

**EXPANDING HEALTH CARE OPTIONS: ALLOWING
AMERICANS TO PURCHASE AFFORDABLE COV-
ERAGE ACROSS STATE LINES**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

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EXPANDING HEALTH CARE OPTIONS: ALLOWING AMERICANS TO PURCHASE AFFORDABLE COVERAGE ACROSS STATE LINES

WEDNESDAY, MAY 25, 2011

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

The subcommittee met, pursuant to call, at 10:05 a.m., in room 2123, Rayburn House Office Building, Hon. Joseph R. Pitts, (chairman of the subcommittee) presiding.

Present: Representatives Pitts, Whitfield, Shimkus, Myrick, Murphy, Blackburn, Gingrey, Latta, McMorris Rodgers, Cassidy, Guthrie, Barton, Upton (ex officio), Pallone, Dingell, Engel, Capps, Schakowsky, Gonzalez, Weiner, Waxman (ex officio), and Green.

Staff Present: Clay Alspach, Counsel, Health; Andy Duberstein, Special Assistant to Chairman Upton; Debbie Keller, Press Secretary; Ryan Long, Chief Counsel, Health; Katie Novaria, Legislative Clerk; John O'Shea, Professional Staff Member, Health; Heidi Stirrup, Health Policy Coordinator; Phil Barnett, Minority Staff Director; Alli Corr, Minority Policy Analyst; Tim Gronniger, Minority Senior Professional Staff Member; Purvee Kempf, Minority Senior Counsel; Karen Lightfoot, Minority Communications Director and Senior Policy Advisor; Karen Nelson, Minority Deputy Committee Staff Director for Health; and Landsay Vidal, Minority Press Secretary.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order. The chair recognizes himself for 5 minutes for an opening statement.

The topic of today's hearing is the purchase of health insurance across state lines. Across state line purchasing of health insurance allows health plans to be portable, to move with an individual from job to job and state to state and gives Americans a wider range of plans from which to choose the one that suits them and their families best. Every state has health insurance mandates; from Idaho with the fewest, 13 mandates, to Rhode Island, topping the list with 69 separate mandates. My home State of Pennsylvania has 57.

Altogether, the Council for Affordable Health Insurance has identified a total of 2,156 mandates across the 50 states and the Dis-

trict of Columbia in 2010. These range from benefit mandates to provider mandates to groups of people who must recover. Each mandate makes the policies sold in that state more comprehensive. However, each mandate also increases the cost of those policies. Most mandates increase the cost of policies by less than 1 percent, which doesn't sound like much, but when a state has 30, 40, or 50 mandates, and some mandates can add 5 percent or even 10 percent more to a policy, you are quickly pricing many people out of the market completely. By some estimates, an average of 30 to 40 mandates can increase a total cost of a policy between 20 and 45 percent.

States have begun to realize that, while well-intentioned, mandating important health benefits provider coverage for their citizens has backfired. At least 12 states now allow mandate-free or mandate-like policies so that people can buy a plan that is more suited to their needs with fewer costly mandates.

Additionally, nearly 30 states now require a cost estimate of a potential mandate before it can be enacted. This should be about consumer choice, not a one-size-fits-all state mandate package that may or may not address a particular individual's needs.

This is about empowering people to make decisions for themselves, not assuming they need the government to protect them for themselves.

If a Pennsylvania policy contained mandated benefits I determined that I did not need or want, why shouldn't I be able to by a policy from New Jersey or New Mexico? Why shouldn't I be able to shop among different states and buy the policy that is at the best price for me, and is the best tailored to my health needs and my situation. Furthermore, why shouldn't I expect that when states and plans have to compete for my business and not take it for granted, that costs will go down and quality will go up.

So with those introductory remarks, I want to thank our witnesses, and I would like to yield the remaining time to the gentlelady from Tennessee, Ms. Blackburn.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The Subcommittee will come to order.

The Chair will recognize himself for an opening statement.

The topic of today's hearing is the purchase of health insurance across state lines.

Across state line purchasing of health insurance allows health plans to be portable—to move with an individual from job to job and state to state—and gives Americans a wider range of plans, from which to choose the one that suits them and their families best.

Every state has health insurance mandates, from Idaho with the fewest—13 mandates—to Rhode Island, topping the list with 69 separate mandates.

My home State of Pennsylvania has 57.

Altogether, the Council for Affordable Health Insurance has identified a total of 2,156 mandates across the 50 states and the District of Columbia in 2010. These range from benefit mandates, to provider mandates, to groups of people who must be covered.

Each mandate makes the policies sold in that state more comprehensive; however, each mandate also increases the cost of those policies.

Most mandates increase the cost of policies by less than 1%, which doesn't sound like much. But, when a state has 30, 40, or 50 mandates—and some mandates can add 5% or even 10% more to a policy—you are quickly pricing many people out of the market completely.

By some estimates, an average of 30 to 40 mandates can increase the total cost of a policy between 20% and 45%.

States have begun to realize that, while well-intentioned, mandating important health benefits and provider coverage for their citizens has backfired.

At least 12 states now allow “mandate-free” or “mandate-lite” policies, so that people can buy a plan that is more suited to their needs, with fewer costly mandates.

Additionally, nearly 30 states now require a cost estimate of a potential mandate before it can be enacted.

This should be about consumer choice, not a one-size-fits-all state mandate package that may or may not address a particular individual’s needs. This is about empowering people to make decisions for themselves, not assuming they need the government to protect them for themselves.

If a Pennsylvania policy contained mandated benefits that I determined I did not need or want, why shouldn’t I be able to buy a policy from New Jersey or New Mexico? Why shouldn’t I be able to shop among different states and buy the policy that is at the best price for me and is the best tailored to my health needs and my situation? Furthermore, why shouldn’t I expect that when states and plans have to compete for my business—and not take it for granted—that costs will go down and quality will go up?

Thank you to our witnesses, and I yield the remaining time to Representative Blackburn.

Mrs. BLACKBURN. Thank you, Mr. Chairman. And I thank you and Chairman Upton for holding the hearing today to discuss what I think is an innovative approach, and of course I believe this is important legislation for us to take up. Thank you to our witnesses for your preparation and your presence here today.

You know, nearly 51 million Americans are lacking health insurance. Eighty-five percent of the uninsured workers cite unaffordability as the top reason for why they are uninsured. There is something we can do about this. The Health Care Choice Act, which is only 31 pages long, will harness market forces to lower the cost of health insurance and reduce the number of uninsured Americans by 12 million without any cost at all to the Federal Government. It is the right-type step.

In 1965 there were only seven state benefit mandates. Today there are over 2,100 mandates on health insurance coverage. These mandates have increased health insurance premiums between 10 and 50 percent for American families. For example, in a high mandate state like New York and Massachusetts, the average family premium is just over \$13,000. Right across the river in a lower mandate state like Pennsylvania, the average is just about \$6,000, which is about the same price as in my home State of Tennessee.

This bill would give consumers the option of buying health insurance that meets their needs and is right for them and their family, even if that means buying a policy that is qualified in another state. And while I may prefer a plan that includes a chiropractor, that choice isn’t going to be right for everyone. So let’s give consumers the choice. As Speaker Hastert used to say, We shouldn’t be forcing people to buy a Cadillac when all they need is a Chevy.

This bill will lower health insurance costs across the country by cutting red tape. Insurance plans won’t have to go through 50 different state certification process. The result will be significant savings, significant savings in the cost.

And it is important to note that this bill will not decrease consumer protection or act as a race to the bottom. As I told President Obama when we did the health care forum at the Blair House, this

bill will let the people out of their states and allow them to choose a product that is good for them.

Thank you, Mr. Chairman, and I yield back the balance of my time.

Mr. PITTS. The Chair thanks the gentlelady.

And I now recognize the ranking member of the subcommittee, Mr. Pallone, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman.

Allowing Americans to purchase insurance coverage across state lines is not a new idea. In fact, it is an idea that has been promoted by Republicans for many years and one that was extensively debated by this committee in 2005. And I think many who sit here today remember those proceedings, so you all know very well that I am strongly opposed to such proposals. But what I am even more opposed to is the way Republicans purport this idea as a proposal that would give consumers choices and access to more affordable health insurance, because the truth is, it does nothing of the sort.

The only choices offered by this proposal are for insurance companies. They are the only ones who gain. It gives the insurance industry the choice to do business in the states that have the most favorable business climate and weakest consumer protections. The result is a complete circumvention and it would end state legislation as we know it.

Now, state regulation and patient protections are vital to protect those who reside in that state from unscrupulous actors. Regulation is needed to protect those who would otherwise have no protection. If H.R. 371, a bill introduced by Representative Blackburn, entitled the "Health Care Choice Act" or any other bill that attempts to allow an insurance company to license their product in one state and sell insurance in another state, if any of those bills were to become law, it would quickly result in a race to the bottom among health insurance plans, a race that would drag down patients in its wake.

H.R. 371 allows insurance companies to choose to operate under laws of states with weaker consumer protection and risk pooling standards. By doing so, plans will be allowed to cherry-pick the best risk, leaving older, sicker individuals isolated in pools without healthier individuals to offset their medical costs. And the result would be insurance markets in disarray, without any real pooling of risk.

Furthermore, state regulators would be unable to provide assistance to individuals in their own states who opt to purchase coverage from a carrier selling under a second state's law. In my home State of New Jersey, we have enacted extensive reforms that go beyond what many other states offer. And thanks to these consumer protections, New Jersey is able to ensure that its residents have access to quality individual insurance products. But in order for New Jersey to guarantee access to this kind of insurance, it must be able to spread risk throughout the market and that means pooling low and high risk together.

If H.R. 371 were enacted, it would completely dismantle New Jersey's existing risk pool. Younger and healthier consumers would flee New Jersey's market in order to obtain cheaper policies that provide less coverage, leaving only high-risk consumers in the market.

Now I don't think we can move back to a system with zero patient protections, putting insurance companies back in charge. This is the very thing that Democrats were trying to reverse when we passed the Affordable Care Act. We don't want to empower insurance companies. So I can't conclude without pointing out that H.R. 371 also reveals the very popular and critical patient bill of rights provisions of the Affordable Care Act. That is no surprise. The insurance companies didn't like those things either because they want to discriminate.

So the protections that would be repealed include, among others, prohibiting gender rating, prohibiting the denial of people and children with preexisting conditions insurance, outlawing rescissions and prohibiting annual and lifetime limits on insurance. These are the antidiscriminatory practices that are already in effect under the health care reform and which my constituents say they very much like. These are all gone, all for the purpose of helping out the insurance companies because the Republicans simply want to be with the big insurance company.

The Affordable Care Act also created state-based health insurance exchanges which would allow other insurance carriers to come into states, thereby increasing competition and lowering premiums. But the stark difference, of course, from the Republicans is that the insurance companies would have to comply with Federal and State mandates for coverage under the Affordable Care Act.

I will also point out that the Affordable Care Act includes a provision known as health care choice compacts that allows insurers to sell insurance across state lines and only be subject to laws in the issuing state, but it includes protections for states and consumers. And, again, the difference: The Affordable Care Act put a decision to allow the insurer to sell across the line in the hands of the state where their product will be sold, not in the hands of insurance companies.

My whole point here is, look, I understand you are talking about selling insurance across state lines; that can be done, but it can't be done in a way that simply gets rid of the state protections, eliminates the risk pools and puts all the choices in the hands of the insurance companies.

That is what you are doing with Ms. Blackburn's bill and others that might be like it. And that is exactly what we don't need. It is not a problem to be able to sell across state lines, it is the patient protections that need to be in place.

Again, I guess this is one case, Mr. Chairman, where the Republicans actually do have a replace plan, but I think that this replace plan is not one that is good for American consumers, and I think it puts the country's health system in a lot of trouble. So thank you for giving me a replace plan, but it is not one that I think we should enact into law.

I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the full committee chairman, Mr. Upton, for 5 minutes.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Thank you, Chairman Pitts, for holding this hearing. Two weeks ago the committee reported out legislation that will help lower health care costs by enacting real medical liability reform. Today we will continue to examine ways that we can replace last year's health care law with commonsense solutions that actually do lower costs.

You heard our side talk about repeal and replace, and I do believe that this is one of those replacement planks and commend my colleague, Mrs. Blackburn, for leading the charge on this issue.

Allowing Americans to purchase coverage across state lines is an idea that has been gaining momentum for good reason. Individuals do use and shop for products every day that are made in other states. Yet, in health care individuals are prohibited from purchasing coverage across state lines.

This policy has major implications for families across the country looking for affordable health care plans. states have imposed over 2,100 benefit mandates on health coverage. Estimates show that these requirements increase premiums anywhere from 10 to 50 percent. Consumers are forced to buy a Cadillac health care plan. They are not even given the option of something that might better fit their needs. As a result, many individuals choose to go without any health care coverage because of the costly mandates. states are realizing benefit mandates are a problem that have to be dealt with. Fifteen states are now considering legislation to allow individuals to purchase coverage across state lines.

Two states with very different political backgrounds, Georgia and Maine, have already recently enacted laws to promote interstate purchase. Even our Democratic colleagues demonstrated that they understood the problem at some level.

Section 1311(d)(3) of PPACA requires states to assume the cost of mandates to make payments to individuals or health care plans to defray the costs of added premiums. I may disagree that this is the best solution, but at least they admitted that we have a problem.

This hearing is about promoting flexibility and reducing cost. It is a stark contrast with PPACA which doubles down on Washington control of health care.

HHS will design the health plan that every American must buy under the threat of a fine from the IRS. Empowering consumers is the key to controlling costs. American families know the value of their dollar. If given the chance, they will demand health plans that provide better quality, lower cost, something the Federal Government has consistently failed to do. The question is: Will Congress and the President give the people the freedom?

I look forward to hearing testimony from today's witnesses and would yield to my friend the chairman emeritus of the full committee, Mr. Barton.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Chairman Pitts, thank you for holding this hearing. Two weeks ago, the committee reported out legislation that will help lower health care costs by enacting real medical liability reform. Today, we will continue to examine ways we can replace last year's health care law with common-sense solutions that actually lower costs. Allowing Americans to purchase coverage across state lines is an idea that has been gaining momentum for good reason. Individuals use and shop for products every day that are made in other states.

Yet in health care, individuals are prohibited from purchasing coverage across state lines. This policy has major implications for families across the country looking for affordable health plans. States have imposed over 2,100 benefit mandates on health coverage. Estimates show that these requirements increase premiums anywhere from 10 to 50 percent.

Consumers are forced to buy a Cadillac health plan; they aren't even given the option of something that better fits their needs. As a result, many individuals choose to go without any health coverage because of these costly mandates.

States are realizing benefit mandates are a problem that must be dealt with. Fifteen states are now considering legislation to allow individuals to purchase coverage across state lines. Two states with very different political backgrounds, Georgia and Maine, have recently enacted laws to promote interstate purchase.

Even my Democrat colleagues demonstrated they understood this problem at some level. Section 1311(d)(3) of PPACA requires states to assume the cost of mandates and make payments to individuals or health plans to defray the cost of added premiums. I may disagree that this is the best solution, but at least they admitted we have a problem.

This hearing is about promoting flexibility and reducing costs. It is a stark contrast with PPACA, which doubles down on Washington control of health care. HHS will design the health plan that every American must buy under the threat of a fine from the IRS.

Empowering consumers is the key to controlling costs. American families know the value of their dollar. If given the chance, they will demand health plans that provide better quality at lower costs—something the federal government has consistently failed to do. The question is, will Congress and the President give the people that freedom? I look forward to hearing testimony from today's witnesses.

Mr. BARTON. Thank you, Chairman Upton.

In a prior Congress we passed a bill very similar to this bill out of committee. It was a priority of then-Speaker Denny Hastert and our former member John Shadegg. There are over 2,000 state mandates in the various states, and the premiums vary from about 5,000 to about 13,000. So it is obvious if you allow plans that are covered in one state, that are approved in one state, to be offered across the state line, it is going to promote competition and should lower costs.

So I am very happy that Chairman Upton and subcommittee Chairman Pitts are holding this hearing, and I would yield the balance of Chairman Upton's time to Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman.

I would just want to add that insurance products aren't bad. In the era of multiple natural disasters, we will see that many people get recovery because of insurance product. They will get recovery for their automobile, they will get recovery of their home. And this attack on a sector that really helps people recover from disasters is always a little frustrating.

All we are trying to say in this debate is those types of policies can be used in the health care industry; it is just some state mandates get in the way of really having a competitive product. I will give you one example. State Senator in my State of Illinois said that the largest increase in a health insurance policy was when the state mandated contraceptive coverage.

Now, should you be forced to buy an individual package that has contraceptive coverage and raise your rate? Many of us would argue, no, you should not. Should there be minimum coverage for things that an insurance commissioner would want to get involved and engaged in and help resolve disputes? Yes.

So I think there is a middle ground here that we could reach, and I will end on saying I do think this is one of many steps that we will have to address the replace aspects of ObamaCare as we move forward.

I yield back the balance of my time.

Mr. PITTS. The chair thanks the gentleman and recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes.

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

Mr. WAXMAN. Mr. Chairman, up until today this committee only acted to repeal provisions of the Affordable Care Act. Today for the first time we see what the replacement is. However, this replacement clearly fails to keep the promises made in the Republican resolution to replace the Affordable Care Act, and it would be a step backward for the American people.

The Republicans promised to increase the number of insured Americans and to lower health care premiums. For people who are sick, where insurance is a lifeline, this proposal of allowing insurance companies to sell their product across state lines does just the opposite.

The Congressional Budget Office analyzed the legislation introduced by Representative Blackburn in 2005 when it was supported by Mr. Shadegg. In its letter, CBO said there would be very little effect on the rate of uninsurance; that this proposal would cause families to lose employer-sponsored insurance; and those needing health care, to lose insurance in the individual market. That is a far cry from the Republican claims that this bill will cover millions of the uninsured. CBO also noted that the bill would increase the price of coverage for those expected to have relatively high health care costs.

How is increasing premiums for the sick, who already spent dollars on health care at the expense of rent and food, a step forward in providing quality health care? This bill basically asked someone with diabetes or breast cancer to pay more or go without health insurance so that someone else can pay less. In other words, they are supposed to buy a lower-priced car. Well, I don't think they are going to be able to buy anything, because they still can be excluded for preexisting conditions.

The goal of the Affordable Care Act is to make affordable coverage available to everyone, sick and healthy alike, not to help one group of people at the expense of another. Let's be clear: states have long had the ability to allow sales of insurance across state lines, but they could control how it happens and when it happens, and the Affordable Care Act affirmed that policy.

Today Maine, Georgia, and Wyoming have passed laws to allow purchasing across state lines. Maine and Wyoming decided to allow this with a limited number of states, but the Federal preemption

of their laws by the Blackburn bill would require they open their borders up to every state in the country.

Numerous other states are debating pending bills and any legislation is merely preempting the states' prerogative to do it their way. That is an amazing thing for the Republicans, who say that states ought to be able to act on their own. All wisdom is not here in Washington. Instead, here in Washington we would tell the states you can't do it your way, you have got to do it our way.

Well, Governor Jan Brewer of Arizona last month vetoed a bill that allowed selling insurance across state lines, saying that this, "provision would change Arizona's benefit requirements based on legislative decisions in other states." She also said she is concerned about other risks to our citizens who may be subject to other states' regulatory procedures that can leave them with little recourse in the event of mistreatment.

The proposal before us today would not allow states to permit the selling of insurance across state lines; it would require it to be done the way the Federal Government insists.

This bill is unlike the Affordable Care Act, which regulates insurance to set a Federal minimum standard but permits states to go further to protect their state's residents.

Republicans claim to support the authority of states to govern themselves as they see fit, but this is not what they stand for when it comes to legislation. The people with breast cancer, diabetes, and newborns, have been guaranteed coverage for their services by most but not all states. So when the Federal Government comes in and preempts those state laws, patients with breast cancer and diabetes may not be able to find insurance that covers their treatments and testing. If it is covered in another state doesn't mean the insurance company is offering a bare-bones package and is going to offer it in every state. We don't mandate the insurance companies to do anything. We only mandate that states allow those insurance companies who think they can make a buck come in and sell it if they are allowed to sell it anywhere else.

Critics claim the state benefit requirement adds as much as 50 percent to health insurance premiums, according—if I might, Mr. Chairman, according to a more impartial source, the National Association of Insurance Commissioners, it was less than 5 percent. This proposal was a bad idea on its own terms as a replacement for the Affordable Care Act. It is disastrous.

Thank you Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman.

I would like again to thank the witnesses for agreeing to appear before the committee this morning. Your willingness to take time out of your busy schedules underscores just how important this issue is to all of you, as it is to all of us.

Our first witness, Mr. Steve Larsen, is the director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services.

Our next witness is Dr. Stephen Parente who is the Minnesota insurance industry professor of health finance and insurance in the Department of Finance in the Carlson School of Management at the University of Minnesota.

Christie Herrera is the director of the American Legislative Exchange Council's Health and Human Services Task Force.

Stephen Finan is the senior director of policy for the American Cancer Society's Cancer Action Network.

And lastly, Dr. Paul Howard is a senior fellow at the Manhattan Institute.

Your written testimony will be entered into the record. We ask you to summarize in 5 minutes, each of you.

STATEMENTS OF STEVE LARSEN, DIRECTOR, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, CENTERS FOR MEDICARE AND MEDICAID SERVICES; STEPHEN PARENTE, PH.D., PROFESSOR OF HEALTH FINANCE, UNIVERSITY OF MINNESOTA; CHRISTIE HERRERA, DIRECTOR, HEALTH AND HUMAN SERVICES TASK FORCE, AMERICAN LEGISLATIVE EXCHANGE COUNCIL; STEPHEN FINAN, SENIOR DIRECTOR OF POLICY, AMERICAN CANCER SOCIETY, CANCER ACTION NETWORK; AND PAUL HOWARD, PH.D., SENIOR FELLOW, MANHATTAN INSTITUTE

Mr. PITTS. Mr. Larsen, you may begin your statement.

STATEMENT OF STEVE LARSEN

Mr. LARSEN. Good morning, Chairman Pitts, Ranking Member Pallone, members of the subcommittee.

Mr. PITTS. Is the mic on?

Mr. LARSEN. Can you hear? OK.

Thanks for the opportunity to appear here today. I have submitted my full testimony for the record. I am pleased to be here and have the opportunity to comment on the issues related to the sale of insurance across state lines.

I know we all share the same goal, of assuring affordable and comprehensive insurance options for individuals and families. And I believe we also agree that healthy competition among private insurers can help drive costs down and provide more consumer choice. But in our view, the Affordable Care Act accomplishes these goals in the best possible way.

First, in 2014, state exchanges will foster competition among insurers by having insurers compete on the basis of price and quality rather than on their ability to underwrite those who need insurance the most: people with preexisting health conditions.

The Affordable Care Act also creates transparency, a key component of a healthy competitive market. state health insurance exchanges provide transparency to consumers who can make apples-to-apples comparisons of coverage options and allow people to understand in plain English what they are buying and how it will protect their families.

The Affordable Care Act ensures that consumers get the benefit of a core set of consumer protections, protections that are critical to a well-functioning market. In 2014 insurers will be barred from denying coverage on the basis of health status and consumers will have high-quality coverage.

The Affordable Care Act also provides key protections and benefits that have already taken effect, such as the prohibition on rescissions and bans on lifetime limits on insurance coverage. We

also expanded access to care for young people by providing coverage for dependents up to age 26 on their parents' policies, a benefit to over 600,000 young adults already.

In addition to the provisions of the Affordable Care Act, many states also have basic consumer protections, including reasonable rating bands or corridors, and restrictions on underwriting. These ensure that people with medical conditions are not excluded from insurance coverage.

Many states also have laws to ensure consumers have access to an adequate network of specialists and other health care providers, and many have mechanisms to deal with complaints consumers might have in dealing with their insurance company. The Affordable Care Act allows consumers to continue utilizing the staff of these state insurance commissioners when they have issues, concerns, or questions.

Speaking from my firsthand experience as a state insurance commissioner for 6 years and also director of CCIIO, the proposition of allowing interstate sales of insurance in a way that eliminates or overrides a state's own authority to protect or assist insurance consumers in their market is, while well-intentioned, a step backward in the effort to provide accessible, affordable, and fair health insurance coverage to all citizens.

Allowing insurers to pick the state they want to be regulated in provides the insurers the choice of which state laws they have to comply with. Insurers can then issue policies with fewer benefits or protections in other states that otherwise would not allow such policies. The laws of the issuing state become a ceiling or a cap for other states. This will likely lead to cherry-picking of healthy groups and individuals. And we know from experience that when we segregate risk pools by selectively selling policies with thinner or fewer benefits, we drive premiums up for the rest of the population. state insurance regulators, legislators, and governors would be powerless to try and fix this, because they would have no jurisdiction over these policies.

In addition, proposals that preempt state insurance laws in one state with those of another leave consumers at a disadvantage. state insurance regulators often provide key consumer assistance to residents of their states. The state regulators were no longer able to provide these services to purchasers of interstate policies. Consumers in one part of the country would be dependent on the time and resources of a state regulator thousands of miles away. It is likely many consumer complaints or problems would be unaddressed.

Insurers can already sell insurance across state lines so long as they comply with state laws. Many companies today operate and provide insurance in multiple states.

In summary, the Affordable Care Act has increased consumer protections and will lead to more affordable comprehensive insurance options. Interstate sales where the laws of one state preempt those of another would leave many consumers with less affordable coverage and no one to turn to if any needed help navigating the market. Thank you.

Mr. PITTS. The chair thanks the gentleman.

