences, both my fiance and I have been emotionally frayed by the whole ordeal. We sit and talk about which of our belongings we can sell to be able to pay the bills. This is humbling. I consider quitting acting altogether in order to find "real" work, although I still feel that what I do is "real" work, just with more competition. I have put all wedding planning on hold until I know how much I ultimately will have to pay toward medical bills in the end, which is frustrating to our families. I am now completing the daunting task of finding my own health insurance, which will definitely cost more monthly, stretching my budget to its limits, and which I am not even guaranteed to receive in the state of California. I am daily frustrated that I was so close, so close, to paying off my debts, and now I feel like I'm right back in a money pit again. Worst, though, is that I feel deceived. I consider myself to be a savvy consumer. I was led to believe that I had signed up for an insurance plan that covered me as a healthy young person and was something that I could afford on a part time salary. However, I now feel like I was tricked by Aetna Affordable Choices, which has turned out to be incredibly unaffordable in the long run.

NATIONAL RETAIL FEDERATION
Washington, DC, November 30, 2010

Hon. JOHN D. ROCKEFELLER IV,
Chairman,
Senate Committee on Commerce,
Science, and Transportation,
Washington, DC.

Hon. KAY BAILEY HUTCHISON,
Ranking Member,
Senate Committee on Commerce,
Science, and Transportation,
Washington, DC.

Dear Chairman Rockefeller and Ranking Member Hutchison:

I write to comment on tomorrow's hearing (*Are Mini-Med Policies Really Health Insurance?*) on behalf of the National Retail Federation (NRF). NRF's global membership includes retailers of all sizes, formats, and channels of distribution as well as chain restaurants and industry partners from the U.S. and more than 45 countries abroad. In the U.S., NRF represents the breadth and diversity of an industry with more than 1.6 million American companies that employ nearly 25 million workers.

NRF raised early concerns about the effect of the Patient Protection and Affordable Care Act (PPACA) on limited benefit coverage (also known as "mini-med" plans). Such plans sometimes are seen in the retail and restaurant communities, frequently for part-time employees. In our regulatory comment letter of August 27, 2010 (*attached*), we argued for waivers or other protection for limited benefit plans from PPACA's phased-in restrictions on annual benefit limits and from the effect of enhanced medical loss ratio (MLR) standards.

The Obama administration subsequently set up criteria for yearly waivers from application of the annual benefit limit restrictions and created, in cooperation with the National Association of Insurance Commissioners (NAIC), a methodology to help limited benefit plans meet the enhanced MLR standards at least in 2011. We continue to compliment the Obama administration for these appropriate and flexible protections.

If we might suggest, this hearing would be better titled *"Are Mini-Med Policies Really Comprehensive Health Insurance?"* NRF would answer this question negatively: limited benefit coverage is, by definition, far less comprehensive but far more affordable than is comprehensive health insurance. Companies with low profit margins and low-income working Americans are some of the biggest purchasers of this coverage.

Around 1.4 million Americans are covered under limited benefit coverage today. Many—if not most these—would be without affordable alternative private coverage if limited benefit coverage disappeared tomorrow. Some coverage—clearly explained and patiently disclosed to consumers—trumps no coverage every time, at least in our view.

Under PPACA, more affordable and comprehensive alternatives are projected to be available by 2014. In fact, as of 2014 individuals must carry, and companies with more than 50 full-time employees or employee equivalents must provide basic, or bronze level, coverage. In the interim between now and 2014, however, limited benefit coverage fills an important need not readily replaced by the market or hard-pressed state Medicaid rolls. We believe that the Obama administration has taken a wise and appropriate course to safeguard this coverage during the difficult transition to 2014.

NRF remains ready to work with you and other lawmakers toward implementing PPACA as well as any future changes to the law. If you have any questions, please contact Neil Trautwein (202–626–8170/*trautweinn@nrf.com*), NRF's Vice President, Employee Benefits Policy Counsel.

Sincerely,

MALLORY DUNCAN,
Senior Vice President, General Counsel.

ATTACHMENT

NATIONAL RETAIL FEDERATION
Washington, DC, August 27, 2010

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO–9994–IFC
P.O. Box 8016
Baltimore, MD.