[The prepared statement of Mr. Larsen follows:]

STATEMENT OF

STEVEN B. LARSEN

DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT,
CENTERS FOR MEDICARE & MEDICAID SERVICES

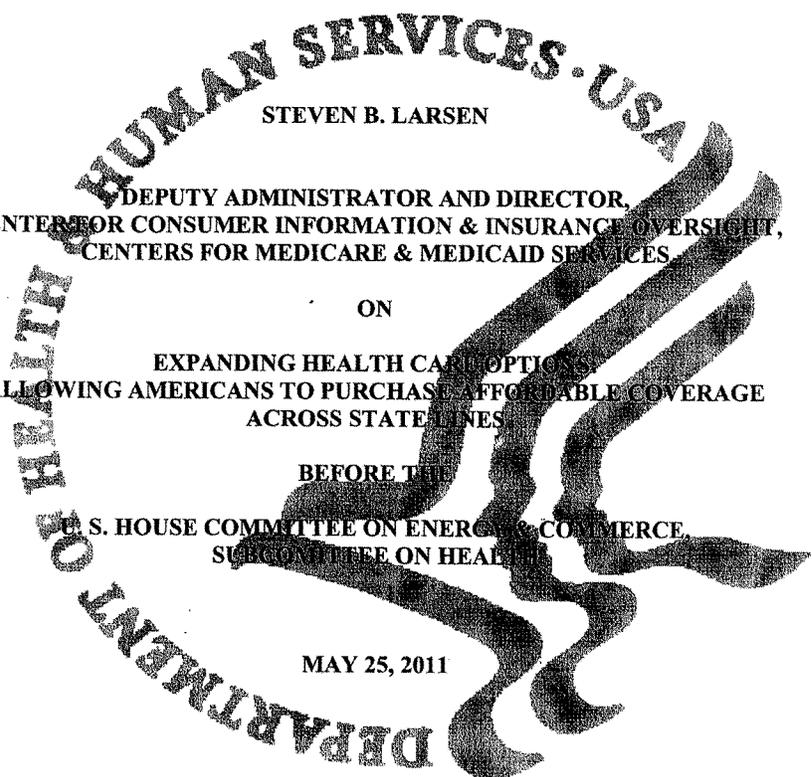
ON

EXPANDING HEALTH CARE OPTIONS
ALLOWING AMERICANS TO PURCHASE AFFORDABLE COVERAGE
ACROSS STATE LINES

BEFORE THE

U. S. HOUSE COMMITTEE ON ENERGY & COMMERCE,
SUBCOMMITTEE ON HEALTH

MAY 25, 2011



House Committee on Energy & Commerce
Subcommittee on Health
Hearing on “Expanding Health Care Options:
Allowing Americans to Purchase Affordable Coverage Across State Lines”
May 25, 2011

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee, thank you for the opportunity to discuss important health insurance reforms that promote choice, affordability, and options for American families. The Patient Protection and Affordable Care Act (P.L.111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), collectively referred to as the Affordable Care Act, ushered in a new era in American health care. The Affordable Care Act improves America’s private health insurance system by instituting reforms that will help make affordable, high-quality insurance coverage accessible to millions of Americans, many of whom were not insured at the time of its passage.

As a former insurance commissioner, these issues are particularly important to me. For the past 14 months, my office, the Center for Consumer Information & Insurance Oversight (CCIIO) within the Centers for Medicare & Medicaid Services (CMS), has been steadily working to implement provisions of the Affordable Care Act that expand access to affordable coverage to millions of Americans, strengthen consumer protections, and help to end some of the worst insurance company abuses. These reforms create an important foundation of patients’ rights in the private health insurance market, increase choices and options for families, and put Americans back in charge of their own health care. To date, we have already implemented several important private market reforms, including: eliminating pre-existing condition exclusions for children; prohibiting insurance companies from rescinding coverage and imposing lifetime dollar limits on coverage; and enabling many adult children to stay on their parent’s insurance plan up to age 26.

The Affordable Care Act also established new programs that make health care more affordable and accessible, such as the Pre-Existing Condition Insurance Plan (PCIP) program and the Early Retiree Reinsurance Program, as a bridge to 2014 when all Americans will have access to

affordable coverage choices. With the Affordable Care Act, our country is finally moving away from the broken health insurance system of the past to a new system that insures more Americans at more affordable rates with more benefits and protections. Because of the new protections and provisions in the law, many insurers will no longer be able to discriminate against the sick, limit coverage, and profit at the expense of America's families.

Selling Insurance Across State Lines

Thanks to the Affordable Care Act, today, Americans have many more health care choices. In 2014, State-based health insurance Exchanges will be in place, providing more options and better value for consumers and small businesses. Health insurance Exchanges, market reforms, and other policies contained in the Affordable Care Act create a health insurance market where health plans will have to compete on price and quality by providing consumers with easy-to-understand choices.

Selling insurance across State lines has long been proposed as an option to increase competition and choices in health insurance, but there are serious pitfalls with this approach when it is not coupled with adequate consumer protections. The Affordable Care Act allows health care to be sold across State lines when both States agree and consumer protections are maintained. Without the consumer protections included in the Affordable Care Act, we run the risk of creating an environment where there is a "race to the bottom" in which insurers have an incentive to sell plans from the State with fewest consumer protections. Under section 1333, by July 1, 2013, the Secretary of HHS, in consultation with the National Association of Insurance Commissioners (NAIC), will issue regulations for the creation of health care choice compacts. Under these compacts, two or more States may agree to allow qualified health plans to sell insurance in their States. Plans will be subject to the laws and regulations of the State in which the plan was written or issued. Additionally, these plans must offer the same required by the consumer's State. Health care choice compacts are effective beginning January 1, 2016. These provisions ensure that interstate sale of health insurance is not a back-door attempt to disadvantage higher-risk individuals or preempt critical consumer protections.

Ensuring Coverage for More Americans

The Affordable Care Act ensures that more Americans have health insurance coverage through programs that are already helping young adults and people with chronic health problems receive the coverage they need. As a result of the Affordable Care Act, most insurance companies now must allow adult children to stay on a parent's plan until age 26 and may not deny children health insurance benefits or coverage because of a health problem. CCIIO has already implemented the Pre-Existing Conditions Insurance Plan (PCIP) program, which makes health coverage available to uninsured Americans who have been without coverage for over six months and have a pre-existing condition - providing a bridge to 2014 when affordable coverage options will be widely available without discrimination. Thousands of Americans who had been turned away by insurers because of their health history are now getting critical treatments and medicines thanks to PCIP.

Between February 1, 2011 and April 1, 2011, enrollment in PCIP has increased by nearly 50 percent, with over 18,000 individuals currently receiving coverage under this important program.¹ The PCIP program has provided invaluable help to people like Jerry Garner. Mr. Garner, a real estate agent from Gowen, Michigan who the *New York Times* recently featured, lost his health insurance after undergoing a kidney transplant. Because of his pre-existing condition, he was unable to obtain new insurance to cover the \$2,000 monthly bills for the immunosuppressive medications that transplant patients must take to prevent rejection of a new organ. Mr. Garner signed up for Michigan's PCIP program and is now paying lower premiums than he did under his previous insurance and is receiving more comprehensive coverage. Mr. Garner's wife told the *New York Times* that the PCIP program "was definitely an answered prayer."²

Before the passage of the Affordable Care Act, many young adults who were enrolled in college or starting in the workforce in entry-level jobs could not maintain coverage under their parent's

¹ "State by State Enrollment in the Pre-Existing Condition Insurance Plan, as of March 31, 2011." Link [here](#).

² Walecia Konrad, "Pre-existing Condition? Now, a Health Policy May Not Be Impossible." [The New York Times](#), March 18, 2011, link [here](#).

health plan. Young adults are more than twice as likely to be uninsured than older adults, making it harder for them to get the health care they need, and putting them at risk of going into debt from high medical bills. Now, thanks to the Affordable Care Act, most health plans that cover children must make coverage available to adult children up to age 26. Alexander Lataille, 23, of Laurel, Maryland is one of many young adults who have benefited from this provision. Alexander graduated from college last spring and was worried his insurance company would kick him off his parent's plan, especially since he has asthma. As a result of the Affordable Care Act, his insurance company allowed him to stay enrolled in his parent's plan, giving him peace of mind while he looked for full-time employment. "It was a big relief," Mr. Lataille told *Kaiser Health News*.³ Because of the Affordable Care Act, over 600,000 young adults⁴ have already signed up for their parent's health plan; we estimate that a total of 1.24 million young adults will gain coverage through this provision in 2011.

In the future, more people will obtain coverage or more comprehensive benefits or realize lower health insurance premiums because of the critical protections of the Affordable Care Act. The Congressional Budget Office estimates that by 2019, 24 million people will gain insurance coverage through the new health insurance Exchanges.⁵ These Exchanges will create affordable, quality insurance options for many Americans who previously did not have health insurance coverage, had inadequate coverage, or were at risk of losing the coverage they had. The Exchanges will make purchasing private health coverage easier by providing eligible consumers and small businesses with "one-stop-shopping" to compare and select from a range of affordable plans.

Additional Consumer Protections and Resources

The Affordable Care Act gives millions of Americans important new health insurance protections. The Affordable Care Act also prohibits most insurers from discriminating against

³ Phil Galewitz, "At Least 600,000 Young Adults Join Parents' Health Plans Under New Law." *Kaiser Health News*, May 3, 2011, link [here](#).

⁴ Phil Galewitz, "At Least 600,000 Young Adults Join Parents' Health Plans Under New Law." *Kaiser Health News*, May 3, 2011, link [here](#).

⁵ CBO's March 2011 Baseline: Health Insurance Exchanges. Link, [here](#).

patients with health conditions like cancer and diabetes. About one in 12 Americans suffer from diabetes,⁶ and nearly one in 25 Americans has cancer.⁷ The Affordable Care Act helps ensure these Americans have access to care. Before passage of the Affordable Care Act, tens of thousands of people were denied insurance each year because of an illness or condition. Today, most plans cannot deny coverage to children because of a pre-existing condition. Up to 72,000 uninsured children are expected to gain coverage through this provision.⁸ In 2014, most insurance companies cannot discriminate against someone because of a pre-existing condition.

We have also prohibited insurance company rescissions, so most insurers can no longer cancel coverage when individuals get sick just because they made a mistake with their application paperwork. We have put an end to lifetime dollar limits on essential benefits – limits that in the past often meant coverage was gone when people needed it most. Patients in non-grandfathered health plans now have greater freedom to choose their own doctor and to go to the nearest emergency room when they are injured or face a life-threatening health situation. By 2014, annual dollar limits on essential benefits will also mostly be a thing of the past. Americans are already benefiting from new rules that require coverage of preventive services; important early detection services like mammograms and colonoscopies must now be available to Americans in new plans without expensive co-pays or deductibles.

Consumers today have unprecedented access to critically important information about insurance options and public programs available to them on a geographic basis. During the past several months, www.HealthCare.gov has had millions of visitors and the information housed in this on-line tool continues to grow rapidly. Visitors can get easy-to-understand information in English and Spanish about the coverage options available to them, their protections, and their rights as health care consumers.

⁶ “Data from the 2011 National Diabetes Fact Sheet.” January 26, 2011, link [here](#).

⁷ “Cancer Prevalence: How Many People Have Cancer?” October 7, 2010, link [here](#).

⁸ “Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patients Protections.” (OCIIO-9994-IFC), link [here](#).

Affordable Coverage for All Americans

The Affordable Care Act makes coverage more affordable by holding insurers accountable for the premiums they charge consumers and helping employers maintain or offer health benefits. Significant health insurance premium hikes proposed by insurers will be publicly available on the internet and will be subject to a review. States will receive \$250 million in grants to bolster their own rate review process. For the first time, insurers will be held accountable for how premium dollars are spent. The new medical loss ratio (MLR) protections implemented last year ensure that insurers spend at least 80 or 85 percent (depending on the market) of premium dollars on actual health care services and quality improvement efforts - not marketing and CEO bonuses. Insurance companies that do not meet the standard will have two choices: reduce premiums or send cash rebates to their customers. Recognizing State flexibility, the law allows for a temporary adjustment to the individual market MLR standard if a State requests it and demonstrates that the 80 percent MLR standard may destabilize its individual insurance market. We are already seeing indications that the MLR and rate review policies are causing insurance companies to think twice about their premium increases and, in some cases, mitigate annual premium hikes. For example, more than 15,000 Aetna customers in Connecticut may see their health insurance premiums drop by between five and 19.5 percent due to, in part, the new MLR policy.⁹

The Affordable Care Act also provides new programs and tax credits to assist employers that offer health benefits to their workers. More than 5,000 businesses, State and local governments, and employee trusts are participating in a new program under the Affordable Care Act¹⁰ that helps employers retain retiree coverage for Americans 55 to 64 years of age. Also, more than 4 million small businesses have been notified that they may be eligible for tax relief to help provide insurance coverage to their workers.¹¹

⁹ Arielle Levin Becker, "As Federal Health Reforms Take Effect, Aetna Proposes Rate Cuts." The Connecticut Mirror. May 11, 2011, link, [here](#).

¹⁰ Progress Report on the Early Retiree Reinsurance Program, March 31, 2011. Link, [here](#).

¹¹ White House Fact Sheet: Small Business Health Care Tax Credit. April 1, 2010. Link, [here](#).

Americans will see additional savings from the health insurance Exchanges that begin by 2014. Beginning in 2014, State-based health insurance Exchanges will improve access to affordable, quality insurance options for Americans who previously had no health insurance coverage or inadequate coverage. The Exchanges will make purchasing private health insurance coverage easier by providing individuals, families, and small businesses with “one-stop shopping” where they will be able to compare a range of plans. Eligible individuals will also have new premium tax credits and cost-sharing reductions available to them to make coverage more affordable. By increasing competition between insurance companies and allowing individuals and small businesses to band together to purchase insurance, Exchanges will help to lower health care costs for consumers.

Moving Forward

Through new coverage options and consumer protections, the Affordable Care Act has already improved America’s health care system for millions of Americans. And every day we move forward to full implementation of the law, when all Americans will have access to quality, affordable health insurance free of restrictions due to pre-existing conditions or benefit caps. In the meantime, I look forward to continuing to implement provisions of the Affordable Care Act, while considering stakeholders’ ideas and input.

Mr. PITTS. Dr. Parente, you are recognized for 5 minutes for your statement.

STATEMENT OF STEPHEN PARENTE

Mr. PARENTE. Thank you, Congressman Pitts and members of the committee, for this opportunity to speak to you today. My name is Steve Parente. I hold the Minnesota Insurance Industry Chair in health finance at the University of Minnesota. I am there to serve as a professor in the finance department as well as running a medical industry MBA program.

My areas of expertise are health economics, health insurance, and medical technology evaluation. Most recently I and my colleagues Roger Feldman, Jean Abraham, and Wendy Xu at Minnesota completed a study on the impact of allowing consumers to purchase health insurance across state lines. This peer-reviewed study was accepted for publication last winter and is forthcoming in the *Journal of Risk and Insurance*.

And on a side note, I must say that the deliberations of this committee 5 years ago were the inspiration for that publication. I have provided a copy of that publication with my remarks for your consideration.

In this study we find evidence of a significant opportunity to reduce the number of uninsured under a proposal to allow the purchase of individual health insurance across state lines, using three different policy scenarios.

First, the best scenario to reduce the uninsured numerically is competition among all 50 states where one or more states emerge as dominant players. This scenario would yield a reduction in the uninsured by 8.1 million people.

With all due respect to Congressman Waxman, insurers don't like this because it puts them at civil war with each other. That is one reason this has not moved forward. This idea is not without precedent outside health care delivery, where Delaware has become the most favored state for incorporating a firm.

Second, the most pragmatic scenario with a good impact is one state dominating each regional market. In this case the uninsured will be reduced by 7.4 million. This is a compromise, since the U.S. health insurance industry is only at halfway national, through national employers contracting with insurers through ERISA. This could provide a practical more politically palatable approach to getting coverage.

Third, the five largest states scenario is the least effective policy for increasing the number of insured people. This is likely due to the fact that only one state of the five, Texas, has a combined regulatory burden that is less than the 50 percentile of all states. The estimated reduction from the five large state scenario is 4.4 million individuals.

It is important to note that these reductions in the uninsured could be achieved without the premium subsidies or Medicaid expansion policies prescribed in ACA. In the paper we did model the impact of combining interstate purchase of insurance with subsidies for private insurance, and found additional reductions in the uninsured were possible, in many cases doubling the reductions, albeit this could happen at considerable cost, though.

The changes we found also took into consideration the different market prices between communities for medical care. For example, cost of living for nurses in Manhattan are higher than those living in Missouri. These differences were factored out.

As a result, the impact is almost entirely due to the differences in the regulatory burden and mandates between the states. In one of the most telling illustrations, we found premium quotes for the same family, from the same insurance company, for the same insurance benefit, to be twice as expensive in a Jersey town, Lambertville, compared to New Hope, Pennsylvania. These two towns are separated by a quarter mile of Delaware River, but their citizens are likely to use many of the same doctors and hospitals.

It is understood that policy simulation simplify many political barriers, but the opportunity costs of not allowing interstate sales might motivate the development of legislative contractual agreements to provide regulatory powers between primary and secondary states. This could be consistent with the exchange policy as well. Of course adequate disclosure to consumers of the primary and secondary states' obligations would be paramount for this to work.

One possible outcome is that consumers who buy insurance in one state but live in another could have two insurance regulators looking out for them rather than just one. This would address a substantial concern that de-mandating the market could leave consumers without adequate consumer protection. At the same time, with the effect of mandates on premiums substantially reduces the probability that someone would buy insurance. One must ask, which is the worst outcome; lack of coverage for a given service, or no coverage at all due to higher premiums from mandates?

Although we modeled the personal level impact of a national market on coverage, we are unable to assess the impact of such a migration on provider access as well as quality. Nevertheless, a national market could lead to substantially more health insurance, even those with chronic conditions and preexisting conditions. In addition, the development of a national market requires no additional Federal resources, other than the support for the legislation, to permit the development of such a change.

In closing I hope these new findings will be considered by the Congressional Budget Office if and when this topic is considered formally. CBO frequently uses peer-reviewed studies as a basis for policy impact. I hope this new study will be considered and that any opportunity with such potential to reduce the uninsured gets serious consideration amidst the fiscal constraints that can handicap so many of the other coming health reforms to be implemented under the Affordable Care Act in 2014. Thank you.

Mr. PITTS. The chair thanks the gentleman.

[The prepared statement of Mr. Parente follows:]

Oral Testimony
U.S. House of Representatives
Committee on Energy & Commerce
Subcommittee on Health Hearing
Wednesday, May 25th

Stephen T. Parente, Ph.D., M.P.H., M.S.
University of Minnesota

Thank you, Congressman Pitts and members of the Committee, for this opportunity to speak to you today.

My name is Steve Parente. I hold the Minnesota Insurance Industry Chair in Health Finance at the University of Minnesota. There, I serve as professor in the Finance Department at the Carlson School of Management and Director of the Medical Industry Leadership Institute, a growing MBA program. My areas of expertise are health insurance, health information technology and medical technology evaluation. I also have an appointment at the Johns Hopkins University School of Public Health.

Most recently, I and my colleagues Roger Feldman, Jean Abraham and Wendy Xu at Minnesota completed a study on the impact of allowing consumers to purchase health insurance across state lines. This peer reviewed study was accepted for publication last winter and is forthcoming in the *Journal of Risk and*

*Insurance*¹. I have provided a copy of the final pre-released publication with these remarks for your consideration.

In this study, we find evidence of a significant opportunity to reduce the number of uninsured under a proposal to allow the purchase of individual health insurance across state lines using three different policy scenarios.

The best scenario to reduce the uninsured, numerically, is competition among all 50 states where one or more states emerge as dominant players. This scenario would yield a reduction in the uninsured by 8.1 million people. This idea is not without precedent outside the health care industry, where Delaware has become the most favored state for incorporating a firm.

The most pragmatic scenario, with a good impact, is one state dominating each regional market. In this case, the uninsured would be reduced by 7.4 million. This is a compromise, since the U.S. health insurance industry is only 'half-way' national (through national employers contracting with insurers that offer national provider panels), and this could provide a practical, more politically palatable approach.

¹ Parente, S., Feldman, R., Abraham, J.M., and Xu, Wendy. "Consumer Response to a National Marketplace for Individual Insurance". *Journal of Risk and Insurance*, Forthcoming.

Finally, the 'five large state' scenario is the least effective policy for increasing the number of insured people. This is likely due to the fact that only one state of the five, Texas, has a combined regulatory burden that is less than the 50th percentile of all states. The estimated reduction in uninsured from the 5 large state scenario is 4.4 million individuals.

It is important to note that these reductions in uninsured would be achieved without the premium subsidies or Medicaid expansion policies proposed in the Patient Protection and Affordable Care Act - ACA. In the paper, we did model the impact of combining interstate purchase of insurance with subsidies for private insurance and found additional reductions in the uninsured were possible – albeit at considerably greater federal cost.

The changes we found also took into consideration the different market prices between communities for medical care. For example, the cost of living for nurses in Manhattan is higher than for those living in Missouri. These differences were factored out. As a result, the impact is almost entirely due to differences in regulatory burden and mandates between the states. In one of the most telling illustrations, we found premium quotes for the same family from the same insurance company for the same insurance benefit to be more than twice as expensive in a New Jersey town, Lambertville, compared to New Hope,

Pennsylvania. These two towns are separated by ¼ mile of Delaware River, but their citizens are likely to use many of the same medical providers.

It is understood that policy simulations simplify many political barriers. But the opportunity cost of not allowing interstate sales might motivate the development of legislated or contractual agreements to divide regulatory powers between primary and secondary states. Of course, adequate disclosure to consumers of the primary and secondary states' obligations will be paramount for this to work.

One possible outcome is that consumers who buy insurance in one state, but live in another, could have two insurance regulators looking out for them rather than just one. This would address a substantial concern that 'de-mandating' the market could leave consumers without adequate protection. At the same time, if the effect of mandates on premiums substantially reduces the probability that someone would buy insurance, one must ask: which is the worse outcome, lack of coverage for a given service or no coverage at all due to higher premiums?

Although we have modeled the person-level impact of a national market on coverage, we are unable to assess the impact of such a migration on provider access or quality of care. Nevertheless, a national market would lead to substantially more health insurance coverage, which should improve access to

health care among the vulnerable populations who currently find health insurance unaffordable. In addition, development of a national market requires no additional federal resources other than support for legislation to permit the development of such a change. Finally, the development of interstate health insurance purchase can be harmonized with state based exchanges resulting from the ACA – but the exchanges, as currently legislated, are not a necessary condition for interstate purchase.

In closing, I hope these new findings will be considered by the Congressional Budget Office if and when this topic is considered formally as legislation. CBO frequently uses peer-reviewed studies as the basis for policy impact. I hope this new study will be considered and that any opportunity with such potential to reduce the uninsured gets serious consideration amidst the fiscal constraints that can handicap so many of the other coming health reforms to be implemented under ACA in 2014.

Mr. PITTS. I recognize Ms. Herrera for 5 minutes for an opening statement.

STATEMENT OF CHRISTIE HERRERA

Ms. HERRERA. Thank you, Mr. Chairman. It is a pleasure to be before the subcommittee today, I am Christie Herrera. I am director of the Health and Human Services Task Force at the American Legislative Exchange Council, or ALEC. ALEC is a nationwide non-partisan organization of state lawmakers. We have nearly 2,000 legislator members across the country, about a third of all legislators nationwide.

Today I will briefly address how an interstate market could bring about affordability, innovation, and choice. And I will also discuss some nascent state proposals that have already been mentioned here: Wyoming, Georgia, Maine, Arizona, and Oklahoma.

Simply put, our Nation faces a crisis of the uninsured. One in six Americans lacks health coverage and increasing numbers either can't afford it or choose not to purchase it at all. Many states are considering legislation to allow the purchase of health insurance across state lines. ALEC believes that these are promising proposals that could bring about affordability, innovation, and choice.

First, affordability. Many Americans live in states where high-cost health insurance is the only option and where more affordable plans can be found just across the state line.

Innovation. When we open up these coverage options, individuals could benefit from innovative plans in other states, and state lawmakers could benefit from new ideas in other states while maintaining core consumer protections in their own state.

Choice., people could choose more customized health plans that meet their health needs. As has been mentioned, each state imposes mandates that require individuals to purchase coverage for specific benefits, procedures, or providers in order to purchase health insurance coverage at all.

While mandates may make more coverage more comprehensive, they also make it more expensive, and it can price people out of the market altogether. An interstate market could allow people to purchase out-of-state coverage with fewer mandates or allow people to top-up for richer coverage in another state.

ALEC is generally supportive of any proposal to allow the purchase of health insurance across state lines. However, ALEC believes that it is the states that are best equipped to develop and implement this kind of targeted health reform solution. First, the states are both constitutionally and statutorily authorized to have primary regulatory authority over health insurance; but more importantly, we believe that states can develop their own policies that reflect their own unique circumstances and this kind of pluralistic state approach can yield best practices with implementation.

We began tracking state-level legislative activity in 2007 when our legislators adopted Model Health Care Choice Act for states. This is state-based model legislation that vests authority in the state's insurance commissioner to allow the sale of health insurance across state lines. In 2011, 15 states considered this legislation.

Last year Wyoming became the first state to enact this kind of legislation. Wyoming's law would establish a multistate consortium that would establish reciprocity agreements for the approval, sale, offer and structure of health insurance plans. This month Georgia and Maine became the second and third states to allow cross-border purchasing of health insurance. In both states, individuals who apply for an out-of-state policy will receive a disclaimer noting which state's laws govern benefits in underwriting. Georgia's law gives wide latitude to a state's insurance commissioner to qualify the sale of out-of-state plans. And it also allows Georgia's own insurers to sell products that are similar to those out-of-state plans.

Maine's law establishes what are called regional insurers, headquartered in Connecticut, Massachusetts, New Hampshire or Rhode Island, and it allows these regional insurers to sell insurance policies in Maine. These out-of-state plans must comply with the individual health insurance laws of its home state and also comply with Maine's consumer protections.

Also of note are the Arizona and Oklahoma approaches that would respectively open Arizona to a 50-state market for health insurance and allow Oklahoma's Governor to negotiate interstate compacts in this area.

In conclusion, ALEC believes in the promise of these state-based initiatives because they can help many Americans choose affordable, innovative, and customized health insurance coverage across state lines. These state-level reforms have only just begun, and now is the time for the states to develop these proposals, to glean best practices for implementation, and hopefully to demonstrate success. Thank you.

Mr. PRITS. The Chair thanks the gentlelady.

[The prepared statement of Ms. Herrera follows:]



Prepared Statement

of

**Christie Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council**

before the

**Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives**

May 25, 2011

Introduction

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee, thank you for the invitation to testify on “Expanding Health Care Options: Allowing Americans to Purchase Affordable Coverage Across State Lines.” I welcome this opportunity to share with you an overview of state activity in this area.

I represent the American Legislative Exchange Council, or “ALEC,” where I have served as director of the Health and Human Services Task Force since 2005. ALEC is a nationwide, nonpartisan membership organization of state lawmakers, with nearly 2,000 legislative members from all 50 states.

ALEC’s mission is to advance the Jeffersonian principles of free markets, limited government, federalism, and individual liberty, through a nonpartisan public-private partnership of America’s state legislators, members of the private sector, the federal government, and the general public. ALEC promotes these principles by developing policies that ensure the powers of government are derived from, and assigned to, first the people, then the states, and finally, the federal government.

ALEC carries out its mission through nine national task forces which focus on the issues of Civil Justice; Commerce, Insurance, and Economic Development; Education; Energy, Environment, and Agriculture; Health and Human Services; International Relations; Public Safety and Elections; Tax and Fiscal Policy; and Telecommunications and Information Technology.

Lowering Costs, Expanding Choices: A State Solution

Our nation faces a crisis of the uninsured. Nationally, 17 percent of the population—or one in six Americans—lacks health coverage. In the states, the uninsured rate ranges from a high of 26 percent in Texas to a low of 5 percent in Massachusetts.¹

¹ The Henry J. Kaiser Family Foundation, “Health Insurance Coverage of the Total Population,” www.statehealthfacts.org.

Although many refer to “the uninsured” as a homogenous group, those who go without health coverage do so for different reasons. Some lack access to employer-sponsored coverage, or are in between jobs that offer health benefits. Some are eligible for Medicaid or SCHIP, but have not yet enrolled.²

But increasing numbers of Americans can’t afford coverage, or choose not to purchase coverage because it isn’t a good “deal” for them. According to the U.S. Census Bureau, the uninsured rate is higher among people with lower incomes. However, 10 million Americans have household incomes greater than \$75,000 but still don’t choose to purchase coverage. And more than one-third of the uninsured are between the ages of 18 and 24—known as the young and healthy “invincible” population.³

A one-size-fits-all solution will not help America’s diverse uninsured population. Lawmakers must support policies that will not only lower the cost of insurance, but also increase access to quality coverage options.

The states can offer promising targeted health reform solutions. First, states can develop their own policies that reflect the diversity of their uninsured populations—and implementation “best practices” can emerge from this kind of pluralistic state approach. Second, the Tenth Amendment to the United States Constitution states that, “The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.” And since the passage of the 1945 *McCarran-Ferguson Act*, the states have had primary regulatory authority over today’s health insurance market and have provided aggressive oversight; enforced consumer protections; and have ensured a local, responsive presence for consumers.⁴

² J.P. Wieske and Christie Herrera, *2010 State Legislators Guide to Health Insurance Solutions*, Council for Affordable Health Insurance, January 2010.

³ Carmen DeNavas-Walt et al., *Income, Poverty, and Health Insurance Coverage in the United States*, U.S. Census Bureau, September 2010.

⁴ ALEC’s *Resolution on Preserving States’ Rights Regarding Federal Health Insurance Exchanges and a Public Plan*, 2009.

The Promise of An Interstate Health Insurance Market

Among other reforms, some states are considering legislation that would allow individuals to purchase quality, affordable health insurance coverage across state lines. The goal of this legislation is to allow the uninsured more access to health plans at lower prices, while expanding coverage choices for those who are already insured.

It may be a daunting prospect for someone to purchase a health insurance policy from a faraway state, and so an interstate health insurance market may initially fare better in certain geographic regions (like New England) or in large metropolitan regions (like Washington D.C.) that encompass several states. According to data from ehealthinsurance.com, many Americans live in states where high-cost individual health insurance is the only coverage option—and where better health insurance deals can be found just across the state line.⁵

For example, Georgia recently enacted House Bill 47, legislation that would authorize Georgia insurers to offer health insurance policies sold in other states. Under Georgia's new legislation, an uninsured Georgian looking for coverage in the individual market (in Georgia, an average of \$163/month) could find more affordable monthly premiums in neighboring Alabama (\$126/month), Tennessee (\$151/month), North Carolina (\$142/month) or South Carolina (\$154/month).

Some states have sizeable uninsured populations despite the availability of low-cost individual health insurance options. Many factors—such as cost, benefit design, and choice of carriers—can influence the decision on which health insurance plan to buy, or whether to purchase health insurance at all. By opening coverage options across state lines, citizens could benefit from innovative plans in other states; insurers would face fewer barriers to entry into a state's health insurance market; and policymakers could benefit from new ideas in other states while maintaining core consumer protections important to their home state.

⁵ See Chart #1 attached.

An interstate health insurance market could also help consumers access a more customized benefits package that meets their health needs. State-imposed mandates require individuals to purchase coverage for specific benefits, procedures, or providers in order to purchase health insurance coverage at all. According to the Council for Affordable Health Insurance, the 50 states impose a total of 2,129 mandates on the purchase of individual health insurance coverage.⁶

Permitting the purchase of health insurance across state lines would allow residents to access plans with benefits that meet their health needs. For example, Georgia's 45 government-imposed health insurance mandates—which include medical services like chlamydia screening and morbid obesity treatment—require Georgians to purchase more expensive coverage they might not want or need. Georgia's newly-enacted legislation could allow Georgia residents to purchase coverage with fewer mandates in neighboring Alabama (19 mandates), Tennessee (41 mandates), or South Carolina (29 mandates). Similarly, the bill could allow Georgians who want more extensive benefits to “top up” for richer coverage in neighboring Florida (49 mandates) or nearby Texas (60 mandates).

Recent State Legislative Activity

ALEC began tracking state-level legislative activity in 2007, when ALEC members adopted its model *Health Care Choice Act for States* that vests authority with a state's insurance commissioner to allow the sale of health insurance plans sold in other states.⁷ Since that time, an increasing number of states are actively considering legislation to allow for the purchase of health insurance across state lines.

In 2008 and 2009, four and 11 states, respectively, introduced the *Health Care Choice Act for States*, but none of the bills were enacted. In 2010, 18 states considered the *Health Care Choice Act for States*, and Wyoming became the first state to enact this legislation. In 2011, 15 states introduced the *Health Care Choice Act for States*, and Georgia and Maine became the second and third states, respectively, to enact this legislation.

⁶ See Chart #2 attached.

⁷ ALEC's *Health Care Choice Act for States*, 2007.

WYOMING

In 2010, Wyoming became the first state to enact legislation, House Bill 128, authorizing the sale of out-of-state health insurance plans. Specifically, the legislation seeks to initiate cooperation of like-minded states to create a multi-state consortium with reciprocity agreements for health insurance plan approval, offer, sale, rating, underwriting, renewal, and issuance.

Wyoming has the smallest population in the country, and often states with small populations have a difficult time attracting insurance carriers for underwriting purposes. And so the goal of House Bill 128 is to create a large-enough population within the consortium so that insurers would be incentivized to develop new insurance products and offer them to Wyoming residents.

Although insurance commissioners from all consortium states will collectively determine the consortium's rules, House Bill 128 stipulates that Wyoming's insurance commissioner will make an initial proposal that would:

- Permit insurers to designate only one consortium state as its domicile state;
- Establish licensing reciprocity so that an insurer domiciled in one consortium state would be licensed to do business in all consortium states;
- Ensure that any plan sold within the consortium retain the covered laws—including offer, sale, rating, underwriting, mandated benefits, renewal, and issuance—of the insurer's domicile state;
- Ensure that any resident of a consortium state will be covered by the consumer protections—including financial solvency requirements, adjudication of claims disputes, and external review processes—of their home state; and
- Require that insurers pay premium taxes, as well as high-risk pool and other assessments, to the consortium state in which the health insurance plan was sold.

Implementation of Wyoming House Bill 128 is still in its infancy, as the legislation states that Wyoming's insurance commissioner "shall be under no obligation to draft rules and regulations

until after March 15, 2011.” To date, Wyoming Governor Matt Mead has sent letters to officials in Wyoming’s border states, asking them to pass similar legislation and join the consortium.⁸

GEORGIA

In May 2011, Georgia became the second state to authorize cross-border purchasing of health insurance with the passage of House Bill 47. The legislation approves the sale of qualified health insurance plans sold in other states, and allows Georgia’s insurers to sell products that are similar to those sold in other states.

What makes a “qualified health insurance plan” is determined by Georgia’s insurance commissioner. However, House Bill 47 does require that out-of-state plans satisfy actuarial standards set forth by the National Association of Insurance Commissioners, and that each application for an out of state policy contain the following disclaimer:

“The benefits of this policy may primarily be governed by the laws of a state other than Georgia; therefore, all of the laws applicable to policies filed in this state may not apply to this policy. Any purchase of individual health insurance should be considered carefully, since future medical conditions may make it impossible to qualify for another individual health insurance policy.”

MAINE

In May 2011, Maine became the third state to enact legislation, Legislative Document 1333, that would allow “regional insurers” domiciled in Connecticut, Massachusetts, New Hampshire, or Rhode Island to sell those health insurance policies in Maine. Out-of-state plans sold in Maine must provide applicants with a disclaimer (similar to Georgia’s); comply with the individual health insurance laws of its domicile state; and comply with Maine’s laws regarding grievance procedures, provider network adequacy, unfair trade practices, and other consumer protections.

ARIZONA AND OKLAHOMA

⁸ Interview with the Office of Wyoming Insurance Commissioner Ken Vines, May 16, 2011.

Also of note are bills in Arizona and Oklahoma that would similarly authorize the purchase of health insurance policies sold in other states. In April 2011, Arizona Governor Jan Brewer vetoed Senate Bill 1593, which would have allowed certain out-of-state insurers to sell health insurance policies to Arizonans if a disclaimer (similar to Georgia's) was made to applicants.

Senate Bill 1593 would have required that out-of-state insurers register with the state and certify that they have not violated laws or regulations related to "claim denials, poor customer service, deceptive marketing practices, or fraudulent activities." The legislation would have also allowed the state Department of Insurance to revoke the license of any insurer that did not meet Arizona's financial solvency requirements, or that had been subject to any "regulatory action level event" in the insurer's domicile state. Finally, the legislation would have given Arizona courts jurisdiction over any out-of-state insurer with regards to the health insurance plans sold in Arizona.

In her letter vetoing Senate Bill 1593, Governor Brewer wrote that although she "has been a strong advocate for injecting more choice and competition into [Arizona's] health insurance market," the major provisions of Senate Bill 1593 were added during floor debate and "not subject to the typical public input that such major policy decisions should receive."⁹

In 2010, the Oklahoma Legislature passed its own *Health Care Choice Act*, Senate Bill 2046, which was vetoed by then-Governor Brad Henry. In 2011, similar legislation, Senate Bill 57, is moving through the Oklahoma legislature and has already passed the Senate. The legislation would authorize Oklahoma's insurance commissioner to negotiate interstate compacts that would allow out-of-state health insurance policies domiciled in compacting states to be sold in Oklahoma.

Specifically, Oklahoma's legislation would allow both domestic and out-of-state insurers to sell policies without Oklahoma's 38 mandated benefits, so long as a disclaimer (similar to disclaimers in the legislation of Georgia, Arizona, and Maine) was made at the time of

⁹ Arizona Governor Janice K. Brewer, Letter to Arizona Secretary of State Ken Bennett on Senate Bill 1593, April 28, 2011.

application. Oklahoma's insurance commissioner would also have the authority to license out-of-state plans; regulate the market conduct and financial solvency of out-of-state insurers; require that out-of-state insurers pay premium taxes to Oklahoma; and require that the out-of-state insurers participate in Oklahoma's high-risk pool. Once the compact is negotiated with another state, it would require approval by the governor (via executive order), or by a majority vote of both houses of the legislature.

Conclusion

We have a responsibility to help the uninsured gain access to meaningful health insurance coverage without added government regulation. That's why I thank you, Chairman Pitts, for holding this hearing and for giving me the opportunity to share state-based initiatives that may help many Americans gain affordable, innovative, and customized health insurance coverage across state lines. We look forward to working with you, and with state legislatures, on developing this promising policy initiative.

Chart #1: AVERAGE MONTHLY PREMIUM, INDIVIDUAL COVERAGE (2010)

STATE	PREMIUM	STATE	PREMIUM
Alabama	\$126.38	Montana	\$168.01
Alaska	\$192.30	North Carolina	\$142.70
Arizona	\$142.44	North Dakota	\$139.54
Arkansas	\$123.07	Nebraska	\$140.22
California	\$156.20	New Hampshire	\$188.46
Colorado	\$145.96	New Jersey	\$268.14
Connecticut	\$197.36	New Mexico	\$152.93
Delaware	\$158.58	New York	\$339.60
Florida	\$165.76	Nevada	\$160.02
Georgia	\$163.10	Ohio	\$127.47
Hawaii	\$159.29	Oklahoma	\$143.93
Idaho	\$141.19	Oregon	\$165.63
Illinois	\$161.15	Pennsylvania	\$156.54
Indiana	\$144.65	Rhode Island	N/A
Iowa	\$110.05	South Carolina	\$154.82
Kansas	\$120.07	South Dakota	\$135.93
Kentucky	\$117.61	Tennessee	\$151.42
Louisiana	\$145.94	Texas	\$175.31
Maine	N/A	Utah	\$128.53
Maryland	\$146.30	Vermont	N/A
Massachusetts	\$303.21	Virginia	\$161.61
Michigan	\$127.41	Washington	\$194.87
Minnesota	\$136.27	West Virginia	\$183.49
Mississippi	\$163.51	Wisconsin	\$135.17
Missouri	\$125.92	Wyoming	\$160.75

Source: ehealthinsurance.com, 2010 Fall Cost Report for Individual and Family Policyholders, September 17, 2010.

Chart #2: TOTAL MANDATES BY STATE (2010)

STATE	TOTAL MANDATES	STATE	TOTAL MANDATES
Alabama	19	Montana	38
Alaska	33	North Carolina	52
Arizona	33	North Dakota	34
Arkansas	45	Nebraska	36
California	56	New Hampshire	44
Colorado	54	New Jersey	45
Connecticut	59	New Mexico	57
Delaware	32	New York	52
Florida	49	Nevada	44
Georgia	45	Ohio	29
Hawaii	23	Oklahoma	38
Idaho	13	Oregon	49
Illinois	46	Pennsylvania	57
Indiana	35	Rhode Island	69
Iowa	27	South Carolina	29
Kansas	42	South Dakota	29
Kentucky	45	Tennessee	41
Louisiana	51	Texas	60
Maine	53	Utah	25
Maryland	67	Vermont	42
Massachusetts	47	Virginia	57
Michigan	25	Washington	57
Minnesota	64	West Virginia	39
Mississippi	29	Wisconsin	35
Missouri	42	Wyoming	37
TOTAL		2129	

Source: Victoria Craig Bunce and J.P. Wieske, *Health Insurance Mandates in the States 2010*, Council for Affordable Health Insurance, October 2010.

**Chart #3: LEGISLATIVE ACTIVITY:
HEALTH CARE CHOICE ACT FOR STATES (2008-2011)**

YEAR	STATE	LEGISLATION	ACTION
2008	Colorado	House Bill 1327	Failed
2008	Minnesota	House File 4218	Failed
2008	Minnesota	House File 4229	Failed
2008	New Jersey	Assembly Bill 2767	Failed
2008	Wisconsin	Assembly Bill 873	Failed
2009	Arkansas	House Bill 1407	Failed
2009	Colorado	House Bill 1256	Failed
2009	Maine	House Bill 230	Failed
2009	Minnesota	Senate File 1280	Failed
2009	New Jersey	Assembly Bill 2767	Failed
2009	North Carolina	Senate Bill 725	Failed
2009	Pennsylvania	House Bill 1744	Failed
2009	Pennsylvania	House Bill 1745	Failed
2009	Pennsylvania	Senate Bill 508	Failed
2009	Texas	Senate Bill 2416	Failed
2009	West Virginia	House Bill 2987	Failed
2009-2010	California	Senate Bill 92	Failed
2009-2010	Wisconsin	Assembly Bill 540	Failed
2010	Colorado	House Bill 1163	Failed
2010	Florida	House Bill 1191	Failed
2010	Florida	Senate Bill 2280	Failed
2010	Georgia	House Bill 1184	Failed
2010	Georgia	Senate Bill 309	Failed
2010	Georgia	Senate Bill 407	Failed
2010	Indiana	House Bill 1152	Failed
2010	Minnesota	House File 2901	Failed
2010	Minnesota	House File 3418	Failed
2010	Missouri	House Bill 2412	Failed
2010	Nebraska	Legislative Bill 693	Failed
2010	New Hampshire	House Bill 1431	Failed
2010	New Hampshire	House Bill 1585	Failed
2010	New Hampshire	Senate Bill 452	Failed
2010	New Jersey	Assembly Bill 1364	Failed
2010	New Jersey	Senate Bill 715	Failed
2010	Oklahoma	Senate Bill 1346	Failed
2010	Oklahoma	Senate Bill 2046	Vetoed
2010	South Carolina	Senate Bill 986	Failed
2010	Tennessee	House Bill 2417	Failed
2010	Tennessee	Senate Bill 3177	Failed
2010	Virginia	House Bill 31	Failed
2010	Virginia	House Bill 339	Failed
2010	Virginia	House Bill 536	Failed
2010	Vermont	House Bill 697	Failed
2010	West Virginia	House Bill 4282	Failed
2010	Wyoming	House Bill 128	Enacted
2011	Arizona	House Bill 2689	Failed
2011	Arizona	Senate Bill 1287	Failed
2011	Arizona	Senate Bill 1593	Vetoed
2011	Connecticut	House Bill 5449	Failed

YEAR	STATE	LEGISLATION	ACTION
2011	Florida	House Bill 1117	Failed
2011	Florida	Senate Bill 1566	Failed
2011	Georgia	House Bill 47	Enacted
2011	Georgia	Senate Bill 216	Failed
2011	Kentucky	House Bill 494	Failed
2011	Indiana	House Bill 1063	Failed
2011	Maine	House Paper 348	Failed
2011	Maine	House Paper 366	Failed
2011	Maine	House Paper 891	Failed
2011	Maine	Senate Paper 77	Failed
2011	Maine	Legislative Document 1333	Enacted
2011	Missouri	House Bill 262	Failed
2011	Montana	House Bill 445	Failed
2011	New Hampshire	House Bill 327	Pending
2011	New Hampshire	Senate Bill 150	Pending
2011	New Jersey	Assembly Bill 1364	Pending
2011	New Jersey	Senate Bill 715	Pending
2011	Oklahoma	Senate Bill 57	Passed Senate
2011	Pennsylvania	House Bill 47	Pending
2011	Pennsylvania	Senate Bill 216	Pending
2011	Virginia	House Bill 2506	Failed
2011	West Virginia	Senate Bill 419	Failed

Source: American Legislative Exchange Council

Mr. PITT. I now recognize the gentleman Mr. Finan for 5 minutes for an opening statement.

STATEMENT OF STEPHEN FINAN

Mr. FINAN. Good morning, Mr. Chairman, Ranking Member Pallone, and distinguished members of the committee. I am Stephen Finan, Senior Director of Policy at the American Cancer Society, Cancer Action Network, which is the advocacy affiliate of the American Cancer Society.

ACS CAN is grateful for the committee's invitation to speak to the issue of interstate sales of health insurance and its potential impact on consumers. Insurance issues are inherently complex and often dense, so I would like to explain the issue through the cancer lens: how the concept might ultimately affect cancer patients and survivors.

Cancer death rates have decreased by 21 percent among men and 12 percent among women since the early 1990s. Despite the significant progress, the American Cancer Society concluded that its long-term goals of significantly reducing the incidence and mortality of cancer cannot be achieved unless the significant coverage gaps that exist within the current health care system are addressed.

Although major advances have been achieved through research in the fight against cancer, too many advances are not being realized by actual patients because of major shortcomings in our Nation's health delivery system. For example, we know that the lack of insurance coverage means later diagnosis, worse outcomes, and thus often higher costs among cancer patients. Even among those with private insurance, many cancer patients are underinsured, meaning their coverage did not provide for all the necessary and appropriate medical treatment.

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. The problem of paying costly medical bills directly affects middle-class families, particularly those with chronic diseases.

The overriding purpose of any insurance reform must be—the overriding purpose of any reform must be to improve the Nation's health for all its citizens. From a consumer perspective, interstate sales offer the theoretical potential of greater choice and lower prices. In fact, this potential will be real under the Affordable Care Act if states choose to participate in multistate exchanges or interstate compacts. However, the work-in-practice interstate sales must be built on a foundation that prevents predatory practices and unfair predatory practices, with strong consumer rights and enforcement protections firmly in place.

The ACA fundamentally alters the rules of the health insurance market to work for consumers and, by extension, the Nation's health and well-being. Moreover, the Affordable Care Act changes the insurance market rules in a manner that significantly enhances its competition by creating a level playing field. Among the most important changes, all insurers must provide access to coverage regardless of health status.

All plans must include benefits to help cover adequately a serious medical condition like cancer. Evidence-based prevention services must be included in all health plans. Financial assistance to purchase health insurance is essential for many Americans because without it, directly or indirectly, the taxpayer winds up paying the remaining costs.

The administrative process of insurance needs to be simplified and standardized. To have a truly consumer-driven, competitive market, people must have easy and essentially free access to comprehensible information so that they can make informed decisions. These conditions exist today for virtually every consumer product, but they don't exist for one of the most important products in our lives: health insurance.

Risk adjustment must be an inherent part of any private health insurance. A great good risk adjustment system will reward insurers for finding efficient ways to provide quality care to all health risks, rather than trying to avoid risk. This is the proper way to harness competition to the benefit of the consumers and our Nation.

And finally, last but not least, interstate sales, that are currently built on a state-based system, you must change the foundations. The consumer protections do exist across state lines and there is adequate means of enforcement and redress.

The general concept of interstate sales of health insurance is consistent with the overall trending consumer products in recent years, especially with the growth of the Internet. Competition across state lines in many consumer product areas often benefit the consumers through greater choice and lower prices.

So the question is, why wouldn't the same be true for health insurance? Unlike other health consumer products, many insurers don't always want to sell their product to any consumer. Their business model is built around not selling to all applicants. The strategy is very simple and clear.

Health claims highly skewed. Roughly 20 percent of the people pay for 80 percent of cost. If an insurer can avoid that 20 percent they would still have a huge market, but they avoided virtually all the costs. This in turn would allow them to provide the opportunity to sell insurance relatively cheaply to a large market of healthy people. The side effect would be that high-risk people like cancer patients are left out, are left in pools with extraordinarily high costs. The competitive pressures of unregulated interstate sales would almost certainly force insurers to embrace the highly discriminatory tactics of cherry-picking. If some insurers cherry-pick the lower costs of the market, the remaining insurers are left with pools that are at a disproportionately high risk compared to competitors.

Let me just conclude by saying it is imperative that we not jump to the conclusion that the high cost of health insurance today is simply a function of too little competition or too much regulation. Interstate sales of health insurance could nominally increase competition at lower price. However, a highly competitive market without good, uniform rules will simply become a faster race to the bottom. The relatively young and healthy pool benefit, but the consequence would be foreclosure of access to or affordability of cov-

erage for those with serious medical conditions like cancer. We do not believe that this is the intent of the law or the idea, but it could happen and that clearly would be an unacceptable outcome.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman.

[The prepared statement of Mr. Finan follows:]



**Statement by
Stephen Finan
Senior Director of Policy
American Cancer Society Cancer Action Network**

**Before the Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
May 25, 2011**

Hearing: Allowing Americans to Purchase Affordable Coverage Across State Lines

Introduction

Good morning, Mr. Chairman, Ranking Member Waxman and distinguished members of the Committee. I am Stephen Finan. I am the Senior Director of Policy at the American Cancer Society Cancer Action Network (ACS CAN). We are the advocacy affiliate of the American Cancer Society (ACS), which is 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 invitation to speak to the issue of interstate sales of health insurance and the potential impact on consumers. We appreciate the committee's long-standing interest in improving consumer access, choice and affordability of health coverage. Insurance issues are inherently complex and often dense, so I would like to explain the issues

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through the “cancer lens” – how the concept might ultimately affect cancer patients and survivors.

I would like to begin by briefly explaining why ACS CAN made the decision to enter the health care debate nearly five years ago to provide context for my comments on interstate sales. From a consumer perspective, interstate sales offer the theoretical potential of greater choice and lower prices. In fact, this potential will be real under the Affordable Care Act (ACA) if states choose to participate in multi-state exchanges. If the committee is interested in other approaches, any expansion of interstate sales must be built on strong consumer protections and uniform rules for insurers. The overriding purpose of any reform must be to improve the nation’s health for all its citizens. Interstate sales must be built on a foundation that prevents predatory practices and unfair practices, with strong consumer rights and enforcement protections firmly in place.

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 concluded that its long-term goals of significantly reducing the incidence and mortality of cancer cannot be achieved unless the significant coverage gaps that exist within the current health care system are addressed. Although major advances have been achieved through research in the fight against cancer, too many of the advances are not being realized by actual patients because of major short-comings in our nation’s health delivery system.

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The Society's leadership and national board decided in 2005 to enter the national health care debate because evidence has shown that improving the nation's health delivery system is vital in the fight against cancer. And it is a huge fight: there are more than 1.5 million new cancer cases diagnosed and more than 550,000 Americans still die from the disease each year. There are more than 11 million cancer survivors currently living in this country. At the same time, the odds are that 1 in 2 men and 1 in 3 women will get cancer sometime in their life. Cancer is truly a disease that touches everyone in some way, regardless of race, income or any other social or demographic factor.

Insurance coverage is critical for the proper treatment of cancer. For example, we know that insurance status is significantly associated with use of cancer screening services, cancer stage at diagnosis and survival outcomes. Cancer patients who were uninsured at the time of diagnosis were 1.6 times as likely to die in 5 years compared to those with private insurance. Not only does insurance make a difference for later stage diagnosis, but it affects a patient's ability to access cancer treatment and their likelihood of survival. Uninsured patients diagnosed with early stage disease are less likely to survive cancer than privately insured patients diagnosed with later-stage disease. Simply put, a patient's insurance status is a strong indicator of the stage of their cancer diagnosis. If you are uninsured, you are more likely to be diagnosed with advanced-stage cancer, which is less curable and more deadly than cancer caught at its earliest stages.

Even among those with private insurance, many cancer patients are "underinsured" – their coverage does not provide for all necessary and appropriate medical treatment. The challenge

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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. The problem of dealing with high-cost medical bills acutely affects middle-class families, particularly those with chronic diseases such as cancer. Often insurance policy deductibles, co-payments and limits on health services can 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.

Last year, ACS CAN commissioned a nationwide poll among households with a cancer patient age 18 or older. Among the findings:

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

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prescription, or cutting pills. Of those currently in active cancer treatment, one in three (33%) has put off some type of health care in the past due to costs.

- Four in ten families (42%) 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%) says his or her deductible has gone up.
- One-third (34%) 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.

Clearly, meaningful insurance has to treat a disease adequately and fully, and the coverage has to be affordable for the patients to fully realize the benefits necessary and appropriate to treat the disease. For these reasons, ACS CAN sought major reforms to the health insurance system to enhance access, adequacy of coverage, affordability of health insurance, and administrative simplicity to increase transparency and accountability.

Insurance Reforms under the Affordable Care Act

The ACA fundamentally alters the rules of the health insurance market to work for consumers, and thereby, the nation's health and well-being. Moreover, the insurance market rules are changed in a manner that significantly enhances competition by creating a level playing field. Among the most important changes:

- **All insurers must provide access to coverage regardless of health status.** Insurers cannot use health status, medical claims or any other indicator of potential risk in determining eligibility for plan enrollment or premium rate setting after 2014. All

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products will be guaranteed issue and there can be no pre-existing condition restrictions on coverage.