Re: *OCIIO–9994–IFC*, Interim Final Rules for Group and Individual Health Plans re Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections

Dear Sir or Madam:

The National Retail Federation (NRF) represents the greater retail industry, employers of one of every five employees in the American economy. As the world's largest retail trade association and the voice of retail worldwide, NRF's global membership includes retailers of all sizes, formats and channels of distribution as well as chain restaurants and industry partners from the U.S. and more than 45 countries abroad. In the U.S., NRF represents the breadth and diversity of an industry with more than 1.6 million American companies that employ nearly 25 million workers.

Our members are strong supporters of employer-based health coverage and thus are vitally interested in the course of reform implementation and its effect on the cost of medical care and coverage. In our view, these interim final regulations addressing market conduct under the heading of patient protections have generally struck an appropriate balance between affected interests. Our comments below seek to clarify or improve upon the existing regulatory framework in the interim final rules in several respects.

NRF also has joined in a separate coalition comment letter (August 26, 2010) with the American Benefits Council, the National Association of Manufacturers and the U.S. Chamber of Commerce. We recognize and appreciate that NRF's comments today will be shared through the electronic portal with the Department of Health and Human Services, the Department of Labor and the Internal Revenue Service of the Department of Treasury.

Annual Limits and Limited Benefit Plans

The Patient Protection and Affordable Care Act (PPACA) and this interim final regulation address both lifetime and annual benefit limits. Lifetime limits are outlawed for plan years beginning after September 2010. Annual limits are phased out between plan years beginning after September 2010 and 2014.

NRF was among several groups that raised concerns about the effect of the phased restrictions on annual benefit limits on existing health coverage, especially limited benefit plans (also sometimes known as "mini-med" plans). Such plans are sometimes seen in the retail and restaurant communities, frequently for part-time employees.

We argued that application of the annual limit restrictions on these plans would remove an important source of health coverage for millions of Americans without recourse to affordable alternatives in advance of 2014. Our allied concerns were clearly heard by the Obama administration, as evidenced by the introduction in the interim final rule of a prospective waiver of the annual limit restrictions before 2014. We commend the administration for taking a flexible approach to this problem. The priority must be on ensuring continuity of existing coverage through a quick and fair waiver process. No one will be helped by the loss of their existing coverage.

NRF is confident that the administration will continue to seek to accelerate subregulatory guidance on the waiver process—particularly in advance of the pending work toward company open seasons for 2011 benefits. Timing is critical to meet this goal. We also urge the Secretary to further exercise her discretion by simultaneously waiving application of medical loss ratio standards to coverage receiving a waiver from application of annual limit restrictions. This is also vitally important to preserve this coverage in the interim period before 2014. Finally, we encourage the administration to extend the waiver or waivers continuously through plan years beginning in 2014 (assuming no substantial changes to the coverage considered under the waiver or waivers) to help ensure the greatest possible continuity of coverage in advance of the landmark changes and premium assistance available beginning in 2014.

Access to Emergency Services

We concur with the objective of improving access to emergency services but urge the administration to take care to ensure that this does not undercut network participation or otherwise substantially increase costs for plan participants. As suggested in our joint employer letter of August 26, 2010, one way to address network incentives might be to allow a cap on out-of-network reimbursement. In addition, we strongly urge you to protect patients by prohibiting balance billing by out-of-network emergency room providers. An out-of-network emergency room door is not really open if a patient will face the prospect of balance bill charges. The capped out-of-network reimbursement really ought to be sufficient for out-of-network emergency room providers.

Pre-existing Condition Exclusions for Children

PPACA and this interim final regulation prohibit pre-existing condition exclusions for children age 19 and younger for plan years beginning after September 2010. All pre-existing condition exclusions are prohibited after 2014. We strongly encourage you to follow the administration's July clarification regarding structured enrollment periods.

PPACA seeks to ensure universal coverage by requiring all individuals to obtain coverage effective in 2014. It is important in the interim between now and 2014 not only to expand coverage for children but also to ensure that coverage is obtained and maintained prior to illness. The old insurance adages that a burning building cannot be freshly insured or that new flood coverage cannot be obtained for a flood-stricken residence hold true here regarding health coverage as well. Structured enrollment is an important accommodation in advance of the individual mandate to obtain coverage in 2014.

Conclusion

Thank you for allowing NRF to comment on the IFR concerning: annual benefit limit restrictions and limited benefit plans; access to emergency services; and the

prohibition on preexisting condition exclusions for children. We look forward to continuing to work with you in the months and years ahead as PPACA phases in.

Sincerely,

E. NEIL TRAUTWEIN,
Vice President,
Employee Benefits Policy Counsel.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. KAY BAILEY HUTCHISON TO AARON SMITH

Question 1. Mr. Smith, in your testimony, you note that less than two-tenths of 1 percent of young adults between the ages of 18 and 30 incur annual health care costs between $50,000 and $100,000. Does this suggest that an insurance policy limited to $100,000 in annual benefits would address the needs of 99.85 percent of young adults?

Answer. Unfortunately, $100,000 of insurance is not adequate coverage for 99.85 percent of young adults—because the point of insurance is to avoid the consequences of getting really sick or injured, and this limit would not address that scenario. It is correct that, according to MEPS data, only .15 percent of young adults exceed $100,000 in medical expenditures. But while young adults do not often collect exorbitant medical expenditures, when they do, they are less able to pay these costs than their older counterparts—at the typical salary range of a young adult, a major car accident could put him or her into a lifetime of debt. That is why health insurance that covers the spectrum of health circumstances is the best option for the health and finances of young adults. Indeed, the low medical expenditure rate does not mean that the healthy cohort were adequately covered with $100,000 benefit caps. It simply means that they were lucky not to get too sick.

We do think that the relatively small number is telling for another reason, though—because it shows that if insurance companies act as true insurance, offering coverage in the case of both typical health necessities and dire health emergencies, that they would financially be able to cover all major medical catastrophes.

Question 2. Your testimony indicates that, with respect to young adults, "raising or eliminating benefit caps has a relatively small impact on premiums." Is this claim based on the comparatively low medical expenses incurred by young adults?

Answer. In a plan such as the mini-meds at issue in this hearing—ones where the plurality of enrollees are young adults—raising or eliminating benefit caps should not have a large impact on premiums. This is because this population incurs relatively few large claims.

Moreover, once all of the basic consumer protections come into place—such as true medical loss ratios and exchanges that provide competition to the marketplace—they will provide further assurances that prohibiting benefit caps will not raise rates significantly. And, given the enormous expansion in Medicaid options and subsidies for this generally low-income age group to purchase insurance, finding affordable coverage will be far easier for the average young adult than it is in the pre-ACA status quo.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. KAY BAILEY HUTCHISON TO RICH FLOERSCH

Question 1. At the hearing, you were asked to comment on a chart comparing the health insurance benefits offered to McDonald's hourly employees and those offered to corporate and management employees. Is there anything more you would like to include in the record regarding the benefits offered to different categories of employees?

Answer. At the December 1, 2010 hearing before the Committee on Commerce, Science and Transportation, McDonald's Executive Vice President for Human Resources Rich Floersch submitted prepared testimony and responded orally to questions from Members. McDonald's refers the Committee to those prepared remarks and Mr. Floersch's responses to questions and strongly stands by those statements. The chart distributed by the Committee at the hearing, however, did not represent a complete comparison of McDonald's plan benefits and premiums. In particular, the "High" comprehensive medical plan that is available to crew at company-owned restaurants was omitted entirely from the chart.

Question 1a. How many hourly workers does McDonald's (to include its franchisees) employ? How many corporate or management employees does McDonald's employ?

Answer. McDonald's and its franchisees operate approximately 14,000 restaurants in the United States. Nearly 12,500 of those restaurants are owned and operated by more than 3,100 independent small business owners—franchisees—throughout the United States. McDonald's USA owns and operates approximately 1,500 restaurants in the United States. The total number of hourly crew (non-management) employees in U.S. company-owned and franchisee restaurants is 573,261. The total number of McDonald's company staff, which includes corporate staff, on U.S. payroll is 4,436. For U.S. company-owned and franchisee restaurants, the total number of *salaried* restaurant management is 30,803 while the total number of *hourly* restaurant management is 108,237.

Question 1b. If McDonald's was required to offer its hourly employees the same health insurance benefits offered to corporate and management employees, what would be the likely effects on your business and your workforce? Do you believe such a requirement would impact the future size of your workforce?

Answer. For crew at company-owned restaurants, nearly 80 percent of which are hourly part-time employees, McDonald's offers four choices for health insurance. Three are low-cost limited-benefit plans and one is a higher-cost comprehensive-medical option. The comprehensive plan provides significantly higher benefit levels, but naturally at a higher premium. For those employees who are making McDonald's a career, including all restaurant managers, assistant managers, certified swing managers, primary maintenance employees and corporate staff, McDonald's offers several comprehensive plans. These plans are designed so that higher-compensated employees are required to pay significantly more in premiums than lower-compensated employees. McDonald's USA could expect a significant impact on its business if it were required to offer identical health insurance to all its employees. It is difficult, however, to quantify that impact and any future business implications of such a requirement given the uncertainties regarding regulatory guidance and in the current and future health insurance marketplace. Moreover, it is also difficult to speculate how such a requirement would impact future business operations and particularly difficult to quantify such an impact on McDonald's workforce.