- **All health plans must include benefits to adequately cover a serious medical condition like cancer.** Arbitrary limits on benefits, such as the number of doctor visits or days in a hospital, are unacceptable. Both the Society and ACS CAN hear too many stories about cancer patients who have had to skip doctor visits or delay the use of vital drugs because of arbitrary limits in their plans. Rather, both to contain costs and improve quality, coverage should be evidence-based. Some insurers have already begun moving in this direction. For this approach to have viability nationwide, all insurers must compete on the same basis, which will be the case when ACA is fully implemented
- **Evidence-based prevention services must be included in all health plans.** A greater emphasis on prevention is absolutely essential to improving our nation's health and controlling long-term costs. Cancer, heart disease and diabetes are among the nation's most expensive medical conditions, and there is an abundance of science to show that proven prevention methods, if made accessible and properly supported, could significantly lower the incidence, severity and costs of these diseases. By requiring all U. S. Preventive Services Task Force "A" or "B" recommendations to be covered by most plans this year, the law takes a significant step toward this goal, but more can be done and will be addressed in future regulations under the law, such as that for the essential benefits package.
- **Financial assistance to purchase health insurance is essential for many Americans.** Whether through tax credits or other means, the government must provide

assistance to ensure that every American can afford coverage that is adequate to treat a serious medical condition like cancer. If we do not provide such assistance, the taxpayer or others, including those who do have insurance, will still foot the bill. Simply put, cancer and other diseases do not discriminate based on a person's insurance status. However, we do know that the uninsured often wait longer to have their condition treated, and this often means worse outcomes and higher costs that are ultimately borne, directly or indirectly, by taxpayers. From both a health and economic perspective, our society is better off assisting people in obtaining and maintaining good coverage.

- **The administrative processes of insurance need to be simplified and standardized.** There is considerable inefficiency in our health care system today that if reduced would represent considerable savings to the consumer. More importantly, the health insurance system is opaque and consumer literacy is extraordinarily low. Today, most consumers have virtually no understanding of health insurance. They may know the price of insurance (though they often mistake an employee contribution as being the total price of their insurance), but they rarely know the range of benefits or how well they would be covered if they got a serious condition like cancer. Furthermore, the processes of insurance must be standardized and readily comprehensible to the vast majority of consumers including, everything from enrollment forms, to bills and appeals. To have a truly consumer-driven, competitive market, consumers must have easy and essentially free access to comprehensible information so they can make informed decisions. These conditions exist today for virtually every consumer product, but they don't exist for one of the most important

products in our lives – health insurance. Fortunately, the ACA sets in place a number of reforms that will do much to increase the transparency of the insurance market and begin to provide consumers with the information and tools to make informed decisions about their coverage.

- **Risk adjustment must be an inherent part of the private health insurance system.** As explained below, the distribution of claims is highly skewed, and in a relatively unregulated market, it is virtually essential that insurers take steps to avoid high risks. A competitive market will drive an insurer (including non-profits) with “too many” cancer patients into bankruptcy. To rectify this potentially destructive consequence of competition, it is imperative that risk adjustment mechanisms be developed and implemented. Instead of rewarding risk avoidance, which will necessarily occur in an unregulated, competitive market, an effective risk-adjustment system could eliminate the incentive to avoid risk and replace it with the incentive to compete for consumers by developing efficient ways of delivering quality care. This is the proper way to harness competition to the benefit of consumers and our nation, and it is a requirement under ACA.
- **Interstate sales would have to be built on an interstate system.** Historically, our private health insurance system has been largely state-based, and thus, many consumer protections and means of recourse are also state-based. But what happens to consumer rights and protections in interstate sales? Are state insurance departments or state courts going to give full recognition to the problems of out-of-state consumers, especially in these times of very tight state budgets? Interstate sales without adequate consumer protections and safeguards could easily become a debacle with grave

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consequences for our nation's health and well-being. Interstate markets could well benefit some consumers, particularly in areas with adjoining small population states, but it is imperative that such states develop the interstate coordination of laws and enforcement to minimize the potential for fraud, abuse and denial of essential consumer protections.

Potential Impact of Interstate Sales on the Health Insurance Market

Let me now turn to the issue of interstate sale of health insurance.

The Society's and ACS CAN have long sought to ensure that access to affordable health coverage is available to every cancer patient and survivor. In addition, both organizations have fought for years at the state level to ensure that coverage of proven cancer screenings, including mammograms, colonoscopies, cervical screenings, and smoking cessation, is available under all insurance products. The evidence is strong that good, continuous health coverage leads to lower costs and better outcomes. The Affordable Care Act represents an enormous step forward in providing affordable care to all Americans by establishing basic, uniform rules for insurance and an essential benefit package that will, for the first time, ensure that every American has the essential benefits to treat a serious condition like cancer.

The general concept of interstate sales of health insurance is consistent with the overall trend in consumer products. In recent years, especially with the development of the internet, competition across state lines in many consumer product areas has resulted in greater

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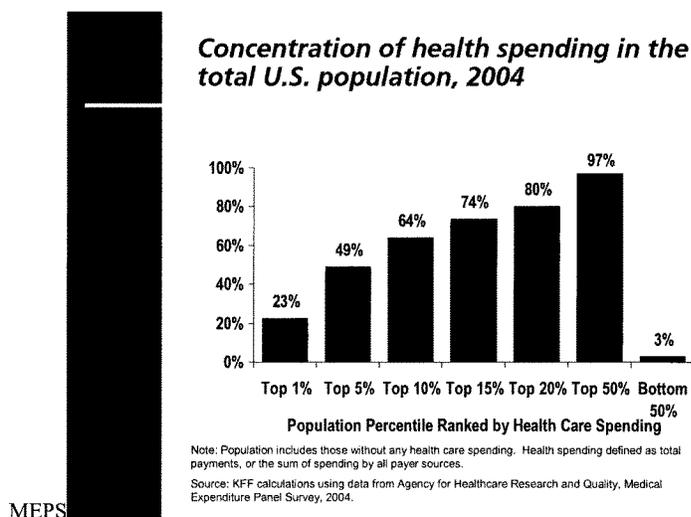
competition, often benefiting the consumer through greater choice and lower prices. So the question is, why wouldn't the same be true for health insurance?

Health insurance is fundamentally different from other consumer products because of the sharing of risk through an insurance pool. Interstate sales could make insurance less expensive for many – specifically for the relatively young and healthy. But if the market is not structured properly, this lowering of costs would come at the expense of cancer patients and survivors and others with serious medical conditions.

Chart 1 below demonstrates this point. It shows the distribution of health care claims for the under 65 population. (The data are from 2004, but this general distribution has remained essentially unchanged for over 30 years.) Simply stated, the chart shows that a relatively few people account for the vast majority of expenses. For example, 20 percent of the population accounts for 80 percent of the health care costs, and conversely, 50 percent of them account for merely 3 percent of all health spending in a given year.

Now look at the data again from the perspective of an insurance company in a largely unregulated and highly competitive market. This chart could easily be a strategic plan for an insurance carrier. If an insurer can identify the top spenders and **NOT** insure them, the claims avoided could be significant. For example, if an insurer can identify the likely 20 percent of claimants, 80 percent of the likely costs will not be incurred. An insurer could sell insurance at relatively low rates, realize good profits and still have a very large market for its products.

Chart 1



Indeed, in relatively unregulated health insurance markets, this is the strategy that has been and continues to be aggressively pursued by many insurers. They invest extensively in underwriting, marketing, benefit design and other techniques to deny or discourage high risk individuals or potentially high risk individuals from entering their pool. In insurance parlance, they “segment” the market. In layman’s terms, they “cherry-pick.”

Permitting interstate sales could, in effect, significantly advance this discriminatory strategy by allowing insurers to cherry-pick across state lines. Indeed, the competitive pressures of the market would almost certainly force insurers to embrace highly discriminatory tactics of cherry-picking. If some insurers are cherry-picking the lower risks in the market, the remaining insurers are left with pools that are disproportionately high risks compared to their

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competitors. No insurer could survive long with such insurance pools. Their premium rates will be higher, which will make it difficult to retain current enrollees or attract new relatively health ones, thus causing their premiums to rise further. The result is the so-called “insurance death spiral,” and the phenomenon is real.

The Consumer Perspective

Interstate sales of health insurance might work in theory, but in practice it would only work if very specific conditions outlined above are met. In many states today, the insurance pool is relatively small, and this is disadvantageous to the consumer because it limits the insurers’ ability to spread risk while offering multiple options of plans at affordable premium rates. The key to making interstate sales work to the benefit of consumers is a level playing field among insurers and across states. Insurers have to compete by the same rules. They cannot be allowed to have a market advantage by discriminating against people with cancer and other serious medical conditions. Rather, when all insurers play by the same rules, they must compete based on the quality and efficiency of coverage they provide to plan participants.

Conclusion

As a nation, we enjoy a high standard of living in part because we have a market-based economy that is highly responsive to consumer preferences. And yes, there are ways to restructure the insurance market to nominally increase competition and lower prices for some. However, it is imperative that we not jump to the conclusion that the high cost of health insurance is simply a function of too little competition or too much regulation. In fact, a highly competitive market, without good, uniform rules, could simply become a race to the

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bottom. Insurers would domicile in states with the least amount of regulation and would offer plans with limited benefit coverage. The relatively young and healthy could realize lower health insurance premiums, but the consequence would be foreclosure of access to or affordability of coverage for those who have serious medical conditions. That is clearly an unacceptable outcome. Any reform of the insurance system has to be premised on the fact that sooner or later, virtually all of us will experience a serious medical condition, whether it is cancer, heart disease, or something else. Largely unregulated interstate sales of health insurance do not lower health care costs overall. Rather, interstate sales simply shifts costs to those individuals who have, or have had, cancer or another disease to a time in their lives when it is harder to work and more difficult to recover from a financial hardship.

As an organization totally committed to the fight against cancer, ACS CAN fully understands the committee's concern about the lack of competition in health insurance in some states. Moreover, as an active participant in the ongoing debate about health care reform, we fully appreciate the concerns and perspectives of those who question current law. ACS CAN, like the American Cancer Society, is an evidence-based organization, and after very considerable and lengthy internal debate and discussion, we came to the conclusion that the evidence demonstrated that the old insurance rules were fatally flawed. The number of uninsured people has been growing steadily for years, as has the problem of underinsurance. Although the increases alone are of great concern, we believe that cancer patients have been disproportionately affected. Insurers have sought to contain costs by engaging in ever increasing discriminatory practices and cost-shifting, to the detriment of those with cancer and other serious medical conditions.

The ACA offers significant opportunity to improve health care and lower costs, not only for cancer patients and survivors, but for the betterment of all. The fundamental health care cost problem today is the inefficient use of health care, the highly fragmented and uncoordinated health delivery system, and the lack of focus on quality that derives from a fee-for-service system that remains highly prevalent today. The ACA, though not perfect, will eliminate much of the historical discriminatory practices in the insurance market and provide a solid foundation to shift the incentive of providers and insurers to focus on greater efficiency and quality of care. These changes won't be easy and they will take time to fully realize, but they represent the direction in which the nation's health system must move.

ACS CAN, along with the Society, is fully committed to finding the best solutions to our health care problems, and we appreciate this opportunity to discuss alternatives that seek to fully engage the power of competition in addressing the problem of enhancing access to affordable, quality health insurance.

Mr. PITTS. The chair recognizes Dr. Howard for 5 minutes for an opening statement.

STATEMENT OF PAUL HOWARD

Mr. HOWARD. First I would like to thank Chairman Pitts and Ranking Member Pallone for holding the hearing today on the important topic of interstate insurance competition. I am speaking today in my capacity as director and senior fellow at the Manhattan Institute's Center for Medical Progress, from my experience writing and researching on health care policy issues, and from speaking to health insurance stakeholders, including large and small employers, insurers, and consumers about the challenges facing the market today.

There is no doubt that the single most important issue facing American health care is the high and rapidly rising cost of that care; and, directly related to it, the high cost of health insurance. The high cost of care is the primary reason why many Americans lack health insurance since they cannot find affordable coverage that meets their needs, and why more employers are dropping coverage in the face of unsustainable cost increases.

The forces driving health care inflation are not the villains we hear of on the campaign trail. Bad incentives, not greedy corporations, are primarily to blame; namely, the unlimited tax deduction for employer-provided health insurance; the dominance of fee-for-service reimbursement system; and, most importantly for our discussion this morning, government regulations of insurance around health care markets that actively deter competition that might offer lower cost but still high-quality products to consumers.

State insurance regulations often mimic the coverage of provider services or insurance benefits in the name of consumer protection, when in reality what such mandates provide is provider protection, or, I should say, provider income protection.

Legislators often justify additional mandates by pointing to anecdotes for coverage of a particular service or provider that appear, at least after the fact, to be critical to the health and well-being of a particular policyholder. But legislation via anecdote is not a justification for adding additional costs to standard insurance packages, particularly when increasing the cost of those packages inevitably prices some consumers out of the market because they can not afford to buy the Cadillac coverage that legislators or the providers who argue for such coverage believe we must offer.

Different consumers will have different preferences for insurance coverage and terms. A 25-year-old male may opt for very different insurance than a 38-year old father of two. Telling a younger man that he must opt for the older man's coverage is likely to price him out of the market entirely.

Creating a viable interstate insurance market will begin the vital process of making the marginal cost of regulation transparent to uninsured individuals who are in the most need of more affordable insurance options. It may also spur innovation in insurance products as states compete to offer the best combination of cost and coverage terms. This is exactly the type of competition that we should be encouraging in health care and health insurance markets.

Objections to the interstate sale of health insurance rest on a purported race to the bottom that would supposedly ensue if consumers could purchase across state lines. However, under legislation like the Health Care Choice Act, products sold in a secondary state would also have to be sold within their primary state. Policymakers and insurance regulators in the primary state would have powerful incentive to ensure that such coverage sold to their own residents was not deceptive and of high quality.

Also insurance departments in the secondary state could still collect premium taxes at high-risk pool assessments from plans sold across state borders, ensuring the financing necessary to maintain important consumer protections and support state high-risk pools.

Also, although under McCarran-Ferguson, states have the primary responsibility for regulating insurance sold to their residents, employers that sell fund health insurance coverage under ERISA are not subject to state regulation. More Americans receive coverage that is exempt from state regulation, about 90 million lives, than receive regulation that is subject to both Federal and state regulations, about 70 million.

Insurance regulation under ERISA has been generally light; indeed, employers have nearly complete freedom under ERISA to design their own insurance coverage, and employees are overwhelming happy with the quality of employer-provided coverage. Since there has been no race to the bottom in the ERISA-protected market, it is unlikely to occur in a national market for health insurance.

Policymakers should also not forget rising health care costs are the single greatest barrier to accessing health insurance for uninsured individuals regardless of health status, and that reducing unsustainable health care cost increases is the single most important thing we can do to ensure that coverage remains affordable.

Mandating Cadillac coverage is the only option for individuals locked into expensive state markets is the surest way to continue the vicious cycle of cost increases, dropped coverage, and large and expensive increases in public coverage in programs like Medicaid.

Thank you for the opportunity to comment on this important issue, and I look forward to your questions.

Mr. PITTS. The chair thanks the gentleman.

[The prepared statement of Mr. Howard follows:]

Written Testimony
U.S. House of Representatives
Committee on Energy & Commerce
Subcommittee on Health Hearing
Wednesday, May 25th

Paul Howard, PhD
Manhattan Institute for Policy Research

“Expanding Health Care Options: Allowing Americans to Purchase
Affordable Coverage Across State Lines”

First, I'd like to thank Chairman Pitts, Ranking Member Pallone, and the entire committee for holding the hearing today on the important topic of interstate insurance competition and H.R. 371, the Health Care Choice Act of 2011. I'm speaking today in my capacity as director and senior fellow of the Manhattan Institute's Center for Medical Progress, my experience writing and researching on health care policy issues, and from speaking to health insurance stakeholders (including large and small employers, insurers, and consumers) about the challenges facing the market today.

There is no doubt that the single most important issue facing American health care today is the high and rapidly rising cost of health care – and, directly related to it, the high cost of health insurance. There no doubt that the passage of the Patient Protection and Affordable Care Act in 2010 has done little to alter the unsustainable trajectory of health care inflation for the federal government, states, employers and consumers.¹ The high cost of care is the primary reason why many Americans lack health insurance, since they cannot find affordable coverage that meets their needs, and why more small employers are dropping coverage in the face of unsustainable coverage increases.

However, while there is widespread agreement that “something” has to be done to curb the high rate of health care inflation, policy solutions tend focus on the villain *du jour* (Big Pharma, Big Insurance, etc, as long as the industry is “Big”) rather than facing the underlying forces contributing to our current woes. Let me briefly outline those forces:

1. Health insurance should function as protection for individuals and families against the potentially devastating financial impact of a catastrophic injury or serious illness, not the coverage of routine costs for families of moderate (and not so moderate) means. However, the tax advantaged status of employer-provided health insurance leads employees to prefer plans with high pre-tax premiums, and low-after tax deductibles and co-pays even for routine care.

¹ As CBO Director Douglas Elmendorf noted not long after the passage of the Patient Protection and Affordable Care Act: “Rising health care costs will put tremendous pressure on the federal budget during the next few decades and beyond. In the CBO's judgment, the health legislation enacted earlier this year does not substantially diminish that pressure.” Presentation to the Institute of Medicine, Health Costs and the Federal Budget, May, 26 2010. Slide 2. Available online at <http://www.cbo.gov/ftpdocs/115xx/doc11544/Presentation5-26-10.pdf>.

Bipartisan economists recognize that the unlimited tax deduction for employer provided insurance increases health care inflation, and makes it more difficult to constrain the consumption of low-value services with marginal benefits. Individuals without group health insurance must also purchase insurance at significantly higher cost, since they must purchase insurance with “after-tax” dollars.

2. Providers are largely paid on a fee-for-service basis, with little competition based on price and quality. In every other sector of the U.S. economy, producers compete with each other to provide consumers with a wide variety of “bundled” products and services at a wide variety of prices. In health care providers have little incentive to compete based on price and quality. In fact, providers that offer lower cost, higher quality services are actively penalized for such improvements, and higher cost competitors can financially benefit from their inefficiency.
3. Government regulation in the health care sector often strays from its legitimate purpose of consumer protection and mandating basic standards to favoring particular groups of incumbent providers (traditional v. physician-owned hospitals; physicians v. nurse practitioners) against competitors who may be able to offer similar products and services at lower prices, or achieve higher quality outcomes. This is particularly true for our discussion today, since state health care markets are often captured by incumbents, particularly in the realm of insurance regulation. Such regulations often mandate the coverage of provider services or insurance benefits in the name of consumer protection, when in reality what such mandates provide is provider protection – or, I should say, provider income protection.

Obviously these issues are intimately intertwined. A limited tax exclusion or tax credit would give consumers a powerful incentive to demand that insurers and providers offer the most cost-effective bundles of health care products and services and contain health care costs. Empowered consumers would also drive hospitals, physicians, and pharmaceutical companies to offer better information on risk-adjusted quality outcomes. Policymakers facing cost-sensitive consumers would have a much greater incentive to consider the cost increasing effects of insurance mandates to determine if their benefits outweighed their aggregate costs.

In other words, if we begin by creating a more efficient market for health care goods and services, we can determine what consumers want and *are actually willing to pay for*, and induce providers and insurers to offer those services efficiently. At that point, we can determine what – if any – true “market failures” remain and act accordingly to provide additional regulations to improve the operation of those markets or consider targeted subsidies for consumers with very low incomes or very high cost health needs that aren’t well served by the standard or most common insurance packages. If we make the market work well for 90% of the population, the task of assisting the remaining 10% will not only be easier, it will be less expensive.

The state regulation of health insurance is a particularly contentious political issue. State legislators often justify additional insurance mandates by pointing to isolated anecdotes where coverage of a

particular service or provider appears, at least after the fact, to be critical to the health and wellbeing of a particular policyholder. But legislation via anecdote is not a justification for adding additional costs to standard insurance packages, particularly when increasing the cost of standard insurance packages inevitably prices some consumers out of the market because they cannot afford to buy the “Cadillac” coverage that legislators (or the providers who argue for such coverage) believe they must pay for. As a joint 2004 Federal Trade Commission and Department of Justice report noted

For mandates to improve the efficiency of the health insurance market, state and federal legislators must be able to identify services the insurance market is not currently covering for which consumers are willing to pay the marginal costs. This task is challenging under the best of circumstances – and benefits are not mandated under the best of circumstances. In practice, mandates are likely to limit consumer choice, eliminate product diversity, raise the cost of health insurance, and increase the number of uninsured Americans.²

Different consumers will have different preferences for insurance coverage and terms – as a 25 year-old male may opt for very different insurance than a 38 year-old married father of two. Telling the younger man that he must opt for the older man’s coverage is likely to price him out of the market entirely.³

Congresswoman Blackburn’s bill (the Health Care Choice Act) would help create a viable interstate insurance market that would begin the vital process of making the marginal costs of regulation and mandated insurance benefits transparent to uninsured individuals who are the most in need of more affordable insurance options. It may also spur innovation in insurance products as states compete to offer the best combination of cost and coverage terms. Finally, once the added costs of regulation were visible to consumers through regulatory competition, providers who wanted to maintain insurance coverage of their services would have to find ways to lower their costs or increase their value of their services to make them more attractive to the majority of insurance consumers. This exactly the type of competition that we should be encouraging in health care and insurance markets.

Many objections to the interstate sale of health insurance rest on a purported “race to the bottom” that would supposedly ensue if consumers could purchase products across state lines. It is unclear what, if any, justification there is for this assertion since products sold in a “secondary state” under H.R. 371 would also have to be sold within their “primary state”. Policymakers and insurance regulators in the primary state would still have powerful incentives to ensure that such coverage sold to state residents was not deceptive, and of high quality. Also under H.R. 371, insurance departments in the “secondary state” could still collect premium taxes and high risk pool assessments from plans sold across state borders, ensuring the financing necessary to maintain their primary role of protecting consumers against fraud and supporting high risk pools for individuals with high cost pre-existing conditions.

² Executive Summary, “Improving Health Care: A Dose of Competition,” p. 24. Available online at <http://www.ftc.gov/reports/healthcare/healthcarerptexecsum.pdf>.

³ See also David A. Hyman, Health Insurance: Market Failure or Government Failure? Connecticut Insurance Law Journal, vol. 14:2008 (316).

This objection also ignores the fact that, although under the McCarron-Ferguson Act states have the primary responsibility for regulating insurance sold to state residents, employers that self-fund health insurance coverage under ERISA are not subject to state regulation. More Americans receive coverage that is exempt from state insurance regulation – about 90 million covered lives – than receive regulation that is subject to both state and federal regulation (about 70 million lives). Insurance regulation under ERISA has been generally light (except for regulations mandating minimum hospital maternity stays; mental health parity; and limits on pre-existing condition exclusions). Indeed, employers have nearly complete freedom under ERISA to design their own insurance coverage, and employees are overwhelmingly happy with the quality of employer-provided coverage. Since there has been no “race to the bottom” in the ERISA-protected employer market and one would expect similar outcomes from the evolution of a national market for health insurance.

A more legitimate concern may be that in very highly regulated states that mandate comprehensive insurance coverage in addition to community rating (like New York), healthy consumers will opt for less regulated but also less expensive policies, leaving the “secondary state” with a less healthy risk pool – and facing ever increasing premiums.

However, we should note that adverse selection is largely the result of regulatory policies (like community rating and guaranteed issue) that prevent insurers from offering younger or healthier consumers affordable policies – leading them to exit insurance markets. In New York, which has had community rating and guaranteed issue regulations in place since the early 1990s, the individual “direct pay” insurance market has almost completely collapsed.

As recently as 2001, more than 128,000 individuals were enrolled in HMOs in the direct-pay market. By 2010, enrollment had plummeted to just 31,000. Premiums have approximately tripled during the same period. *The New York Times* noted: “New York’s insurance system has been a working laboratory for the core provision of the new federal health-care law—insurance even for those who are already sick and facing huge medical bills—and an expensive lesson in unplanned consequences. Premiums for individual and small-group policies have risen so high that state officials and patients’ advocates say that New York’s extensive insurance safety net ... is falling apart.”⁴

As long as insurers can charge premiums that accurately reflect policyholders underlying risk, they should have no disincentive to offer plans that meet the needs of policyholders with less than pristine health. Rather than constraining the prices insurers can charge the vast majority of healthy consumers, legislators who are concerned about maintaining access for individuals with very costly pre-existing conditions should consider long-term federal funding for state high risk pools that helps make coverage affordable for such populations. (As noted earlier, under H.R. 371, states would still be able to collect premium taxes for state-funded high risk pools from plans sold across state lines.)

Policymakers should also not forget that rising health care costs are the single greatest barrier to accessing health insurance for uninsured individuals, regardless of health status, and that reducing unsustainable health care cost increases is the single most important thing we can do to ensure that

⁴ Anemona Hartocollis, “New York Offers Costly Lessons on Insurance,” *New York Times*, April 17, 2010.

coverage remains affordable. Mandating "Cadillac" coverage as the only option for individuals locked into state markets is the surest way to continue the vicious cycle of cost increases, dropped coverage, and large (and expensive) increases in public coverage programs like Medicaid.

Let me offer one final observation by way of conclusion. The U.S. economy is as dynamic and innovative as it is because firms are forced to compete across state lines for everything from cell phones to stock trades. The ensuing competition drives innovation and productivity through many American industries, to the enormous benefit of consumers. Health care is one of the very few sectors where competition and consumer choice is restrained, as federal and state regulations insulate inefficient providers from potentially more nimble competitors. Until we create a successful national market for health care – not only for health insurance, but at least starting there – health care will continue to exhibit the uneven quality and high costs associated with "protected" industries.

Thank you for the opportunity to comment on this important issue and I look forward to your questions.

Mr. PITTS. Thanks to the panel for your opening statements.

I will now begin the questioning. I recognize myself for 5 minutes. Dr. Howard, we will start with you.

Some of my colleagues on the other side of the aisle have argued that imposing individual mandates will lower premiums for everyone by promoting larger risk pools and discouraging emergency room utilization. Have we seen any evidence of lower premiums or decreased our utilization in Massachusetts?

Mr. HOWARD. No. What you have seen in Massachusetts is that ER use has actually gone up, despite the expansion of coverage there to nearly the entire population, and costs have not gone down. Massachusetts insurance costs have continued to go up and it continues to lead the Nation in health insurance premiums. So it is both a highly regulated state and a high-cost state, and individuals have not been able to find more affordable coverage outside of Massachusetts Commonwealth Care Program, which is extraordinarily heavily subsidized insurance. So the market has remained very expensive. It is extraordinarily costly for both the state and individuals.