Question 2. Has McDonald's attempted to calculate the likely costs of compliance with the requirements of the new health care law if it is fully implemented? If so, what has the company determined?

Answer. McDonald's is proud of the benefits it offers to its employees. While McDonald's cannot control the rising cost of health care or dictate what insurance products health insurers are willing to offer, it is committed to making available to its employees, and those of participating franchisees, benefit options that fit their needs. As McDonald's is a system of mostly franchisees who are independent business owners, the impact of the Patient Protection and Affordable Care Act will vary across each franchise organization. Those variables include factors such as the number of full-time employees for each franchise, the marketplace, employees' specific health care elections, and other factors that will not be determined until the regulatory process is complete. However, at this time, based upon rough assumptions and incomplete information, McDonald's has calculated preliminary cost estimates that range from $10,000–$30,000 per restaurant.

Question 3. One criticism of Mini-Med plans is that they spend too little on the delivery of health care, as compared to administrative costs and profits. Yet, your testimony indicates that the medical loss ratios for the limited benefit plans offered to McDonald's hourly employees have ranged from 78 percent to more than 90 percent over the past 5 years, which suggests they may satisfy the medical loss ratio requirements of the new health care law. Can you explain why McDonald's medical loss ratios, or those of your insurer, so closely approach the ratios required by the new law?

Answer. While some have criticized limited benefit plans, McDonald's has worked hard to provide its employees with multiple coverage options at several affordable premium levels. Though details about medical loss ratios are largely questions for insurance carriers, based on data compiled and submitted to the Committee by BCS Insurance Group, the loss ratio for the limited benefit plans offered to McDonald's hourly employees apparently has ranged from a low of 78 percent to a high of 91 percent over the past 5 years, with the most recent year being 86 percent. While these levels appear comparable to the goals established by the recent legislation and while BCS is the most appropriate source of this information, McDonald's is proud that its employees receive high value health insurance benefits which it actively promotes by emphasizing wellness programs, health education and prevention.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. KAY BAILEY HUTCHISON TO TIMOTHY S. JOST

Question 1. Professor Jost, you were recently quoted in a *New York Times* article discussing the medical loss ratio exemption approved by the Department of Health and Human Services (HHS) for limited benefit plans ("U.S. Turns to Waivers to Address Talk of Dropping Health Coverage," *New York Times*, October 7, 2010). Specifically, you were quoted as saying that, if Congress had "wanted to exclude mini-meds, they would have excluded mini-meds." Do you believe that HHS has acted contrary to Congressional intent by fashioning Mini-Med exclusions and waivers?

Answer. The quote to which you refer was specifically in reference to the treatment by NHS of limited benefit policies with respect to the medical loss ratios. It has always been clear to me that prior to 2014 HHS has the discretion under section 2711 of the Public Health Services Act (as added by section 1001 of the Affordable Care Act) to waive on a caseby-case basis the annual limits limitation imposed by the ACA to "ensure that access to needed services is made available with a minimal impact on premiums." I did not, however, believe that HHS had the authority under section 2718 of the Public Health Services Act, added by section 10101 of the ACA, to waive the medical loss ratio requirements of the law with respect to mini-meds.

Section 2718 does, however, allow HHS to "take into account the special circumstances of smaller plans, different types of plans, and newer plans," in establishing methodologies for calculating the medical loss ratios. Pursuant to this authority, HHS has, for example, applied credibility adjustments for calculating the medical loss ratios of small plans and allowed issuers to delay calculating their medical loss ratios when they enter a new market. In its interim final rule of December 1, 2010 on medical loss ratios, HHS did not exclude limited benefit plans from the medical loss ratio rule, but rather created for 1 year a special methodology for calculating their incurred claims and quality improvement expenses. While I do not necessarily agree with this methodology, I believe that it is legal under section 2718. I did not, of course, have the December 1 rule available when I made the statement to Reed Abelson that was quoted in the *New York Times*.

Question 2. You testified that, at least prior to 2014, when additional provisions of the health care law are scheduled to go into effect, "there may be few affordable alternatives available for limited benefit plan enrollees." If implementation of the law is delayed beyond 2014, would you anticipate a need to continue making this affordable insurance available?