Mr. PITTS. Dr. Parente, do the regulations of guarantee issue and community rating penalize people that have been responsible and purchased insurance before they were sick?

Mr. PARENTE. Absolutely. In our models and from the literature that has come out before our study, the biggest thing the community rating and guarantee issue do is push up the premium cost. It is just automatically what an insurance actuary does when they factor in the price. And if someone had been on the insurance policy and suddenly they had that mandate that comes on and says now they are a community-rated state, they are likely to be seeing a premium increase, by no fault of their own, of 20 to 25 percent, sometimes as much as 30 percent, just to in effect spread that risk by the imposition of that policy component. If you want to see that illustration, go to New York where the individual insurance market has been decimated by the combination of community rating and guarantee issue over the last 10 years.

Mr. PITTS. If you would continue, Dr. Parente, would the optimum policy goal be to have a system where consumers have more choice, are encouraged to buy insurance when they are healthy, and provide a safety net with those with preexisting conditions, be able to purchase affordable coverage through functioning high-risk pools? Would that be a lot cheaper to accomplish than PPACA?

Mr. PARENTE. That would be the ideal. The logistical challenge is to make sure that the folks that are vulnerable and don't buy coverage, that lose coverage because of preexisting conditions, have that high-risk pool that is available to them.

Minnesota actually has that in place. They have had a high-risk pool designed very successfully since 1978. It is probably associated with about half of what would otherwise be folks who are uninsured because of that design. If that type of design was available more commonly across the U.S., it could actually be quite effective.

What is nice about the interstate policy is what it does is it levels the playing field in terms of letting people shop freely across states, potentially electronically; ehealthinsurance.com has shown that that can be done quite easily. And then for those who may be in

a vulnerable situation, as long as they are identified, they can essentially apply for premium subsidy support and essentially get it either through a state high-risk pool design or some other type of system.

Mr. PITTS. Ms. Herrera, you mentioned Georgia. Georgia recently enacted a law to allow the purchase of health coverage across state lines. Can you give us an idea of how many states Georgia residents can now buy more affordable coverage from?

Ms. HERRERA. Absolutely. In the case of Georgia, it shares a border with Alabama, which has a relatively low number of mandates and a relatively lightly regulated health insurance market. Premiums are lower. So for folks in Georgia who are uninsured, allowing them to go over to Alabama to buy a more affordable policy would be good.

However, Georgia also shares a border with Florida, which has mandate-rich coverage and many consumer protections. Folks in Georgia looking for those options could buy from Florida as well.

Mr. PITTS. Could you elaborate on the effects on coverage in New York after PPACA-like reforms such as guaranteed issue and community rating were adopted?

Ms. HERRERA. I am not familiar with the New York market.

Mr. PITTS. Dr. Parente, can you elaborate on that?

Mr. PARENTE. Actually, Dr. Howard and I did a study that came out last year that more or less showed that when that legislation was changed in the mid-1990s it pretty much took a functioning individual insurance market with a several hundred thousand individuals and reduced it now to I think close to less than 100,000 people, 50,000 people in the private insurance market. There was additional state subsidy components that came in place, but the cost to New York to put that subsidy program in place ended up being net expensive and potentially putting many New Yorkers in a much more vulnerable position.

When we have done simulation models using the same models in the study showing what would happen if New Yorkers could buy from Pennsylvania and Connecticut, it potentially could reduce the uninsured for that population affected by half.

Mr. PITTS. Thank you. My time has expired.

The chair recognizes the ranking member for 5 minutes for questions, Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman.

I ask unanimous consent to have Mr. Green participate in the questions and answers, Mr. Chairman.

Mr. PITTS. Without objection, so ordered.

Mr. PALLONE. I wanted to start with Mr. Larsen.

Mr. Larsen, I would like to discuss with you some of the effects that H.R. 371 or a similar proposal might have on state governance in the insurance market. You probably know that Arizona Governor Jan Brewer recently vetoed legislation that would allow out-of-state carriers to sell policies in Arizona.

Mr. Chairman, I would ask unanimous consent to enter the veto message of Governor Brewer into the record. I don't know if you have it.

Mr. PITTS. We have it. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. Is it your understanding that the proposal like H.R. 371 would vacate the state of Arizona's decision and in essence overturn the Governor's decision?

Mr. LARSEN. That is my understanding, yes.

Mr. PALLONE. OK. Governor Brewer, when she vetoed the bill last month allowing selling insurance across state lines, she said in the message—and that was what I just entered into the record—she said she “is concerned about risk to our citizens who may be subject to other states’ regulatory procedures that could leave them with little recourse in the event of mistreatment.”

Recalling your days when you were the insurance commissioner for Maryland, did you, for example, have enough money in your budget to assist consumers in other states if a plan licensed in your state was causing problems for them elsewhere?

Mr. LARSEN. It was always a challenge to get funding for our department, so it would have been difficult to handle the complaints from any number of other states.

Mr. PALLONE. But wouldn't we end up with more sham plans on the marketplace and more consumers in trouble, essentially?

Mr. LARSEN. I think it certainly creates that possibility. It is very likely, yes.

Mr. PALLONE. Is there anything in your experience at HHS that leads you to believe that it would be a good idea for the Federal Government to preempt all state insurance laws subject to the whims of insurance companies?

Mr. LARSEN. For states or the Federal Government?

Mr. PALLONE. For the Federal Government to preempt all the state insurance laws?

Mr. LARSEN. No.

Mr. PALLONE. I will ask you and also Mr. Finan, if I could. I am concerned under this legislation, Ms. Blackburn's legislation, or something similar, the incentive would be for insurance companies to choose to locate in the state with the least amount of protections and the least amount of oversight of the industry.

So let me ask Mr. Larsen first, do you believe that insurers would rush to sell products from the single state with least possible consumer protections and other requirements?

Mr. LARSEN. I do.

Mr. PALLONE. And then, Mr. Finan, how would this affect the individual health insurance market in most states? Because you know a number of states require insurance companies to offer coverage to everyone in their state, the guaranteed issue, and some states require insurance companies to offer that coverage at one rate, community rating. What effect do you think that Ms. Blackburn's bill would have on those in most need of health care services in these states, for example, people with cancer?

Mr. FINAN. There is no question that without a level playing field, without standardized rules across the market, it will be a race to the bottom. States will—excuse me, insurance companies will migrate to the least regulated states. And, as I said in my testimony, without a guaranteed issue, they will cherry-pick, and therefore they will be looking to pick off from other states the best risk. They will offer minimal benefit packages. The cost will be very low.

We know today that the consumers, most consumers, the consumer literacy about health insurance is extremely low. They buy in price. So they see a product across state lines with a low price and they say, yes, that is great. But the reality is, particularly for cancer patients, is they are not going to be able to buy across state lines. Insurers won't accept them. They don't have to. And they are going to be left behind in their states with smaller risk pools with much higher risks. And the costs will be extraordinarily high, where you are going to end up with a bifurcated system where the young and healthy can do very, very well, but those, once they become sick, wind up in high-risk pools where the access to insurance is either not available because it is denied or it is beyond their reach.

But let me just end by saying the reality is that most of us sooner or later will get sick. One in two men and one in three women will ultimately have cancer. And that means there is a good chance, particularly for those in the individual market, someday, when they most need it, they are going to be without it.

Mr. PALLONE. Let me just ask one more thing. You know, I am worried that legislation like Ms. Blackburn's would have a disproportionately negative impact on older Americans or near elderly. How would this bill affect the near elderly? What do you think it would mean?

Mr. FINAN. Again, it benefits the young and healthy. But, as you get older, the costs do correlate with age. As we get older, the costs rise.

And in the case of cancer, cancer is a disease of the aged. So, therefore, your chances of getting cancer increases as you get older. And for people say in their 50s and 60s, pre-Medicare, this becomes highly problematic, because at that point they have no choice, and they don't have the means or access to find alternatives. And we see too often many people in their 50s and 60s struggling to get through until they can get Medicare coverage.

Mr. PALLONE. Thank you.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman; and the chair recognizes the gentleman from Illinois, Mr. Shimkus, for 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman.

I appreciate you all being here today. It is really good to sit and listen, because, obviously, there are differing views.

I would just take issue, Mr. Finan, by saying that what is more critical to the individual who has cancer is when they have no insurance.

This whole debate is having quality, accessible, low-cost insurance; and the debate is really the mandates on issues that may not deal with the catastrophic issues of health care delivery. In my opening statement I deal with contraceptive coverage. That prices people—if it is 1 percent per mandate and you have 30 mandates, you have a 30 percent increase on private health insurance.

I love ALEC, and I appreciate their position. I have got in your testimony individual health policies as low as \$110.05 in Iowa, compared to New York which is \$339.60. That is a huge difference.

Are we saying that the folks in Iowa have sham plans? Ms. Herrera, is that a sham plan?

Ms. HERRERA. Absolutely not.

Mr. SHIMKUS. You mean the folks in Iowa are not supporting sham plans that their constituents—it is not just a payoff to the insurance industry? These are quality health insurance plans that cover catastrophic issues.

Ms. HERRERA. That is a great point. I think that is the beauty of this kind of proposal. As Dr. Parente mentioned in his testimony, you not only have your insurance regulator, commissioner, looking out for you, but you also have the insurance commissioner of the insurer's home state. So we are adding up these layers of protection as we open up the market.

Mr. SHIMKUS. And Iowa borders my state of Illinois. Illinois' individual policy averages about—and this is in your testimony—\$161.16. This is a monthly. So you multiply that by 12.

So the issue is affordable, accessible, quality catastrophic coverage, unencumbered by things that you may not want to have covered. That is kind of this debate, from my perspective. Obviously, other people have different perspectives.

Let me move to—

Mr. FINAN. Congressman, may I—

Mr. SHIMKUS. No, I have got 2 minutes and 30 seconds left, and I need to get to this. I want to go to Mr. Larsen.

The Secretary of HHS with your counsel will be charged with determining what benefits must be in a health plan purchased by my constituents, is that correct?

Mr. LARSEN. There is a requirement in the Affordable Care Act that we will define what are called essential health benefits.

Mr. SHIMKUS. So you will be in this mandate debate, too.

Mr. LARSEN. I am not sure if we call it a mandate debate, but—

Mr. SHIMKUS. Well, it will be if you determine what is in the essential package. That was part of our debate on this whole—why a lot of us opposed it. Because if you get into now a national standard that adds mandates that the individual consumer may now be forced to purchase because of the new health care law, we are in the same boat as this entire debate.

Mr. LARSEN. I would say it is different in this respect. First, to focus on the terminology, these are essential health benefits.

Mr. SHIMKUS. Well, I think the state of Illinois has decided that contraceptive coverage is an essential health benefit, and I would argue that a lot of my constituents do not think so, nor do they want to pay for that. So I would be very, very careful as you all move forward to make sure that it is essential—I would say catastrophic coverage would be essential. What you are doing now is part of this mandate debate.

Let me move to another question real quick. Secretary Sebelius has stated that the fraud and abuse in our medical system increases costs. Do you agree with that assessment?

Mr. LARSEN. I think, yes, we can reduce costs through doing an improved job of ferreting out fraud and abuse. Yes.

Mr. SHIMKUS. So part of the health care plan is going to have a huge focus on ferreting out waste, fraud, and abuse.

Mr. LARSEN. Yes.

Mr. SHIMKUS. And with your attention and the Secretary's attentive focus on this.

Mr. LARSEN. Yes.

Mr. SHIMKUS. Good. Great. Thanks.

With 30 seconds remaining, you also mention that patients in non-grandfathered plans now have greater freedom to choose their own doctor. Section 1311(h) of the health care law, page 78 in the yellow book that is on the table there, authorizes HHS to issue regulations that would prohibit health plans from contracting with certain physicians, is that correct?

Mr. LARSEN. I apologize, I am not quite sure what you are saying.

Mr. SHIMKUS. Well, I am done. Maybe one of my colleagues will follow up. It is page 78. The health care law is right there. You are welcome to grab it. I think your health care law will allow HHS to deny individuals access to the doctor of their choice.

I yield back.

Mr. PITTS. The chair thanks the gentleman and recognizes the ranking member emeritus, Mr. Dingell, for 5 minutes for questions.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy. The French have a great saying: The more things change, the more they are the same.

I have seen this before. About 20 years ago, this committee went into the matter of mischief rascality in interstate sales in insurance, and it was a scandalous thing to behold. And we found the state regulatory agencies didn't have the authority to address it, that they couldn't address it, and they wouldn't address it.

Beyond that, we found something else. We found that folks were traveling around the country with suitcases full of cash running off to the Cayman Islands and all kinds of other places, that places like Louisiana and Texas, next-door neighbors, couldn't deal with their problems of enforcing the laws. It was a terrible mess. And insurance ratepayers were getting skimmed left and right, and commissioners of insurance came into this committee to complain about the fact that this was going on.

So I can see that the insurance companies have been busy, and I can see they are looking forward to cutting a fat hog, which this bill will permit. So I have a few questions here.

So, to Director Larsen, please answer yes or no. Section 2796 of H.R. 371, the Health Care Choices Act of 2011, would exempt health insurers in a secondary state from complying with any state law regarding fraud and abuse other than those that meet the definition in section 2795. I am concerned that the definition of fraud and abuse in H.R. 371 is so high states would find it nearly impossible to prosecute an insurer for fraud and abuse, thereby opening wide the door to fraudulent activity. Now, do you agree with that statement, yes or no?

Mr. LARSEN. Yes.

Mr. DINGELL. All right. I happen to believe that H.R. 371 would increase the opportunity for rascality, particularly due to lack of enforcement authority and oversight tools, and, as Mr. Pallone has pointed out, money and the capabilities to deal with these things that would be available in the secondary state. These states would

be unable to revoke the license of an out-of-state insurer if they were found to be acting fraudulently; and, without this type of tool to discourage abuse, I am curious how a secondary state could in fact protect their constituents.

Again, as a former insurance commissioner, do you believe that a secondary state would be able to audit an insurer's license in another state under H.R. 371, yes or no?

Mr. LARSEN. I am sorry, that they would or would not be able to audit?

Mr. DINGELL. Say it again?

Mr. LARSEN. Well, let me answer this way: I think that provision of the law would give me great pause as a former commission in my ability to oversee.

Mr. DINGELL. It would be a wonderful opportunity for rascals and rascality.

Further, if a secondary state found that an insurer acted fraudulent in their state, do you believe again that H.R. 371 would allow a Secretary of a secondary state to prevent the insurer that acted fraudulently from operating within their boundaries? Yes or no?

Mr. LARSEN. I think it would be difficult, yes.

Mr. DINGELL. Now, Mr. Finan, it is clear that one of the side effects of this bill will be a race to the bottom, and insurance companies will be huddling up in the states with the most lenient regulations. For example, under current law, if a constituent of mine suffering from breast cancer has a complaint about their insurer not covering the cancer treatment recommended by their oncologist, my office could help them receive recourse through the Michigan Insurance Commissioner.

I am curious how my office would handle such requests under H.R. 371. If a constituent purchased their inadequate insurance in Iowa, am I to expect that the Iowa Insurance Commissioner is going to regulate this insurer? I happen to think that this puts too much hope and trust in the insurance industry and in a ramshackle system of regulation. I previously told my friends on this committee this would be like using one pat of butter for a whole loaf of bread.

Is it your opinion, Mr. Finan, that you believe that one state or even a small group of states would be equipped to handle the concerns and complaints of residents of a neighboring state?

Mr. FINAN. We are deeply concerned about the ability of any state insurance department to enforce or act across state lines.

Mr. DINGLE. Thank you.

Now, one of the biggest accomplishments of The Affordable Care Act is that consumer protections make up what is called the Patient's Bill of Rights. H.R. 371 would repeal these protections, leaving consumers once again vulnerable to lifetime limits, annual limits, discrimination for pre-existing coverage, limited health benefits, and rescissions. I tend to believe that repealing these protections would enable the insurance companies to discourage or prevent those suffering from cancer or other illness from entering their pool.

Do you agree with this assessment, yes or no?

Mr. FINAN. Absolutely.

Mr. DINGELL. Thank you.

Mr. Chairman, I thank you for your kindness. I think we have a bad bill here.

Mr. PITTS. The chair thanks the gentleman; and the chair recognizes the gentleman from Pennsylvania, Dr. Murphy, for 56 minutes for questions.

Mr. MURPHY. Thank you very much.

Mr. Larsen, at the end of your testimony—I couldn't find your written testimony—you made reference to that if a person has to go back to another state because they are having problems with their insurance company, you said, basically, it was likely their consumer complaints or problems would go unresponded to or unheeded. Can you explain that?

Mr. LARSEN. I think the issue is, if there is—I think the terminology that this uses is the primary and secondary state. If you are a resident of the secondary state, now you are essentially beholden to the resources of the insurance department in the primary state.

Mr. MURPHY. But how did you word that, though? If you were not from that state you felt they weren't going to be responsive?

Mr. LARSEN. It is a resource issue, frankly. If you have got a company that is selling in 50 states from one primary state and that primary state has to address the concerns or complaints, which you always get as an insurance commissioner—

Mr. MURPHY. So you feel they would be less likely to be responsive?

Mr. LARSEN. It is a resource issue. There are only so many people—

Mr. MURPHY. OK. Have you ever been to a restaurant where you got bad service or bad food?

Mr. LARSEN. Yes, I have.

Mr. MURPHY. Do you go back?

Mr. LARSEN. I try not to.

Mr. MURPHY. Do you tell your friends not to go back?

The answer is that I think if a person goes to a restaurant with bad service, they are about 12 times more likely to tell friends about it, but they go to a good restaurant, they tell a few. But the point is, word gets out; and that ruins that restaurant's reputation.

Let me ask this: Does Medicare run things well? Because I know I have got staff that are always dealing with Medicare and Medicaid problems. As a matter of fact, I have introduced a bill to deal with some of things that CMS has promised. Yet when plaintiffs' attorneys and trial attorneys are trying to seek information, just information, from Medicare with regard to how much Medicare has paid on a bill, it can take them weeks or months to find this out, and oftentimes this is an error.

Now, my problem is seniors who have this issue, they have nowhere else to go. They have no other restaurant they can turn to. They have no other car dealer they can turn to. They are in a single market here where they have nowhere else to go.

So, along those lines, one of the things I hope you will look into, when an organization has a monopoly on something, there is no competition or anything else that anybody can do, and that is part of what we are seeking here, is to find another way of that. So if a person doesn't like the service from one insurance company, they say I am not going to go back, and that information does get out.

So I would ask the other panelists along those lines, what mechanisms does someone see in this bill or something that should be added to it that, if a person is shopping across state lines, that should be available for people to have information as to whether or not an insurance company covers certain things or they are in effect inefficient.

Can someone answer that for me?

Mr. FINAN. I would like it address that.

First of all, health insurance is not like a restaurant. I totally agree with you. You get lousy service, you don't go back. That is the end of that.

But what about the cancer patient who is in the middle of a treatment, is being denied coverage they think they are entitled to under the contract? What is the recourse? They can't go to another health insurance plan at that point. That is impossible.

Mr. MURPHY. That is a good point. But that is a different—I understand the point. Look, I don't want anybody to be denied coverage. I don't want anybody cut from coverage. That is another issue. And I do want to ask you a question about cancer.

But my point is, however, I know in the Pittsburgh market, we are basically locked into two companies who cover the dominant part of the market and a couple other ones. But people don't have any other choice. So even if they say I didn't get good service from this insurance carrier and didn't get that one, they have got nowhere else to go.

Ms. Herrera, can you answer that? Is there any mechanism you see that states can help demand or provide along these lines?

Ms. HERRERA. Well, my expertise is in the area of state legislation; and in all of the states that have enacted this legislation, the primary state's insurance commissioner, the primary state's courts, would adjudicate those views.

Mr. MURPHY. Well, then let me go back to this cancer question. Because, Mr. Finan, this is very important for cancer. Because I strongly support your concerns here. But do you see anything in this bill that prevents us from either—maybe it should be added to this bill, maybe another bill—that would deal with the issue of denial of coverage or denial of pre-existing conditions or cutting someone? Do you think that is something we still need to make sure that we address as Congress, to make sure you still can't deny coverage?

Mr. FINAN. Yes. The Affordable Care Act, one of the big advances from a cancer patient and survivor perspective is that there is establishment of clear consumer rights, including, for example, the right to appeal and the clarification. This bill, as I understand it, would repeal all of those provisions. So, therefore, you go back to the old system where there are—

Mr. MURPHY. It would repeal every single provision?

Mr. FINAN. As I understand it, it would repeal title I of the Affordable Care Act, which embeds all of those consumer rights. So, therefore, you go back to a system where the consumer is totally confused. We have seen this very often among cancer patients, that they are denied coverage, they don't know how to appeal, the rules are convoluted.

Mr. MURPHY. Well, there is something in here on page 22 about the right to an external appeal process, so maybe we should discuss that more and review that, because I would like to find out. Thank you.

I yield back.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentlewoman from California, Mrs. Capps, for 5 minutes for questions.

Mrs. CAPPS. Thank you. And I appreciate the previous 5 minutes.

I don't want to keep you on the hot seat, Mr. Finan, but I would like to continue this conversation about chronic diseases.

When most people think about individuals who can't get health insurance coverage because they are sick, they do think about individuals with catastrophic illnesses like cancer or AIDS or multiple sclerosis or any number of debilitating progressive conditions. I will give you a little more time to amplify it for us, some of the difficulties you have documented in cancer patients getting insurance and accessing treatment once they have insurance and the challenges that would be posed by this bill, as you understand it.

Mr. FINAN. What I stated in my statement and are absolutely essential are the common rules. There needs to be guaranteed issues, that insurers are not discriminating. That helps level the risk and level the cost.

Insurance is about cost sharing. It is about sharing risk. I mean, I have had homeowner's insurance for 30 years and have never collected, but I am perfectly fine with that.

In health insurance, we know that sooner or later most of us will experience a serious claim, and so we have to set the rules so that cost is spread. It is essential to have essential benefits. Because, too often, and we see this increasingly often, where patients don't—get in the middle of treatment and then they realize they have run out of benefits.

Mrs. CAPPS. Right.

Let me just ask you, because we are faced with two choices. We have the law now that the approach, as you understand it under the Affordable Care Act, but now the Health Care Choice Act, how would you contrast ramifications for people with cancer? Do you believe that the protections on access to coverage would be eroded under this bill that is before us?

Mr. FINAN. Oh, very quickly. No question.

Mrs. CAPPS. Just highlight a couple of the areas, if you would.

Mr. FINAN. Well, again, it is a race to the bottom. Insurers are going to sell weak benefit plans at a relatively low cost to relatively healthy people.

Mrs. CAPPS. And if you become sick—because a healthy person can have a diagnosis with cancer, and then life changes in an instant before their eyes.

Mr. FINAN. And that is correct. And then, all too often, insurers engage in practices to force people out. There have been rescissions. This committee has done a lot of excellent work in that area. And where do they go? Then they wind up in pools that are extraordinarily expensive.

I know of an example of a few years ago of a woman who moved from Alabama with insurance, wanted to move to Virginia, which

is an insurer of last resort, which means the Blue Cross there does have to provide insurance, but they can rate based on the risk. And a woman with breast cancer that had completed her treatment was given a premium of over \$60,000 a year. If you inflated that to current costs, it is probably more than \$75,000 to \$85,000 a year. That is what will happen to cancer patients under this kind of system where you bifurcate the risk pools.

Ms. KAPTUR. And cherry-pick—

Mr. FINAN. Cherry-pick. They will get great prices. But people with chronic conditions like cancer are going to wind up with extraordinarily expensive insurance.

Mrs. CAPPS. And, like you say, the reason we have health insurance is to protect us if something catastrophic happens.

Mr. FINAN. When you become ill.

Mrs. CAPPS. Yes.

Mr. Larsen, I want to use the rest of the time to talk about the difference between— well, talk about what states' rights involve. You highlight in your testimony that this bill would create an unlevel playing field where some of your constituents are protected by the laws in their states and some are not.

In addition, you note that this bill would undercut the authorities of state governors, state legislators, and insurance regulators. So states' rights are out the window, something that most of our colleagues on the other side of the aisle often point to as the reason to block-grant Medicaid or to repeal the Affordable Care Act.

What would this do to consumers? How would it ultimately hurt them, if it would?

Mr. LARSEN. Well, I think it would. And it is a huge change. I mean, compare the resources that different insurance departments have. I think the state of Texas has 20 times the staff as a state like Idaho. So if, for example, an insurer decided to use as its primary state a lightly regulated state with very little staff, it is hard to imagine how that staff could handle essentially regulating products that might be sold in 50 states.

Mrs. CAPPS. How would you imagine a state insurance commissioner—that is something you know something about. How would that state insurance commissioner punish abusive insurance companies that may be located in another state?

Mr. LARSEN. Again, if you don't have the authority over the company that is selling to your residents, you—

Mrs. CAPPS. You have no control.

Mr. LARSEN. Certainly you can, you know, talk to the other insurance commissioner, but, at the end of the day, if they are selling products legally under a proposal like this in your state and they have only so many resources and so many laws—because it is not just the resources. It is the consumer protection provisions.

Mrs. CAPPS. And wouldn't most of the insurance companies want to locate in a state that had very few regulations?

Mr. LARSEN. Well, I mean, I think that is the purpose, to sell your policies out of a lightly regulated state, both from a resource standpoint and certainly from a benefit requirement. You going to be selling, you know, thin, light policies in my state. My healthy young people will gravitate to these policies, and it will essentially destroy the risk pool in my state, and I can't do anything about it.

Mrs. CAPPS. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentlelady and recognizes the gentlelady from Tennessee, Mrs. Blackburn, for 5 minutes for questions.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

I appreciate so much you all are here to talk about this issue. This is one we have talked about for a good period of time. At the core of it is how do you increase access to affordable health care insurance and affordable health care delivery for all of our citizens.

Now, you know, there are a couple of ways that we can go about this, but I find it very interesting that there are some in this room who seem to believe that individuals can't make their own decisions about health insurance, that it is going to take the Federal Government, and I find that very sad. I think that most people find a product that works for them, and they are knowledgeable consumers, and they want to go out and buy the best that they can afford. We see it in other sectors of the free market system.

Mr. Finan, did you read the bill?

Mr. FINAN. Yes.

Mrs. BLACKBURN. You read the bill.

Mr. FINAN. Yes.

Mrs. BLACKBURN. OK. You know, I would encourage you to go back and read the portion—and Mr. Parente actually spoke to this. You not only have your primary state but your secondary state insurance.

Mr. Parente, would you like to elaborate on that point, when it comes to consumer protection?

Mr. PARENTE. You have both states having your back, basically, which is better than just having one state.

And, yes, you have the issue of essentially whether the state insurance commissioner does have the resources to be able to do this. But understand that if insurers start to migrate to that state and that insurer pays taxes because they are migrating to that state based on their revenue, guess what the insurance commissioner office is going to do? Staff up.

You are going to set up a competition amongst the states on who wants to actually have the insurance companies operating within their parameters. And to the restaurant comment, do a good job.

So the issue of cancer and chronic conditions, one thing I would like to point out that is in this study that we looked at that was discussed in the previous committee hearings, if you have a chronic condition and you have cancer, you are better off under an interstate provision than the status quo. And the status quo will take us to 56 million uninsured by 2014.

This law that is being discussed or things like that addresses those people with cancer and chronic conditions today, not in 2014. How can you say to somebody 3 years from now it is oK for you to die because you can't have insurance coverage because we have to wait for the law to come into power?

Mrs. BLACKBURN. OK, Ms. Herrera, let's talk about state insurance commissioners and legislatures. Do you find that they evaluate the cost of the mandates before they implement them or do they put them in place and then do a review?

Ms. HERRERA. In about 28 states, they have what is called a Mandated Benefits Review Act, which requires a cost-benefit analysis for proposed state mandates before they take effect.

Mrs. BLACKBURN. OK. As a practical matter—and, Mr. Howard, let me come to you on this. Because I think that some of the research work you all at Manhattan Institute have done—as a practical matter, insurers have to offer policies that consumers are willing to purchase. We know that. And I believe consumers are pretty savvy. Shouldn't they be able to determine which type of benefits that they want, that insurers are willing to buy, that they can go to one of the states which has offered a certain set of mandates, a certain set of benefits, and then make those choices, knowing that they are going to have that benefit review in that state, find a product that fits them, and then be able to move that into the marketplace? So shouldn't they have the ability to make that decision?

Mr. HOWARD. Absolutely. And I think that what we need to think of this is as a dynamic system. So no state is going to want to have the reputation of being a fly-by-night state where they were allowing terrible or abusive insurance practices. They in effect would want to become the Delaware of insurance, where they would want to have the reputation for the best solvency requirements, the best consumer protection, and the most affordable policies. So states would have powerful incentives to attract consumers, as Dr. Parente just pointed out, for reasons of accruing premium taxes, to have the right mix of coverage that was both affordable and—

Mrs. BLACKBURN. Thank you for that.

I have got another question. Mr. Larsen, your testimony praises PPACA for supposedly aiding children with pre-existing conditions. Yet what we have seen in some surveys since PPACA was signed into law is that the carriers are no longer offering child-only health policies in 20 states. The so-called protection for children with pre-existing conditions has turned into a nightmare, an absolute nightmare, where many parents cannot find coverage for their children at all. Do you believe that that is an acceptable outcome?

Mr. LARSEN. Here is what I would say. We have—

Mrs. BLACKBURN. Yes or no?

Mr. LARSEN. We have stopped the process. We tried to stop the process of insurance companies not providing coverage to sick kids, which they actually agreed to do and then decided that they didn't want to do. And we have given them every tool possible in terms of open enrollment, rating options, everything. And I think—

Mrs. BLACKBURN. Do you find it acceptable that premiums have increased on young adults 17 percent? AP reported that young adult health premiums have increased 17 percent because of the new law. Do you find that acceptable?

Mr. LARSEN. Those certainly aren't the numbers that we have seen, and I am not familiar with that.

Mrs. BLACKBURN. I will be happy to supply you with the article. I yield back.

Mr. PITTS. The chair thanks the gentlelady and recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes for questions.

Mr. WAXMAN. Thank you, Mr. Chairman.

I find this bill like a bad penny—it keeps on coming back. And it doesn't make sense now, particularly since we have the Affordable Care Act. The Affordable Care Act was supposed to deal with the problem of people who have pre-existing—one of the big problems. People can't buy insurance, and they can't buy insurance in the individual market often because they have pre-existing conditions.

Dr. Howard, would this change the practice for pre-existing conditions if an insurance company still wanted to discriminate?

Mr. HOWARD. You know, in states that have implemented both community rating guaranteed issue—

Mr. WAXMAN. I am just asking you, is there anything in this bill that would prevent denying coverage because of pre-existing conditions?

Mr. HOWARD. It would allow people to buy insurance that was more affordable. It would give people more options to buy insurance.

Mr. WAXMAN. Well, what if the insurance companies didn't want to cover them because they had pre-existing conditions?

Mr. HOWARD. Insurance companies that didn't offer coverage or offered unaffordable coverage should have the option of state high-risk pools, federally funded, hopefully, to have that option.

Mr. WAXMAN. That is not in this bill. That is not existing law.

Now, let me go through, rather than the abstract of some of these issues, let me get into some details.

Dr. Howard, do you believe that insurance companies should cover the adopted children of their policyholders?

Mr. HOWARD. If they would like to pay for that additional coverage. If people want to pay for additional coverage, it shouldn't be mandated that everybody has to cover that, which just passes costs along to other consumers.

Mr. WAXMAN. You don't think it is appropriate for states to require coverage of adopted children the same as their other natural-born children? In fact, I can't imagine how anybody could justify an insurer not covering adopted children in the same way they cover other children. The Blackburn bill would end that protection that has been adopted by 45 states.

Dr. Howard, do you believe that insurance companies should be required to cover disabled dependents, such as disabled adult children living with their parents?

Mr. HOWARD. I believe that states that have those requirements—the problem is that insurers will offer any benefit to consumers—

Mr. WAXMAN. You could buy anything if you have the money, but there would be no requirement that the insurance companies cover disabled adult children. Disabled adult children, often unable to work, would have nowhere to turn for their health care unless they could be covered under their parents' policy. Nowhere, of course, except Medicaid, which the Republicans are proposing to destroy. The Blackburn bill would eliminate this protection that 42 states have chosen to cover.

What about coverage for well child care?

Mr. HOWARD. states in this market—if we move to an interstate insurance market, individual states will decide what the best mix

of coverage is. So for things such as disabled children or covering adopted children, a state would say that is a valuable policy. We are going to keep that.

Mr. WAXMAN. Can they mandate it? They can't require it. A policy approved in Iowa must be sold in the state of Nebraska, isn't that right? And if that policy doesn't cover it and other policies decide they have to compete with this cheaper policy and they stop offering coverage, the state has no ability to mandate, is that right?

Mr. HOWARD. That is correct. But they have—

Mr. WAXMAN. OK. Now what about this coverage for well child care? This is now guaranteed by 34 states that help healthy babies stay healthy. And that would be eliminated. Thirty-four states have required it, and this would be eliminated.

Do you believe insurers should cover diabetic testing supplies to make sure that diabetics can manage their diabetes?

Mr. HOWARD. Congressman, I believe what would happen is that insurers would look at individual mandates on a case-by-case basis and say does this add value to the policy and help keep our individual policyholders healthy? In many cases, they may keep some of those mandates. They are likely to get rid of mandates that don't have the right cost-benefit balance.

Mr. WAXMAN. Excuse me, the insurance companies will decide if they want to cover that, and they won't be told they have to, only if they think it is something they think is part of the package they want to offer.

Mr. HOWARD. That gets consumers to buy their policies.

Mr. WAXMAN. Yes. But if consumers don't have a choice of any policy that covers it, then they just have to buy whatever is available. This particular requirement on diabetic testing supplies has been guaranteed by 47 states, and that would be eliminated by the Blackburn bill in those states.

I could keep going. Emergency care is required in 47 states; alcoholism-substance abuse treatment, 45 states. Maybe an insurance company would decide that is too much, and they don't want to provide that. Colon-rectal cancer screening, out of the munificence of an insurance company, they may decide that keeps people from getting colon cancer, but it is cheaper to sell a policy that doesn't cover that. Cervical cancer screening. And we can go on and on.

I must say, Mr. Chairman, that I find it amazing when people quote the wisdom of Dennis Hastert to say you don't force them to buy a Cadillac. If we don't allow people with pre-existing conditions to buy anything because there is nothing available to them, they won't even be able to buy a jalopy. And I am always amazed when I hear people say we are going to give people the freedom, give them the freedom to buy something that won't be available to them because they can't afford it or it is just not even offered.

So I yield back my time.

Mr. PITTS. Thank you, Mr. Waxman.

I yield to the gentleman from Georgia, Dr. Gingrey, for 5 minutes.

Dr. GINGREY. Mr. Chairman, thank you very much.

I am going to turn to Mr. Larsen.

Mr. Larsen, would you explain to us again what your position is within the Center for Medicare and Medicaid Services, what your title and responsibilities are?

Mr. LARSEN. Sure. I am the director of the Center for Consumer Information and Insurance Oversight, and this Center focuses strictly on the private-market health insurance reforms with the Affordable Care Act. So exchanges, implementation of the MLR provisions, rate review. We do not handle—a different Center handles Medicaid and a different Center within CMS handles Medicare.

Dr. GINGREY. Right.

Mr. LARSEN. We are strictly the private market.

Dr. GINGREY. Thank you for clarifying that.

In your testimony, you state that because of the Affordable Care Act, sometimes referred to as ObamaCare, that most insurance companies cannot discriminate against someone because of pre-existing conditions; and you go on to state that “we have also prohibited insurance company rescissions, so most insurers can no longer cancel coverage when individuals get sick just because they may have made a mistake in filling out the application and doing the paperwork.”

In all, you use the phrase “most”—the word “most”—eight times in your testimony when referring to insurance plans or companies. I am curious, Mr. Larsen, which insurance plans do not fall under the protections you praise for the Affordable Care Act? You say most, not all.

Mr. LARSEN. I will go back and look.

The nutshell version is, for example, rescissions, which is one of the provisions that takes effect now, that is in effect today, that applies to all insurers. And then when we get to the exchanges in 2014, the prohibition on pre-existing conditions, exclusions, and exclusions, you know, based on health status will disappear.

Dr. GINGREY. Well, let me interrupt you just for a second. Would you say then that maybe one particular plan that is not covered is the Medigap plan, the Medigap plan offered by AARP, which controls over 30 percent of that market? My reading of the bill suggests that they are not really covered. You don't have jurisdiction over the Medigap plans that are offered by AARP, is that correct?

Mr. LARSEN. Not in my shop, no. There is a different set of rules that apply to the Medigap plans and the conditions under which they have to be issued. So we don't deal with the Medigap in the exchanges.

Dr. GINGREY. Are the Medigap plans, for which we all know in previous testimony that AARP reaps a pretty significant profit, royalties they call it, are they subject to these same consumer protections that you talked about in regard to—

Mr. LARSEN. There is a whole different set of protections and provisions that deal with the Medigap policies. So, for example, Medigap isn't part of the private-market reforms we are talking about.

Dr. GINGREY. The fact is, of course, that AARP, the American Association of Retired Persons, who promotes and markets this Medigap policy for a particular insurance company from whom they receive a lot of royalties since it is 30 percent of the market, that

they were granted an exemption from a lot of this oversight and regulation. Who knows whether that is a political support sort of thing, a reward for endorsing ObamaCare.

But help me understand something else. You are here today testifying on behalf of the administration that, without ObamaCare's consumer protection, cross-state purchasing is a bad idea. Yet seniors under Medigap plans are not afforded those same protections. Yes or no?

Mr. LARSEN. Well, I can't really speak to kind of the details of the Medigap plan.

Dr. GINGREY. Well, I can speak yes or no, and the answer is no.

Do you believe that seniors under Medigap plans should enjoy the same consumer protection as younger Americans?

Mr. LARSEN. As which Americans?

Dr. GINGREY. Younger.

Mr. LARSEN. I think anybody in a Medigap plan should have the right to consumer protections, and what those are compared to what other policies are I can't get into.

Dr. GINGREY. Can you explain to me why seniors were not given the same consumer protection under the Affordable Care Act as younger Americans?

Mr. LARSEN. Again, it is a different regime, the Medigap or supplemental policies to Medicare, as opposed to policies issued in the commercial market.

Dr. GINGREY. But wouldn't you agree that they deserve the same consumer protections as any other Americans?

Mr. LARSEN. They may, and they may get them. I don't know.

Dr. GINGREY. Mr. Larsen, the Obama administration and the congressional Democrats cut over \$500 billion out of Medicare to help finance ObamaCare. And ObamaCare is not Medicare. It is a new entitlement program, maybe an entitlement program for younger people. They didn't provide consumer protection for seniors that were afforded to every other American.

It is hard to ignore the fact that this administration purposely, purposely, raided Medicare to fund a political takeover of health care and quite simply ignored the needs of seniors in the process. And now the solution they say is iPad. If you think the first rate was bad, what until you see the second.

I yield back.

Mr. PITTS. The chair thanks the gentleman and yields 5 minutes to the gentlelady from Illinois, Ms. Schakowsky, for questions.

Ms. SCHAKOWSKY. Well, that is interesting, that the gentleman is criticizing the Democrats on Medicare, when he and all but four other Republicans voted for a plan that essentially ends Medicare. It could have a different name, but it won't be Medicare-guaranteed benefits for the elderly.

I wanted to clarify something else, and that is the Affordable Care Act, as I understand it, does include a provision to allow insurers to sell insurance across state lines and only be subject to laws in the issuing states, but that there is also a provision known as the health care choice compact that includes a number of protections for states and for consumers. So insurance companies can sell across state lines under the Affordable Care Act, am I right?

Mr. LARSEN. There is a mechanism to do that. The only difference is it doesn't result in the preemption of either state's laws.

Ms. SCHAKOWSKY. Right. So the state laws that were cited by Ms. Herrera—I think you mentioned Georgia, Maine, Wyoming, maybe some others—those laws would, under the bill we are talking about today, would be preempted. They would be eliminated. Am I right?

Mr. LARSEN. That is correct.

Ms. SCHAKOWSKY. Under the Affordable Care Act, those states would be able to maintain their laws.

Mr. LARSEN. Right. We get the benefit of interstate sales without the problems associated with one state preempting the laws of another state.

Ms. SCHAKOWSKY. I really wanted to clarify that, because I think we are talking about it as if the Affordable Care Act doesn't allow for states to sell policies. We just do it with the interest of consumers in mind.

Mr. Finan, you seem anxious to respond to comments or questions that were raised by my colleague from Illinois, and I wanted to let you do that. But I wanted also to clarify something else.

Mr. Parente said—and it is true that some of the protections of the Affordable Care Act don't go in place for 3 years. So, you know, he is saying that, right now, cancer patients can just die or something. But does this bill really protect cancer patients? So if you could say what you wanted to say and then also—

Mr. FINAN. I just wanted to go back to the gentleman from Illinois, who has left, but he said cancer patients should be most concerned about uninsured. We are obviously very concerned about that. But the problem of under-insurance is an extremely important one, too. And we do see this, and it is becoming nefarious, where patients are in the middle of treatment, realize their benefits have run out, that they simply can't go to the doctor anymore, they can't get more treatment because it is not covered.

Ms. SCHAKOWSKY. So it is not like they can pick another restaurant.

Mr. FINAN. No. Exactly. That is exactly the point.

I am sorry, what was your second question?

Ms. SCHAKOWSKY. The second question was that, while it is true, and for some people I am sure troubling, that the Affordable Care Act's full provisions don't come in for another 3 years, do the provisions under this bill provide the kind of protection that you need?

Mr. FINAN. Well, first of all, some of the provisions of the Affordable Care Act have kicked in. We do have extensions of dependent coverage. There is no ban on lifetime limits now. There are raising of the annual limits. So some of the benefits have kicked in. There is a transition.

But the point is, if we didn't have the Affordable Care Act act, we would be in a worse place. We would go back to the pre-Affordable Care Act where none of those provisions are in place. So the Affordable Care Act is moving—

Ms. SCHAKOWSKY. But would this bill—

Mr. FINAN. No, as I understand the bill, it would essentially go back to the world of protections we had before the Affordable Care Act; and, in fact, it would exacerbate it for all of the reasons I said.

You wind up with a race to the bottom and you wind up with cherry-picking, which makes things—ultimately, we would wind up with a worse situation than we had before.

Ms. SCHAKOWSKY. Let me just finish with this. As a former state legislator, we worked very hard on both sides of the aisle to put in the consumer protections that are in our state legislation that range from mammograms to all kinds of things that we thought should be available in our state. And that is true, and Mr. Waxman enumerated many that are so popular that 40–45 states have those. Those, as I understand it, Mr. Larsen, would all be eliminated if there were something from out of state.

Mr. LARSEN. Sure. If an insurer picked as its primary state a state that didn't have those benefits, and there are a small number that don't, then, yes, that would set the standard or the ceiling for all other states in which those policies were sold and you would not get the benefit of those.

Ms. SCHAKOWSKY. Thank you.

I yield back.

Mr. PITTS. The chair thanks the gentlelady and recognizes the gentleman from Louisiana, Dr. Cassidy, for 5 minutes for question.

Dr. CASSIDY. Folks, I have 5 minutes. If I interrupt you, I am not being rude, I am just trying to maximize.

Dr. Howard, Mr. Pallone spoke glowingly of how New Jersey regulates, protects consumers, et cetera, et cetera, and they don't want a race to the bottom. What I see, though, from your excellent testimony, Ms. Herrera, is that the premiums for somebody with an individual policy in New Jersey are about 40 percent higher than in Pennsylvania. New York, which also has banned community rating, I suppose, and guaranteed issue, it is more than double.

What is going to be the impacts upon insurance? What is the data? Everybody is talking about how they feel. I want data. What are the data about doubling of premium and what that does to your rate of uninsured?

Mr. HOWARD. I defer to Dr. Parente on the exact numbers.

Mr. PARENTE. I mean, basically, if you have premiums that are, you know, substantially less, obviously more people are going to get coverage. That is the best way to deal with it.

Dr. CASSIDY. If you lower premiums by 50 percent, that would have a significant impact on the ability of people to get good coverage, correct?

Mr. PARENTE. Yes.

Dr. CASSIDY. And data shows that?

Mr. PARENTE. Yes. That is what the study shows. That is what we are trying to say.

Dr. CASSIDY. Mr. Finan, we actually have empiric data. We know that ERISA plans have few mandates. No cancer mandates that I know of. And yet we know that they, if you will, can be compared to plans which have lots of mandates, including some ERISA plans governed by state insurance companies.

Is there any difference that you know of, data, not feelings, but data that you know of, in difference in cancer outcomes between those covered by ERISA plans without mandates and those covered by plans subject to mandates?

Mr. FINAN. I do not know of any specific data, no.

Dr. CASSIDY. I didn't think so. So, in fact, much of what you are saying is kind of an existential anxiety. I am not sure you actually have data to show that the mandates improve. Just comparing ERISA to non-ERISA, no mandates to mandates, I am not sure you have that data.

Mr. FINAN. But the problem is—

Dr. CASSIDY. No, no, no, no, I am sorry. I am really into data right now.

Dr. Parente or Dr. Howard—I am checking for your Ph.D.s, I am sorry—Mr. Larsen suggests that the community rating keeps the young and healthy in the market. He kind of painted a catastrophic, oh my gosh, if we don't keep them in market, terrible things happen.

Can you elaborate—maybe it was you, Dr. Howard—what happened in New York state to the rates of uninsured among the young when they put in community rating?

Mr. HOWARD. The market collapsed.

Dr. CASSIDY. I am sorry. What did the market do?

Mr. HOWARD. The market collapsed.

Dr. CASSIDY. And that is not an existential anxiety. That is data, correct?

Mr. HOWARD. That is correct.

Dr. CASSIDY. Do you want to elaborate a little bit more?

Mr. HOWARD. Yes. As recently as 2000, I believe, there were over 128,000, 130,000 people in New York's individual direct pay market. Today, there are fewer than 30,000 in that market. And people have recognized because costs have skyrocketed and young and healthy people have had to drop out of the market.

Dr. CASSIDY. So it went to this highly regulated market that theoretically is going to provide protections for people. You say the market collapsed.

Mr. HOWARD. Theoretically, it is supposed to get people to stay in the market, but because young people are very cost sensitive, they drop out.

Dr. CASSIDY. OK, got you.

And obviously one thing that was a problem that PPACA had to address was the problem of the disproportionate rate of the lack of insurance among the young. If you will, we created the problem that we then had to cure.

Dr. Parente, in your data, in your paper, you suggest that Alabama would be really at a competitive advantage because they have few mandates.

Mr. PARENTE. That is correct.

Dr. CASSIDY. I was thinking, Mr. Finan is discussing a woman that moved from Alabama to Virginia, had to drop her policy apparently because she was no longer allowed to purchase that from Alabama and so was faced with a large increase. But in your paper you would suppose that Alabama would begin to sell. If you will, she would have been able to keep her policy. The more robust we have interstate commerce, the more likely someone could continue to keep their policy upon which they were, correct?

Mr. PARENTE. That is correct.

Dr. CASSIDY. OK. That is pretty interesting.

Now, Mr. Finan, I just see you biting your lip. I know you want to respond to me. What would you say, man? And I only have 59 seconds, so I may cut you off to respond to you.

Mr. FINAN. Going back to your ERISA issue, you are talking apples and oranges. For the most part, large employers, whether they be self-insured or have commercial insurance, do a very good job or a relatively good job of covering serious conditions because they can spread the risk. They have a large number—

Dr. CASSIDY. If we have somebody who is interstate, interstate, we actually have the ability to share risk. Some of the concerns you and Mr. Larsen have actually don't pertain to this bill. We could easily have an anti-rescission bill in here. We could easily have other things that you are postulating would be a problem.

Mr. FINAN. But the fundamental difference is in the individual market you are selling to individuals. You are not selling to large groups. When you sell a plan to a large group of 5,000 or 10,000—

Dr. CASSIDY. We could have a guaranteed renewability. I mean, that could be added.

Mr. FINAN. But you are not going to sell in the first instance. If you are an insurance company, you are looking at the individual and his or her risk at the point of enrollment. If that person has cancer or a history of cancer, you are—you the insurance company—are going to deny coverage.

Dr. CASSIDY. If you look at the experience in Holland, if you look at the experience in Holland, there are actually companies that specialize in people that are high risk.

Mr. FINAN. I am sorry, which company?

Dr. CASSIDY. In Holland. If you actually look at the experience in Holland, there are actually companies that make a living specializing in those who at higher risk. The market will respond.

I yield back. I am out of time.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from Texas, Mr. Green, for 5 minutes.

I am sorry, I am out of order. Mr. Guthrie for 5 minutes.

Mr. GUTHRIE. Thank you, Mr. Chairman. I appreciate it very much.

To Mr. Larsen and Mr. Finan, the concern, the major concern—there are several concerns you voiced—but the major concern you voiced is that if a state with low mandates came into Kentucky—Kentucky has 34 mandates, I believe—and offered health insurance, and the young, healthy would purchase that health insurance, and, therefore, as a matter of fact—to quote Mr. Larsen—destroy the risk pool. And that is your major concern. So it is acknowledged that people are sharing costs as you went forward.

You also mentioned, Mr. Finan, that you had homeowners insurance, which I have as well, and you paid 30 years on it, and I paid for quite awhile, because we have the risk of something happening. I want to be covered for a calamity.

However, if I could purchase homeowner's insurance when my house is on fire or when it was burning or when a tornado was coming, you wouldn't have paid for it for 30 years if you could have bought it when you needed it.

Mr. FINAN. Absolutely.

Mr. GUTHRIE. So when Mr. Larsen talks about the market working with the exchanges, I think you are going to have the exact same problem you are talking about here with the Health Care Act. If you are 27 years old and healthy and you are going to have a list of mandates that your guys are going to subscribe, because you are going to have essential health benefits, if you call them that, and you are going to have to pretty much match the most expensive state. Because if you don't, all of the lists that—Ranking Member Waxman listed all of those. If a state goes beyond what you offer, the state has to pay for it. They have to actually subsidize those coverages. So either you are going to sit here and listen to a list that he is going to read off about you not covering, you are going to cover everything.

So my point is, I don't see how you can get around the premiums are going to increase for anybody because of the Health Care Act. It has to. Therefore, if you are young and healthy and you get guaranteed issue and you get community rating—and we have seen it New York. We have examples of it happening, talking about data. What is going to happen to the young and healthy? They are going to drop out of the market.

Now you have the mandate to buy, but if my math is correct, I think it is a \$600 fine plus 1 percent of your salary. So if you are a 27-year-old engineer making \$50,000 a year and are healthy, you can pay an \$1,100 fine—and the most expensive state I think is Massachusetts. It is \$14,000 a year, health insurance. And let's even factor that back down to \$10,000. So I can pay an \$1,100 fine or \$10,000 health insurance policy.

And if I need health insurance—as a matter of fact, I think you can tell your anesthesiologist just before he puts you out to let you make one last phone call to your health insurance company to buy health insurance. But I think that would actually be allowed in the law.

And I don't see how this whole argument about this bill destroying the risk pool, how does the Health Care Act not destroy the risk pool under that scenario?

Mr. LARSEN. Well, you are still going to have coverage options with the various levels within the exchanges for individuals. You are going to expand the risk pool, which is a good thing. The problem with these proposals is the risk segmentation that we get into.

Mr. GUTHRIE. Well, why would a young, healthy person purchase health insurance with guaranteed issue? In New York, you have seen it. You have seen it. Why would a young, healthy person under PPACA purchase health insurance when the fine is \$1,100?

Mr. LARSEN. People are going to have the opportunity to get comprehensive, affordable care in the exchanges. Even the CBO estimates that the exchanges are going to reduce administrative costs for insurers because they are not going to have to spend the time and the money and the resources underwriting people and setting up rating rules to exclude sick people. So it is going to be an attractive option.

Mr. GUTHRIE. But if the premium is not somewhere close to the fine, or \$1,100 a year under my scenario of \$50,000 a year for a 27-year-old, if the premium is not somewhere close to that and you can get it when you need it, why would you buy it?

Mr. LARSEN. I think people want comprehensive health care.

Mr. GUTHRIE. But they can get it if they need it, as opposed to paying \$10,000 a year. I mean, why would somebody under that scenario laid out in health care buy health insurance if they are a young person? I mean, that is the major problem with the law. The guaranteed issue, the mandate to buy is covered by if you don't buy it, you have to pay a fine.

But I don't understand—if the market is going to work as you have seen in New York—I don't know if New York has a fine, but people can drop out of the market and pay the fine. I don't understand why you are not going to have the same problem under the Health Care Act on a national scale that you are talking about having by letting people having mandate-like benefits to purchase. Why that is not going to happen. I mean, I just don't see how that is not going to happen.

Mr. LARSEN. I think you are going to see people that want to get comprehensive coverage through the exchanges.

Mr. GUTHRIE. But I believe they can buy it—but the guaranteed issue, why would they do it? That is my point. Why would a healthy person, young, do it?

Mr. LARSEN. There is a lot of people that can't get their coverage today. I mean, that is the issue that we are dealing with today, which is the broken market.