Answer. If implementation of the Affordable Care Act is delayed beyond 2014, we will continue to have tens of millions of American who remain uninsured and underinsured. Health care providers, employers, and persons who purchase health insurance will continue to spend billions of dollars covering the costs of uncompensated care provided to Americans who are uninsured and underinsured. Hundreds of thousands of Americans will continue to go through bankruptcy every year because their insurance is not adequate to cover their medical costs.

If however, this is the case, I suppose some people who knowingly purchase insurance that they understand will not begin to cover their needs if they suffer illness or injury may believe that inadequate insurance that covers minor medical bills is better than no insurance, and that they should be allowed this choice. To paraphrase the example of Chairman Rockefeller, I suppose it is better to have brakes that work some of the time than to have no brakes at all. I pray that after January 1, 2014, Americans will no longer be forced to make this choice.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. KAY BAILEY HUTCHISON TO DEVON HERRICK

Question 1. Your testimony seems to suggest that, by moving toward a one-size-fits-all solution to the health care problem, the new health care law may actually threaten the jobs of some workers. Can you elaborate on that point?

Answer. Providing health insurance isn't merely a cost of doing business. Health benefits received at work are part of workers' total compensation package—portion of which is taken as a non-cash "fringe" benefit. Economists generally agree that it's workers themselves who ultimately bear the cost of employee health insurance. Workers pay for coverage with direct contributions, but also as wage reductions, receiving coverage in lieu of greater take-home pay. When the cost of health insurance rises, employers generally try to pass on the increase to workers by requiring more direct contributions or employers slow wage increases to compensate.

Overall, employee compensation approximately equals the added value workers produce. If mandated health insurance boosts the minimum cost to hire a worker higher than what that worker is able to produce, they will be priced out of the labor market.

According to data from the Congressional Budget Office, the estimated minimum benefit package that large firms will be required to provide under the Affordable Care Act is about $4,750 per worker ($12,250 for family plans). That is a minimum health benefit of $2.28 an hour for full-time workers (individual coverage) and $5.89 per hour (family coverage) for full-time employees. When added to the federal minimum wage of $7.25 in 2014, the minimum cost per hour to employ a worker is about $13.14 an hour ($27,331 per year). Young workers just starting out and those who lack job skills may not be able to produce that much value at the margin. Thus, they are at risk of never being hired or even fired.

A well-known economic theorem posits that there is a trade-off between labor and capital. If the price of labor rises, firms will substitute capital. In other words, firms might choose to hire fewer low-skilled workers and substitute a higher ratio of automated machinery requiring fewer workers that possess more skills.

Question 2. You testified that, as compared to the recently enacted health care law, a better way to help moderate income workers afford health coverage would be to provide a uniform tax credit. Could you elaborate on the advantages of such an approach to health insurance reform?

Answer. Right now the federal government primarily uses the tax system to encourage private health insurance, handing out more than $200 billion in tax subsidies every year. The Affordable Care Act leaves this system largely intact. For instance, estimates vary but around 111 million people live in families with annual income that theoretically qualifies them for subsidized coverage in the Exchange. Yet, the Congressional Budget Office assume only about 25 million people will actually get subsidized coverage in the Exchange. This suggests nearly 86 million moderate income Americans will receive a tax subsidy that makes them no better off than under the current system.

Under the current system, every dollar in health insurance premiums paid by an employer is excluded from employee income and payroll taxes. Take an employee in the 25 percent income tax bracket. Throw in state and local income taxes, add the 15.3 percent (FICA) payroll tax, and the tax exclusion for a middle income family is worth almost 50 cents on the dollar.

According to the Lewin Group, a private health care consulting firm, families earning $100,000 a year get four times as much tax relief as families earning $25,000. In other words, the biggest subsidy goes to those who least need it and who probably would have purchased insurance anyway.

Yet a uniform tax credit as Senator McCain, Senator Coburn and Representative Ryan have all proposed, would help moderate income workers afford health coverage regardless of where they receive their health coverage. All health insurance would be sold on a level playing field under the tax law, regardless of how it is purchased. This would allow them to set some of the tax credit aside in a Health Savings Account for later use, or purchase whatever coverage meets their need and fits their budget. The tax credit would likely be sufficient to pay for the core insurance that all families need. Families wishing to have more comprehensive benefits would have to purchase those additional benefits out-of-pocket. This would discourage over-insurance and would encourage families to be more prudent purchasers of insurance and medical services.