Mr. GUTHRIE. But it is still going to have a different risk pool. Because if you are young and healthy and drop out, then it is going to be more expensive; and, therefore, more young and health will drop out and it will become more expensive.

I yield back.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from New York, Mr. Weiner, for 5 minutes for questions.

Mr. WEINER. Thank you, Mr. Chairman.

I think actually this is an interesting conversation about whether or not you should have insurance regulated by states. I think you can make a pretty good argument that maybe this should be something that should be governed nationally.

Now I would be interested in knowing whether my Republican friends would be interested in the repeal of the provision that essentially permits insurance companies to operate outside many of the antitrust laws because they share information. The argument always was, let them share information because it is important for their business model to be able to do it.

But I actually think that most citizens when you ask them, do they want, if they live in Tennessee, to have Blue Cross of Utah covering them, there is a practical reason why that doesn't happen, right? If you are Blue Cross of Utah, you have to hire a bunch—or get a lot of people in your program that are Tennessee doctors. You don't want to go to a doctor in Utah. You are shaking your head no, Dr. Parente?

Mr. PARENTE. Yes.

Mr. WEINER. You think that patients in Tennessee would like to have a doctor in Utah?

Mr. PARENTE. I am saying if they are in the ERISA plan, or more than likely if they are a Federal employee that is living in Ten-

nessee, they are already working through United Health Care, GEHA, Blue Cross/Blue Shield National Association, getting a national provider—

Mr. WEINER. But Blue Cross of Utah—let's assume for a moment I am in Tennessee, let's say Chattanooga, and I have a doctor in Provost and I am sick. So it is a long flight. I think it is going to be a pretty long flight, so I am probably going to want a doctor in Tennessee.

So Provost, the firm in Utah, is going to have to set up some kind of a plan for Tennessee. They have to serve some doctors, right?

Mr. PARENTE. No, they are going to have a reciprocity agreement with the—

Mr. WEINER. So, frankly, you do want to have some level of state regulation on where people are going to be operating, but I do think that if you really want to have interstate—ability of people to buy interstate, then you definitely like what you saw in ObamaCare, because by establishing basic standards that allow a foundation that we can all kind of compare—which is the fundamental notion here—is that we should be able to compare these products. We should have access to them. Interstate compacts could be formed, maybe even someday a national compact, although I think that would be offensive to the sensibilities of many of my Republican friends. And, frankly, you are much closer to having this. But the real objective has to be it has to be something that someone in New Jersey wants from someone in Tennessee.

And the effect of the law, if this were to become law, is that basically you are saying to a citizen, you are going to outsource your rulemaking and your regulatory structure to another state. Why even have the states? Why have the states be involved in the insurance market at all then, at that point? Why not just get them out of it completely and just regulate it nationally? I mean, is that the position of the panel? I guess it would be an intellectually consistent position to say to do that. Why do the states have to be involved here at all?

The reason the states are historically, is because it is thought that you needed some consumer protection be done at a state level, that you be able to call your local state attorney general or your state insurance commissioner and say, "I've got a beef with this insurance company and how they are treating me."

Under this law that we are considering today, this bill that we are considering today, it is my understanding that what will happen is you are going to have some authority of the local guy to call Tennessee and say, "Hey, stop violating my citizen's rights." But that is really it; you are not going to really be able to march into Tennessee and be able to—I guess you can sue them in Tennessee court if you want.

But this is another instance where my friends want to take—they did this last week with their tort proposal—they want to remove the state's authority to govern this stuff, to govern their own citizens. It is a strange place that that they argue. They always talk about the needs, the rights of states. And what you are doing now is not only taking rights away from states and giving them to the Federal Government, which they did last week with the tort re-

form proposal, but now they are saying give it from one state to another state. I think that is truly problematic.

But if you do believe in the idea, and I kind of in a general sense I believe in the idea, like having more ability of people to purchase products that are more advantageous to them. But I don't believe that I should outsource New York's authority to govern insurance to Texas or to New Jersey.

And I think my state legislature, for all its weaknesses and flaws, I want to vote for them, and I want them to have the power to pass laws. My state insurance commissioner is appointed by my Governor. I don't think that is outside the realm of what is practical.

What it really comes down to is my Republican friends, they don't have a consistent thrust on what they don't like about health care reform. They just know they don't like anything that is being done presently by the people who are trying to fix it, and I think that's evident here today..

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Texas, Mr. Green, for 5 minutes of questions.

Mr. GREEN. Thank you, Mr. Chairman. Thank you and the ranking member for allowing me to waive on.

Mr. Finan, I know we were discussing Congresswoman Blackburn's bill. There is an old saying that an ounce of prevention is worth a pound of cure. And I am concerned this proposal may actually raise health care costs overall as many individuals who need preventative care don't get it.

A good example: Some cancers can be treated early if detected early, with better results for the patient's health and lower costs.

Colorectal cancer is one of the examples. According to the CDC, nine out of every ten people whose colorectal cancer is found early and treated are still alive 5 years later. If everyone age 55 or over had regular screenings and all precancerous polyps were removed, as many as 60 percent of the deaths from colorectal cancer could be prevented.

Could you please comment on how this legislation will worsen health care outcomes for individuals with cancer and raise health care costs overall?

Mr. FINAN. Yes, thank you, Congressman. That is an extremely good and important question. The health care system today, or up until today, has given way too little attention to prevention and screening. We, the American Cancer Society and the Cancer Society Action Network, have fought vigorously to expand mandates in states on mammograms and colonoscopies, for example, because they are proven—they are cost-effective in reducing cancer. If people get screened properly and according to guidelines, they are much more likely to be detected at an earlier stage, and therefore they are likely to get better treatment.

But as I understand the way this bill would work, interstate sales would not be required to cover those screenings, so we would be taking a huge step backward in terms of addressing chronic illness. And chronic illness is the major driver of health care costs in this country.

Mr. GREEN. My other question is for the whole panel. Mr. Finan, of the problems you mentioned is those who are uninsured and receiving a diagnosis of cancer. You also mention that even insured people, 25 million face major struggles paying their bills now. How is it that people with insurance are not able to cover their health care costs? And I know there are lots of different products out there that you can buy a \$25,000 plan. And if you have cancer, \$25,000 may not even cover your first surgery.

Can you talk about how folks who have insurance are not covered by that insurance for their treatment, particularly in cancer?

Mr. FINAN. Well, because today there is no such thing as an essential benefits package, insurers can offer a wide variety of sources, and some will argue that that provides choice. But the reality that we have seen all too often is that cancer patients who get in the middle of treatment all of a sudden discover there are limits within their plans. They can only go to the doctor X number of times, or there is no coverage for anesthesiologists or something in network.

And one of the very serious problems we have is the lack of transparency in insurance. Most consumers buy insurance because of the cost, but they don't have any understanding of what is in the benefits package. They don't know how well it will cover them if they get a chronic disease like cancer or heart disease.

One of the great advantages of the Affordable Care Act is much more requirements to increase transparency, to force insurers to disclose more information, and to provide consumers with more information.

Mr. GREEN. Well, and I understand, because up until the Affordable Care Act, typically insurance was a state product, except for ERISA. And I have a lot of companies who come under Federal laws, no essential benefits under ERISA either. And there have been problems in some of my large industries, but most states make up for that by having a mandated benefit.

I have to admit I was in the state legislature in Texas for 20 years, and we started out really well, because my first term we actually required insurance companies as mandated benefits that covered children from the time they were born, and not wait until they survived 30 days from birth before they would provide health care. That was great.

But then I saw over the rest of the years, and even maybe now, the laundry list got so big it was almost incomprehensible.

Now, I know Alabama has a very small list, but I would compare some states that had such huge mandated benefits, it is really difficult. And I would like the panel to talk about that at least in the last 20 seconds that I have.

Mr. PARENTE. Just a quick comment. I am a professor of finance and insurance. There is technically not a term called "underinsurance" in theory in insurance law. It is a term that has been popularized by Karen Davis at the Commonwealth Fund to basically talk about the cost hardships associated with just living. And insurance is part of just living in a western industrialized society.

The point is this law, this policy, will reduce the premium cost on average for all Americans, and that will enable them to buy insurance easier and faster.

Mr. GREEN. You are talking about the Affordable Care Act?

Mr. PARENTE. No, I am talking about letting people buy insurance across state lines. Anything the Affordable Care Act is going to do is hypothetical and 3 years in the future, other than the provisions passed already that have provided some protections that are there.

To be very clear I applaud some of the things that are in the exchanges. And my idea, the exchange is a bipartisan idea that actually has a lot of potential and is consistent with the interstate components.

Mr. GREEN. You surprise me because typically everything bad—everything that is in the law is bad. Although there are a lot of things in there that we worked on very bipartisan, you are right.

Mr. PARENTE. Yes, well, I am speaking from the value of tenure.

So what I am trying to say is that this thing that we are discussing, interstate commerce of sales of health insurance, could reduce, and actually from our research, shows would reduce the number of people who cannot buy coverage because the price points are too high from the mandates.

And what I want to know is how can the human physiology be so different across states that the mandates have such wide swings? Or is it the true difference is simply a difference in lobbying skill across the states in conjunction with insurance commissioners?

Mr. PITTS. The chair thanks the gentleman and yields to the gentleman from New York, Mr. Engel, for 5 minutes for questions.

Mr. ENGEL. Thank you very much, Mr. Chairman. I appreciate it.

I would like to start by saying I am very concerned that we are holding this hearing today to discuss H.R. 371, legislation that would facilitate the purchase of insurance coverage across state lines. And my concern is the fact that H.R. 371 preempts state consumer protections that are critical to the quality of care and health of a patient. And in addition, this legislation repeals all insurance reforms and patient protections that were included in the Affordable Care Act. I think it is throwing the baby out with the bath water.

I find it aggravating, disappointing, and frustrating that this committee has continuously done nothing but take up legislation that would repeal the Affordable Care Act, punish patients, and put the insurance companies back in control of our health system.

I would like to direct my question to Mr. Larsen. Mr. Larsen, many states have spent years developing standards for insurance plans that they believe not only provide adequate minimum coverage for beneficiaries, but also make sure that providers will be adequately reimbursed for services rendered. If we allow the purchase of insurance policies across state lines, why wouldn't employers look to purchase insurance on the basis of the least cost to them and not on the basis of whether it will adequately provide coverage or payments to providers? I would call it a race to the bottom; would you?

Mr. LARSEN. I think that is exactly right. You are going to see companies, both the insurers and the companies, looking for the market that has the thinnest and therefore cheapest coverage. And,

of course, everyone wants inexpensive coverage until they get sick, and then they want comprehensive coverage. That is why we have got to get a comprehensive benefit package that is available to everyone, that is still affordable.

But when you go down this route, you end up segregating the market, and the young people get peeled off and the healthy people get peeled off, and what you have left in a market is sicker people who get sicker and more expensive, and you are not solving the problem. The only savings you are getting is from peeling off the healthy.

Mr. ENGEL. That is why we have the individual mandate in the Affordable Health Care Act, because if everybody is insured, then everybody has the good coverage and you don't cherry-pick or, as you say, have a situation where everybody wants to pay a minimum and then wants maximum coverage when they do get sick.

You know, when you are 26 or 27—my kids are around that age—you think you are never getting sick. And then suddenly there is an accident or whatever, and then you find out that you are sick. And if you are uninsured, where do you go? You go right to the emergency room, which is the most expensive health care for everybody, and we are all paying for it.

Now a number of states, including my home state of New York, have developed programs that assure that if a given insurer in their state were to go under, that the state would step in and pay the bills, assuring that the affected customers would have access to care and providers are paid.

So let me ask you this: As a former insurance commissioner, can you tell me if we allow interstate purchase of insurance, how would individual states protect their citizens and providers from the insolvency of an insurer?

Mr. LARSEN. And with all the talk about health care reform, you know, that is one of the critical functions of what states do, is make sure that the companies are there when the claims need to be paid. So solvency regulation is critical. And if you lose your ability to ensure the solvency of companies that are selling policies to people in your state, that is a huge loss.

Mr. ENGEL. Thank you.

Dr. Parente, I saw you shaking—nodding your head, so I was wondering if you have any comment.

Mr. PARENTE. No, I agree. What we are talking about in these laws doesn't get rid of insurance commissioners' functions at all. It lets the insurance commissioners basically be accountable to lobbyists, that the stuff comes in for the individual mandates and say, Do you realize by putting that mandate into place, you have now priced out somebody that otherwise really needs this care from being able to afford it, and basically makes that more of a dynamic economy about understanding the pros and cons of having that lobbying function.

It is great to have protections, but they don't come without cost, because at the end of the day an actuary will look at anything that you add, and put "This will now add cost to it." It has already happened with ACA, even though people didn't think that would happen when it was first developed.

Mr. ENGEL. Thank you. Mr. Chairman, I yield back. Thank you.

Mr. PITTS. The chair thanks the gentleman. That concludes our questioning.

This was an excellent panel. I want to thank all the witnesses and members for their participation. I remind members that they have 10 business days to submit questions for the record, and I ask that the witnesses all agree to respond promptly to those questions.

Mr. PITTS. This subcommittee is now adjourned.

[Whereupon, at 12:19 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. LEONARD LANCE

I want to thank Chairman Pitts for scheduling a hearing on this very important subject.

Mr. Chairman, many experts agree that the high cost of health care is a key contributing factor to the high number of uninsured Americans. A survey done by the Employee Benefit Research Institute found that 85 percent of uninsured workers reported that they did not have coverage because it was either, "too expensive or they could not afford it."

The cost of health care is rising rapidly. It is imperative that Congress enact innovative solutions to make health insurance coverage more affordable for individuals and small businesses alike. Allowing the purchase of health care coverage across state lines will increase competition and choice, drive down prices and could dramatically reduce the number of uninsured.

I look forward to hearing this morning's testimony and am ready to work in a bipartisan capacity to promote interstate purchase of health coverage and expand the number of affordable health care options for all Americans.

PREPARED STATEMENT OF HON. JOHN D. DINGELL

Thank you Mr. Chairman.

Today's hearing focuses on a topic that should be familiar to some Members of this Committee. H.R. 371, the Health Care Choices Act of 2011, is strikingly similar to H.R. 2355, the Health Care Choices Act of 2005. Although as we have seen in the 112th Congress, my colleagues would not dare miss an opportunity to strike away at the heart of the Affordable Care Act, and have included in H.R. 371 language to repeal the consumer protections that make up the Patients Bill of Rights.

Now I know that good legislating is a difficult process, but continually reaching back to the arsenal of old legislation does nothing to help move our debate and discussion around improving our health care system forward.

Quite frankly Mr. Chairman, this is legislation that is not needed. States can already pass laws to allow for the sale of health insurance across state lines. Further, the Affordable Care Act, which my colleagues on the other side profess to hate so much, would allow for states to band together to enter into a health care choice compact that would allow for the sale of insurance across state lines while also maintaining the critical consumer protections.

Allowing such a reckless piece of legislation to move forward would be a race to the bottom—for our health care system and for our nation's health.

We will see insurance companies fleeing for whatever state will either let the industry write the regulations or ensure the least amount of oversight and restrictions on their practices, guaranteeing overwhelming profits for their coffers, and drastic cuts in the coverage available to those most in need of health insurance. This will harm the sick, the elderly, and the disabled—all of whom already pay high costs for their medical care.

This should not be a surprise to my colleagues as we have seen this exact situation play out in the credit card industry.

My colleagues point out that this legislation will help to lower premiums, and highlight the differences in premiums between New York and Iowa. If a New York family is able purchase their insurance in Iowa they may see lower premiums, but this will not lower the cost of a medical service in New York. If I was a smart businessman in Iowa, why would I choose to cover a New York family knowing the high cost of medical services there?

Reduced insurance premiums for some people are little consolation for the consumers who, under H.R. 371, would be left without coverage or would no longer

have coverage for critically needed benefit such as diabetes care or maternity care or cancer treatment.

Insurance companies would be empowered to avoid caring for the sick people who cut into their profit margin and would instead look for the young and healthy who afford them the greatest opportunity for profit and the least opportunity for payoff and payout.

I hope that today's hearing will be a useful one for my colleagues, and I hope that this hearing will help to show that the solution proposed in the Health Care Choice Act will not help to protect our people from serious wrongdoing and will instead allow the rascals who have been able to exploit the weakness of the current system to achieve great economic success.



STATE OF ARIZONA

JANICE K. BREWER
GOVERNOR

EXECUTIVE OFFICE

April 28, 2011

The Honorable Ken Bennett
Secretary of State
1700 West Washington, 7th Floor
Phoenix, Arizona 85007

RE: Senate Bill 1593 (health insurance; interstate purchase)

Dear Secretary Bennett:

Today I vetoed Senate Bill 1593. I have long been a strong advocate for injecting more choice and competition into our health insurance market, and I applaud the sponsor's efforts toward that end. I share the Legislature's concerns about the impacts of mandates on the affordability of health insurance -- for these reasons I have joined in litigation with many of my fellow Governors to stop the federal government's intrusion into private health insurance. Arizona, not the federal government or legislatures in other states, should determine what coverage requirements are right for Arizonans.

Over the years, the Legislature has carefully weighed the priorities of Arizonans when determining what should be included in a standard health benefits package. The same level of public scrutiny should be applied whenever the Legislature attempts to remove a mandate. Senate Bill 1593 includes a provision that would, under certain conditions, change Arizona's benefit requirements based on legislative decisions in other states. This change was added on the floor and not subject to the typical public input that such major policy decisions should receive.

I am also concerned about risks to our citizens who may be subject to other states' regulatory procedures that could leave them with little recourse in the event of mistreatment. Senate Bill 1593 limits the jurisdiction of the Arizona Department of Insurance over out-of-state companies, potentially putting Arizona policyholders at risk. Arizonans should not have to litigate against an insurer when the State has an existing process by which insurance disputes can be resolved.

I continue to support a vigorous and competitive private health insurance market and look forward to working with the legislature on reforms to that end.

Sincerely,

 A handwritten signature in cursive script that reads "Janice K. Brewer".

Janice K. Brewer
Governor

cc: The Honorable Russell Pearce
The Honorable Andy Tobin
The Honorable Nancy Barto
Senate Secretary
Chief Clerk of the House of Representatives

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CONSUMER RESPONSE TO A NATIONAL MARKETPLACE FOR INDIVIDUAL HEALTH INSURANCE

Stephen T. Parente
Roger Feldman
Jean Abraham
Yi Xu

ABSTRACT

The objective of this analysis is to simulate the difference between national and state-specific individual insurance markets on take-up of individual health insurance. This simulation analysis was completed in three steps. First, we reviewed the literature to characterize the state-specific individual insurance markets with respect to state regulations and to identify the effect of those regulations on health insurance premiums. Second, we used empirical data to develop premium estimates for the simulation that reflect case-mix as well as state-specific differences in health care markets. Third, we used a revised version of the 2005 Medical Expenditure Panel Survey (MEPS) to complete a set of simulations to identify the impact of three different scenarios for national market development. (National market estimates are based on the simulation model with competition among all 50 states and moderate impact assumptions.) We find evidence of a significant opportunity to reduce the number of uninsured under a proposal to allow the purchase of health insurance across state lines. The best scenario to reduce the uninsured, numerically, is competition among all 50 states with one clear winner. The most pragmatic scenario, with a good impact, is one winner in each regional market.

INTRODUCTION

The McCarran-Ferguson Act (15 U.S.C. §§ 1011–1015) was adopted in 1945 after extended controversy over the jurisdiction of state and federal governments in

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regulating the business of insurance. The principal objective of the Act was to establish the primacy of the states in regulating the insurance industry. The “purpose clause” of the Act states that regulation and taxation of the business of insurance by the states is in the public interest. As a result of McCarran-Ferguson, each health insurer must be licensed in each state in which it intends to sell insurance.

Today most large employers that offer health insurance are exempt from McCarran-Ferguson by virtue of another federal law, the Employee Retirement Income Security Act (ERISA), which states that self-insured firms, that is, those that provide insurance as an employee benefit without the assistance of a risk-bearing insurer, are not subject to state regulation. Only the individual (nongroup) and fully insured group markets, composed mostly of small- and medium-sized employers, are regulated by the states. States have approached the regulation of health insurance differently, which has led to extensive variation across states in the benefit designs and premiums charged by health insurers in these regulated markets.

Federal lawmakers are interested in changing the law that prohibits nongroup/individual health insurance from being sold across state lines. For example, Representative John Shadegg’s (R-AZ) and Senator Jim DeMint’s (R-SC) Health Care Choice Act of 2005 (H.R. 2355 and S.1015) would amend the Public Health Service Act to allow for interstate commerce in health insurance while preserving the states’ primary responsibility for regulation of health insurance. More recently, the proposal for interstate commerce in health insurance was featured by Senator John McCain (R-AZ) in his 2008 presidential campaign, as well as by Senator Tom Coburn (R-OK) described as The Patients’ Choice Act of 2009 (S.1099). Advocates of this reform argue that state-level mandates for providers, benefits, and coverage, as well as other types of regulations (e.g., guaranteed issue, community rating, and any willing provider status) lead to higher prices and that permitting national competition for such insurance has the potential to strengthen competition, reduce prices, and increase demand for individual health insurance policies.

The recent passage of sweeping health insurance reform in March 2010 has altered the policy landscape. With the passage of P.L. 111-148 (The Patient Protection and Affordable Care Act), states can enter into compacts that could permit the sale of insurance across state lines through insurance exchanges that will be fully operational by 2014. However, the law does not permit interstate sales of insurance as directly as an exemption from McCarran-Ferguson or the bills previously introduced by Senators DeMint and Coburn as well as Representative Shadegg.

The objective of this analysis is to simulate the difference between national and state-specific individual insurance markets on take-up of individual health insurance. Though the analysis focuses on the individual insurance market, results are presented for both the individual and group markets because a national marketplace for individual insurance will affect the group market. By leading to premiums sufficiently lower than those in the group market, a national marketplace for individual insurance may encourage some employers to drop group coverage and employees in those firms to shop in the individual market.

SIMULATION METHODS

This simulation analysis was completed in three steps. First, we reviewed the literature to characterize the state-specific markets for individual insurance with respect to state regulations and to identify the estimated effects of those regulations on health insurance premiums. Second, using secondary data, we developed premium estimates for the simulation that reflect contract-level differences in age, gender, and preexisting conditions as well as state-specific differences in health care markets. Third, we used a customized version of the 2005 Medical Expenditure Panel Survey (MEPS), described in more detail below, to complete a set of simulations to identify the impact of three different scenarios for national market development. We briefly summarize these steps.

Step 1: Characterize the State-Specific Individual Insurance Markets

The first step in this simulation is to describe the regulatory environment of individual insurance in each state and the effect of those regulations on individual health insurance premiums. We used several secondary sources for this description, including Blue Cross/Blue Shield for state mandates, the Georgetown University Health Policy Institute for guaranteed issue and community rating, and Thomson-West's Netscan/Health Policy Tracking Service ("Major Health Care Policies, 50 State Profiles, 2003/2004") for any willing provider laws.

Next, using findings from the research literature, we identified estimates of the marginal cost of particular regulations, including mandates, guaranteed issue, community rating, and any willing provider laws.

- Mandates are state regulations that require insurers to cover particular services or providers. We opted to use the count of mandates in a state rather than trying to identify the separate cost of each mandate. This decision follows the majority of empirical studies, which typically use a count of state mandates.¹
- Guaranteed issue laws require insurers to sell insurance to all potential customers regardless of health status or preexisting conditions. However, this does not necessarily bar insurers from including restrictions on coverage associated with preexisting conditions or from incorporating premium adjustments for preexisting conditions. Guaranteed issue provisions can be broad (applying to all products, all consumers, at all times) or narrow (applying to very specific populations or during specific open enrollment periods). Our coding rules focused on states that had fairly broad guaranteed issue provisions as a template for the national simulation.
- Community rating requires insurers to limit premium differences across individuals based on observable characteristics (e.g., age, gender, tobacco status). We coded a state as having community rating if it had "pure" (no premium differences are allowed) or "adjusted" community rating. We did not consider rating bands as part of this definition.

¹We used a count of mandates in our simulation. While not ideal, that is what most of the literature provides to estimate the effect of mandates on premiums. We recognize that all mandates are not equivalent in their scope or impact. For example, in 2008, 13 states had a fairly expensive mandate such as guaranteed coverage for *in vitro* fertilization. In contrast, 17 states had mandates for newborn hearing screening, which is associated with lesser cost.

- Any willing provider (AWP) laws restrict insurers' ability to exclude providers from their networks. States vary considerably with respect to how narrowly or broadly they define such restrictions. For example, many states apply AWP laws to pharmacies only. We coded a state as having an AWP law only if it applied broadly to providers.²

We reviewed the literature to identify the impact of these state laws and regulations on health insurance premiums.³ We used only studies of the individual insurance market, since this is the market in which we are interested. This ruled out studies that focus on the relationship between regulations and premiums in the small-group market (e.g., Simon, 2005).

We utilized estimates from the following four studies: Congdon, Kowalski, and Showalter (2008), Henderson et al. (2009), New (2006), and Hadley and Reschovsky (2003).⁴ It should be noted that New has not been published in a peer-reviewed journal. We considered using estimates from only the peer-reviewed studies but found the methods of the other paper sufficiently rigorous to include in this analysis. Table 1 summarizes the key findings.

To make our analysis comprehensive, we used three summary measures of the regulatory effects: (1) the midpoint of the range⁵ of the estimated effect of each regulation/mandate—our moderate estimate, (2) the minimum estimated effect, and (3) the maximum estimated effect. These effects are summarized in Table 2. State-specific variation in regulations and average single and family-coverage premiums in the individual market are shown in Table 3.

Regulations and mandates represent important differences across state-specific individual insurance markets, but there may be other factors as well.⁶ We note three

²One concern is that the estimated effect of AWP laws on premiums is too large because such laws are picking up unobservable "chilling effects" on managed care entry. In defense of using the estimated AWP effect, suppose that AWP directly increases premiums because it forces health plans to take any willing provider, and that this indirectly increases health care costs by chilling managed care entry into the state. The estimated effect of managed care on premiums will include both of these routes to higher premiums.

³A copy of the literature review with complete references is available from the first author.

⁴Other studies have examined the effects of individual-market regulations on insurance coverage (e.g., Percy, 2000; Sloan and Conover, 1998; Zuckerman and Rajan, 1999). However, these studies did not have sufficient information to inform the modeling requirements of our analysis. In order to use them for our purposes, we would have needed to supplement them with estimates of the responsiveness of coverage to prices, that is, $d\text{Price}/d\text{Regulation} = (d\text{Coverage}/d\text{Regulation})/(d\text{Coverage}/d\text{Price})$. The addition of a second level of uncertainty into our simulations is the drawback of this two-step approach.

⁵The midpoint is simply half-way between the minimum and maximum effects of the regulations.

⁶One factor might be that regulations reflect the "tastes" of the market and thus the association between regulations and premiums might not be causal. We relied on cross-sectional studies to inform our estimates. Multiyear estimates would have been preferred but are unavailable. Hadley and Reschovsky (2003), while using cross-sectional data, use a selection-correction approach to control for unmeasured personal attributes related to both insurance take-up and premiums.

TABLE 1
Summary of Studies of the Effects of State Regulations on Premiums in the Individual Health Insurance Market

Regulation/ Law	Congdon, Kowalski, and Showalter	Henderson et al.	New	Hadley and Reschovsky
Guaranteed issue	94–114% increase in premium in one state (NJ)	No effect	NA (not assessed)	No effect
Community rating	20–27% increase in premium	No effect	NA	15–34.6% increase in premium
Any willing provider Mandates	1.5–9% increase in premium Each additional mandate increases premium 0.4–0.9%.	5–12% increase Used indicator variables for a very comprehensive set of mandates. Some increase and some decrease premium.	NA Each additional mandate raises the monthly premium by 75 cents, approximately 0.5%.	NA

TABLE 2
Minimum, Maximum, and Midpoint Estimates of the Effects of Regulations

Regulation	Minimum Increase	Midpoint Increase	Maximum Increase
Guaranteed issue	0	57%	114%
Community rating	0	17.3%	34.6%
Any willing provider	1.5%	6.75%	12%
Mandates	0.4% per mandate	0.65% per mandate	0.9% per mandate

in particular. First, variation exists across states with respect to mandates regarding look-back periods and coverage of preexisting conditions. This will particularly impact individuals with chronic illnesses in terms of their perceived value of coverage, premiums (potentially), and take-up. Although we have information on state regulations for look-back periods and preexisting conditions, we know of no peer-reviewed studies that model the effect of these regulations on premiums.

A second difference is premium taxes. For this simulation, we did not attempt to determine the effects of premium taxes on premiums in the nongroup market. Third, provider market structure and its resulting effect on insurers' network formation and payment rates likely differ by state. Premium variation may also reflect differences across states (and plans within states) regarding the size of the provider network and plan types. AWP laws may capture some of this variation, but the extent of provider market power and local variation in prices are also likely to be important premium drivers.

TABLE 3
State-Level Variation Premiums and Regulations

State	Average State Single 2008	Premium Family 2008	State Regulation Presence (0/1)			Number of Mandates
			Community Rating	Any Willing Provider	Guaranteed Issue	
AK	\$3,435	\$5,821	0	0	0	25
AL	\$2,548	\$4,545	0	0	0	15
AR	\$1,440	\$1,953	0	0	0	29
AZ	\$2,440	\$3,984	0	0	0	18
CA	\$1,885	\$3,972	0	0	0	40
CO	\$2,198	\$4,216	0	0	0	31
CT	\$2,963	\$5,660	0	0	0	37
DE	\$1,220	\$2,026	0	0	1	16
FL	\$2,539	\$4,882	0	0	1	38
GA	\$2,910	\$4,956	0	1	0	27
HI	\$1,455	\$2,678	0	0	1	18
IA	\$1,965	\$3,753	0	0	1	15
ID	\$2,207	\$3,788	0	1	1	6
IL	\$2,591	\$4,991	0	0	0	27
IN	\$2,330	\$2,505	0	1	0	24
KS	\$2,260	\$4,510	0	0	0	25
KY	\$2,033	\$4,442	0	1	0	23
LA	\$2,858	\$4,874	0	0	0	31
MA	\$5,257	\$10,126	1	0	1	33
MD	\$3,279	\$6,574	0	0	1	46
ME	\$1,455	\$2,678	1	0	1	33
MI	\$1,926	\$3,968	0	0	1	19
MN	\$2,121	\$4,141	0	0	0	34
MO	\$2,299	\$3,985	0	0	0	31
MS	\$1,205	\$4,721	0	0	0	20
MT	\$2,418	\$4,350	0	0	0	27
NC	\$2,623	\$4,467	0	0	1	34
ND	\$2,420	\$4,072	0	0	0	20
NE	\$2,295	\$4,119	0	0	0	19
NH	\$3,134	\$5,382	0	0	0	30
NJ	\$6,048	\$14,403	1	0	1	30
NM	\$1,982	\$2,985	0	0	0	29
NV	\$2,364	\$5,096	0	0	0	38
NY	\$3,743	\$9,696	1	0	1	34
OH	\$2,304	\$4,541	0	0	1	19
OK	\$3,047	\$4,813	0	0	0	26
OR	\$2,162	\$3,971	1	0	1	21
PA	\$1,989	\$3,916	0	0	1	25
RI	\$1,298	\$2,584	0	0	1	29
SC	\$3,328	\$5,230	0	0	0	20
SD	\$3,133	\$5,228	0	0	0	26
TN	\$2,851	\$5,047	0	0	0	29
TX	\$2,836	\$4,940	0	0	0	38

(Continued)

TABLE 3
Continued

State	State Regulation Presence (0/1)					
	Average State Single 2008	Premium Family 2008	Community Rating	Any Willing Provider	Guaranteed Issue	Number of Mandates
UT	\$1,308	\$2,530	0	0	0	28
VA	\$2,332	\$4,631	0	0	1	39
VT	\$1,455	\$2,678	1	0	1	14
WA	\$3,141	\$3,342	1	0	1	29
WI	\$2,373	\$4,462	0	0	0	21
WV	\$3,141	\$5,338	0	0	1	28
WY	\$2,734	\$4,734	0	1	0	25
USA	\$2,506	\$4,646				

Step 2: Calculate Adjusted Premiums

The second step in the analysis requires calculation of premiums adjusted for the effects of state regulations. The basic idea behind a national market is that a person living in heavily regulated State A will be able to buy insurance licensed in less-regulated State B. Suppose that a person lives in State A where the premium is \$100 per month. This premium reflects the influence of State A's medical practice style and provider prices (which would not change if the person bought insurance in State B) as well as the effects of regulations and mandates (which would change). If a person bought insurance in State B, the premium would be \$100 minus the effects of fewer regulations in State B.

To implement this step, we relied on the premiums reported by Congdon, Kowalski, and Showalter (2008). We adjusted these premiums by age and sex to reflect standard actuarial differences in health care costs and then adjusted them for the effects of regulations. The adjusted premiums were used as inputs into the insurance take-up simulation model.

Step 3: Simulation

In the third step we simulated the effect of a national market on take-up of individual health insurance. Our core data file for this part of the simulation is the MEPS Household Component, which is a nationally representative sample of the noninstitutionalized population in the United States. The MEPS includes detailed information on individuals' demographics, employment status, and health insurance. Of course, knowing the state of residence of individuals is key information. However, the MEPS does not release person-specific state identifiers on a public use file. Therefore, we devised a method for imputing each person's state of residence. This step is described in more detail in the Appendix.

Using the synthetic state-based MEPS described in the Appendix, we adapted a microsimulation model from our previous analyses (Feldman et al., 2005; Parente and Feldman, 2007) to develop a set of national estimates. The simulation model is

capable of generating estimates of health insurance take-up for both the individual and employer-sponsored (group) markets.

The model estimation included several steps. As a first step, we pooled data from four large employers to estimate a conditional logit plan choice model similar to our earlier work (Feldman et al., 2005).⁷ Conceptually, the choice model is based on utility maximization, where utility is considered to be a function of personal attributes such as age, gender, income, chronic illness, and family status; health plan attributes such as the tax-adjusted out-of-pocket premium and the deductible amount; and personal characteristics, which enter the model as interactions of personal and plan attributes. The coefficient estimates produced by this model represent the utility of each plan attribute or interaction to an employee.

We then used the estimated choice-model coefficients to predict health plan choices for individuals in the synthetic state-based MEPS file. In order to complete this step, it was necessary first to assign the number and types of health insurance choices that are available to each respondent in the MEPS-HC. For this purpose we turned to the smaller, but more-detailed MEPS Household Component–Insurance Component linked file, which contained the needed information.⁸ Using this data set, we estimated an ordered probit model to predict whether those with an offer of employer-sponsored insurance were offered 1, 2, 3, or 4+ plans. We computed the predicted probability for each category and identified the category with the maximum probability as the number of offered plans. The plan types offered to employees were based on the most popular offerings within each of the categories.

One of the distinguishing attributes of the simulation model is the presence of consumer-driven health plans (CDHPs). Specifically, the four employers offered two types of CDHPs: a low-option Health Reimbursement Arrangement (HRA) and a high-option HRA. The low-option HRA is very similar in deductible, coinsurance and premium structure to a Health Savings Account (HSA) plan.⁹ This enabled us to model both HRA and HSA choices in the simulation as well as high-, moderate-, and low-option Preferred Provider Organizations (PPOs), and a Health Maintenance Organization (HMO).

Consumers in the group market also have the option to decline the employer's offer of coverage. If they do so, we assume they will either purchase an HSA in the individual market or they will decline to be insured (e.g., because their spouse can cover them). Altogether, consumers in the group market have up to eight choices—the employer's offers, an individually purchased HSA, and no insurance.

⁷These large employers have workers who reside in at least four states. In the two largest employers, over 40 states are represented. This employee population is quite consistent with national census estimates for those under the age of 65 in terms of age and income.

⁸These data are not publicly available. They were analyzed at the AHRQ Data Center in Rockville, Maryland.

⁹In an HRA, the employer creates an account that the employee can use to pay for eligible medical expenses on a pretax basis. Unlike the HSA, however, the employee does not own this account.

In the model, each consumer in the individual market has five choices: high-, moderate-, and low-option PPOs, a high-deductible health insurance plan with a HSA, and the choice to be uninsured.

Chronic illness is modeled at the contract level in the simulations. That is, either the person choosing insurance, or someone covered by their insurance contract, has a chronic illness. This assumption was made because the data used to estimate the health plan choice model could only be attributed to contract holders, not the person receiving care under a contract. As a result, the chronic illness measure reflects a household's illness burden, more than that of one individual, unless the person is buying a single-coverage contract.

The econometric specification of the choice model driving the simulations was a conditional logit regression model. We considered utility to be a function of personal attributes such as age, health plan attributes such as the out-of-pocket premium, and the interactions of personal and health plan attributes, formally stated as

$$U_{ij} = f(Z_j, Y_i * Z_j), \quad (1)$$

where i is the decision-making person choosing among j health plans (including no insurance), Z_j is the health plan attributes, and Y_i is the personal attributes.

An important constraint in our modeling was that any variable used in the health plan choice model from the employer data also had to be available in the MEPS data to be used for the simulations. As a result, the key variables in the health plan choice model were the after-tax premium paid by the employee, the deductible paid by the employee, and the coinsurance rate. Also included in the health plan choice model were alternative-specific constants (intercepts) for each of the possible choices. These intercepts capture plan-specific features not represented by measured elements of plan design. Finally, for the HSA plans in the group and individual markets, we included a contribution into the account for a given year that depended upon income, single or family contract type, and the contract holder's age.

The personal variables in the choice model were: employee or dependent has a chronic illness; employee's age (years), gender, and annual wage income; and employee has single or family contract. The personal variables were interacted with the plan-specific intercepts. We also allowed the out-of-pocket premium to interact with health status to identify whether contract holders with any covered person in poorer health were more or less price sensitive.¹⁰

The simulation adjusts premiums for the tax treatment of health insurance offered by employers in the group market. Specifically, premiums are adjusted by the marginal federal income tax rate as well as the Social Security tax rate. The ability to adjust for state income taxes is also possible but not considered in this model in order to identify the pure effects of differences in insurance regulations by state.

We relied on the individual-market premiums reported by Congdon, Kowalski, and Showalter (2008). We adjusted these premiums by age and sex (except in

¹⁰Econometric results and parameter estimates from the health plan choice model are available at: http://aspe.hhs.gov/health/reports/09/cdhp02/report.shtml#_Toc229902360.

community-rated states) to reflect standard actuarial differences in health care costs; then we adjusted them for the effects of regulations and updated them to 2008 dollars.

To account for the complexity of health insurance regulations, we modeled the impact of state regulations on premiums charged to contracts with different health status. This is important because of the likely personal state dependence of the regulatory impact. For example, a person shopping for insurance in a state without a community rating might find the average premium lower by 10 percent compared with a community-rating state. However, healthy people would see a larger reduction than sicker people, while sicker people might see a smaller reduction or even possibly an increase. We can account for these differences because the original premiums in our analysis were based on estimated medical costs at the individual level. We identified contracts where any person (policyholder or dependents) had a history of cancer and decreased the premium cost of shopping in guaranteed-issue states such as Delaware, Maryland, or Hawaii by 50 percent to reflect the marginal cost of that condition for such contracts. But contracts without a history of cancer would experience an 8 percent premium increase in guaranteed-issue states. Similarly, we decreased the premium cost of shopping in community-rated states by 35 percent for contracts with chronic conditions and increased it by 15 percent for those without chronic conditions. These adjustments preserved the average premium differential across states. In sensitivity tests, we found these adjustments made shopping in an unregulated state less desirable to contracts with cancer or a chronic illness due to the high cost and the likely benefit they were deriving from being in a regulated state.

The simulation is based only on choices made by adults aged 19–64 who are not students, not covered by public insurance, and not eligible for coverage under someone else's group policy (we edited out military, students, age under 18 or 65 and older, and those without an employer offer who could be covered by their spouse). As a result, our baseline uninsured and turned down population represents 32.3 million people. However, we present results for our selected sample as well as a national extrapolation that would yield 47 million people uninsured.

SCENARIOS FOR POLICY SIMULATION

We developed three different scenarios for policy simulation. Each of these scenarios was run on a set of minimum, moderate, and maximum impacts of state-specific regulations derived from the literature. The impact of each scenario was calculated by multiplying a given person's original premium by a state-specific min/mod/max multiplier. For each scenario, if the consumer faces a lower premium as a result of the proposed policy change, the consumer will choose the better price. If the new possible premium is not a better deal than that in the consumer's home state, they will stick with their home state in the simulation. The three scenarios are:

Scenario 1: Competition Among Five Largest States

In this scenario, only the five largest states are available for the national market along with the consumer's own state. The rationale for this scenario was based on it being included in a previous legislative proposal discussed in the U.S. House of Representatives Energy and Commerce Committee in 2006. The idea is that insurance departments in the largest states would have the critical skills to take on additional

regulatory responsibilities for new out-of-state consumers. The five largest states in order of descending population size are California, Texas, New York, Florida, and Illinois. Of these, Texas has the least regulated health insurance environment and is the comparison state in the simulations.

Scenario 2: Competition Among All 50 States

For this scenario, the state with the least regulation is identified as Alabama. All interstate consumers are assumed to switch policies to Alabama unless they were already residents of Alabama. This scenario could provide the most extreme outcome of legislation similar to that proposed by Rep. John Shadegg (R-AZ).

Scenario 3: Competition Within Regions

Under this scenario, the national health insurance market is divided into four regions: Northeast, South, Midwest, and West. Residents in each region can buy insurance from a state within their region with the most favorable premium resulting from decreased regulation. This scenario was motivated by the regional Medicare Part D drug coverage and TriCare¹¹ contract models for insurance carriers. For the Northeast, the state with least regulatory impact was New Hampshire. In the Midwest, Nebraska was the favored state. In the West, the state of choice was Arizona, and in the South, it was Alabama.

FINDINGS

The findings from the simulations are presented below. First, results for each scenario are presented. Second, we describe the impact of the moderate estimates for the national market scenario in breakdowns by income and state of residence.

For each scenario, the change in the number of insured is presented from a 2008 status quo estimate. The insurance market is divided into the individual and group markets and further demarcated by the types of health insurance taken up from the simulation model. The "HSA No-Offer" category in the group market refers to individuals who were offered coverage but turned it down and bought an HSA policy on their own. For each scenario, we provide a "within-sample" estimate and a national estimate. The within-sample estimate is based on the 18–64 aged population from MEPS, and the national estimate is an extrapolation to the non-Medicare age U.S. population.

The impact of competition among the five largest states is presented in Table 4. Under the minimum, moderate, and maximum effects of state policies, the level of insurance increases. The impact ranges from 53,853 (minimum) to 7.8 million (maximum) newly insured from a base of 47 million uninsured. The moderate impact is 4.5 million newly insured individuals. Almost all of the effect is observed in the individual market.

Allowing for a national market where a person can shop for health insurance in any state yields the simulated results presented in Table 5. The reduction in the number of uninsured is greater than in the first scenario across the minimum, moderate, and maximum regulation effects. The moderate national impact is 8.2 million previously

¹¹TriCare is the Department of Defense's health care program for members of the uniformed services, their families, and survivors.

TABLE 4
Scenario 1: Competition Among Five Largest States

	Status Quo	Scenario 1					
		Regulated Top 5 State—Texas					
		Minimum		Moderate		Maximum	
Individual							
HSA	4,723,768	10,659	0%	768,697	16%	1,209,743	26%
PPO high	7,717,302	26,446	0%	2,251,661	29%	4,109,275	53%
PPO low	298,355	(535)	0%	(56,496)	-19%	(80,848)	-27%
PPO medium	1,910,840	1,242	0%	161,543	8%	236,567	12%
Uninsured	28,084,067	(37,812)	0%	(3,125,405)	-11%	(5,474,737)	-19%
Group market							
HMO	5,505,466	(0)	0%	(179)	0%	(1,487)	0%
HRA	6,166,134	(4)	0%	(791)	0%	(2,711)	0%
HSA offered	307,298	(0)	0%	(37)	0%	(165)	0%
HSA no-offer	11,088	69	1%	27,301	246%	135,973	1226%
PPO high	16,535,831	(2)	0%	(578)	0%	(3,229)	0%
PPO low	665,950	(0)	0%	(72)	0%	(796)	0%
PPO medium	53,470,814	(62)	0%	(25,093)	0%	(119,262)	0%
Turned down	3,530,681	(0)	0%	(552)	0%	(8,323)	0%
		Within		National			
		Sample					
Minimum		37,812		53,853			
insurance estimate							
Moderate		3,125,958		4,452,122			
insurance estimate							
Maximum		5,483,060		7,809,207			
insurance estimate							

uninsured who now have coverage. The greatest take-up is for the high-option PPO, followed by the HSA. There is a net transfer out of low-option PPO plans toward high-option PPO plans. This finding makes sense in that if someone could afford a more generous plan design due to a lower premium they would make the switch. In the group market, there is movement out of medium-option PPOs in favor of the opt-out HSA purchased as an individual.

Under the scenario of competition within four regions in the United States shown in Table 6, we find greater insurance take-up than the status quo, but less impact than a national market among all 50 states. Interestingly, coverage is higher under this scenario than under the "five largest states" scenario. The moderate insurance estimate for this scenario indicates a net increase of 7.4 million newly insured. Movement across plans is fairly consistent with what was observed in previous tables. The minimum insurance estimate is proportionately smaller than the national market minimum estimate, suggesting that regional competition might expose greater sensitivity to expected differences in state mandates.

TABLE 5
Scenario 2: Competition Among All States

	Status Quo	Scenario 2					
		Least Regulated State—Alabama					
		Minimum		Moderate		Maximum	
Individual							
HSA	4,723,768	346,682	7%	1,326,375	28%	1,636,962	35%
PPO high	7,717,302	958,484	12%	4,259,008	55%	6,987,918	91%
PPO low	298,355	(18,061)	-6%	(78,188)	-26%	(122,061)	-41%
PPO medium	1,910,840	61,394	3%	230,257	12%	269,513	14%
Uninsured	28,084,067	(1,348,499)	-5%	(5,737,452)	-20%	(8,772,332)	-31%
Group market							
HMO	5,505,466	(16)	0%	(508)	0%	(4,985)	0%
HRA	6,166,134	(157)	0%	(1,711)	0%	(5,990)	0%
HSA offered	307,298	(6)	0%	(86)	0%	(428)	0%
HSA no-offer	11,088	3,780	34%	64,982	586%	353,446	3188%
PPO high	16,535,831	(79)	0%	(1,424)	0%	(9,120)	0%
PPO low	665,950	(3)	0%	(231)	0%	(2,841)	0%
PPO medium	53,470,814	(3,511)	0%	(58,965)	0%	(297,398)	-1%
Turned down	3,530,681	(8)	0%	(2,057)	0%	(32,684)	-1%
		Within Sample		National			
Minimum insurance estimate		1,348,507		1,920,600			
Moderate insurance estimate		5,739,508		8,174,451			
Maximum insurance estimate		8,805,016		12,540,478			

Using the person-specific estimates from the simulations, we generated an estimate of insurance take-up by those with annual wage income greater than \$45,000 and those with income less than \$45,000. We chose to focus on the national competition scenario 2 and used the moderate insurance estimate to identify the impact by different income levels. An income level of \$45,000 was chosen to represent an estimated national mean household income. The income-specific results are shown in Table 7.

In the individual market, we find the greatest percentage increase in insurance among the population with less than \$45,000 income (40 percent), compared with those with more than \$45,000 income (35 percent). Interestingly, we find a smaller percentage decrease in the uninsured among lower-income individuals (-19 percent) than higher-income individuals (-30 percent). This difference suggests that premium costs remain too high for lower-income individuals to take up insurance even with the ability to shop in a less regulated state.

In the group market, the response is very small due to the low opt-out into individually financed HSAs. The impact is greatest for those with lower incomes in the group market.

TABLE 6
Scenario 3: Competition Among States in Four Regions

	Status Quo	Scenario 3					
		Least Regulated State in Four Regions—AL, AZ, NE, NH					
		Minimum		Moderate		Maximum	
Individual							
HSA	4,723,768	276,962	6%	1,176,220	25%	1,540,873	33%
PPO high	7,717,302	785,251	10%	3,892,227	50%	6,453,945	84%
PPO low	298,355	(15,965)	-5%	(77,686)	-26%	(113,218)	-38%
PPO medium	1,910,840	52,852	3%	202,296	11%	240,653	13%
Uninsured	28,084,067	(1,099,100)	-4%	(5,193,057)	-18%	(8,122,253)	-29%
Group market							
HMO	5,505,466	(12)	0%	(301)	0%	(2,402)	0%
HRA	6,166,134	(125)	0%	(1,467)	0%	(4,667)	0%
HSA offered	307,298	(5)	0%	(69)	0%	(285)	0%
HSA no-offer	11,088	2,894	26%	48,592	438%	224,457	2024%
PPO high	16,535,831	(60)	0%	(996)	0%	(5,184)	0%
PPO low	665,950	(2)	0%	(116)	0%	(1,264)	0%
PPO medium	53,470,814	(2,685)	0%	(44,738)	0%	(196,852)	0%
Turned down	3,530,681	(4)	0%	(905)	0%	(13,803)	0%
		Within		National			
		Sample					
Minimum		1,099,104		1,565,391			
insurance estimate							
Moderate		5,193,962		7,397,461			
insurance estimate							
Maximum		8,136,055		11,587,715			
insurance estimate							

In Table 7 we also show the impact of a combination of a national marketplace and former President George Bush's 2008 State of the Union (SOTU) health insurance proposals (Department of the Treasury, 2008). Those buying a single-coverage contract would get a \$7,500 tax deduction and those buying a family contract would get a \$15,000 tax deduction. For the individual market, the combination of these two policies is fairly substantial, with a 71% reduction in the uninsured among those earning less than \$45,000 a year. In the group market, significantly more people opt to take employer-provided health insurance than under the status quo.

Another perspective on the impact of a national insurance market is the effect on individual states. We expect that states with the highest regulatory burden would have the greatest movement to a less regulated state. In Table 8, we show the range of increased insurance coverage from the state of origin in the status quo situation to a national marketplace. Percent changes reflect the difference from the combined individual and group markets at status quo to a different scenario. Highly regulated states such as Maryland, Washington, Virginia, and West Virginia have the greatest percent changes.

TABLE 7
Impact of National Market (Scenario 2) and 2008 State of the Union Proposal by Insurance Status and Income

	Status Quo Sample	Scenario 2			
		AL as Default Least Regulated State			
		National		National & SOTU 2008	
Individual		Sample	% Change	Sample	% Change
Uninsured < \$45K income	24,673,907	19,966,584	-19%	7,252,207	-71%
Uninsured >= \$45K income	3,410,160	2,380,032	-30%	3,211	-100%
Insured < \$45K income	11,735,122	16,442,445	40%	29,156,822	148%
Insured >= \$45K income	2,915,142	3,945,270	35%	6,322,092	117%
Group Market					
Uninsured < \$45K income	3,084,578	3,083,009	0%	1,205,980	-61%
Uninsured >= \$45K income	446,103	445,616	0%	272,228	-39%
Insured < \$45K income	47,414,484	47,416,053	0%	49,293,082	4%
Insured >= \$45K income	35,248,098	35,248,585	0%	35,421,973	0%
National market uninsured change		Within Sample (5,739,508)		National (8,174,451)	
National market & 2008 SOTU uninsured change		(22,881,124)		(32,588,267)	

We also modeled the combined impact of a national marketplace and the 2008 SOTU proposal and found similar distributional patterns but a clearly accelerated movement from states where the insured are domiciled. In Maryland, the share of individuals with insurance increased from 14 percent to 37 percent due to the addition of the SOTU proposal.

One concern about interstate purchase of insurance is that vulnerable populations with chronic illnesses would face rising premiums over time because of increasing cost pressures and limited health plan options. This criticism of a national marketplace for individual health insurance is based on adverse selection concerns. The hypothesis is that younger, healthier individuals will find the premiums and policies in the less regulated states more appealing while older, sicker individuals will prefer policies in more regulated states. Thus, a more open insurance market could allow those

TABLE 8
Impact of National Market (Scenario 2) and 2008 State of the Union Proposal by State

State	Status Quo		National Market		%	National Market & SOTU 2008		%
	Individual	Group	Individual	Group		Individual	Group	
AK	25,037	254,263	28,179	254,263	1%	88,637	268,059	28%
AL	358,089	1,524,624	358,089	1,524,624	0%	756,128	1,559,473	23%
AR	468,958	906,086	486,742	906,086	1%	591,815	907,849	9%
AZ	458,356	2,000,931	473,107	2,000,931	1%	960,364	2,024,927	21%
CA	3,463,657	12,594,829	4,134,239	12,594,831	4%	6,524,469	12,695,943	20%
CO	345,832	1,719,774	397,590	1,719,774	3%	795,157	1,750,321	23%
CT	89,322	1,416,085	112,755	1,416,085	2%	285,887	1,455,191	16%
DE	75,678	353,904	92,348	353,904	4%	103,407	354,096	6%
FL	1,304,122	5,972,619	2,255,675	5,972,654	13%	3,343,401	6,086,599	30%
GA	532,298	3,415,490	705,663	3,415,491	4%	1,459,406	3,503,879	26%
HI	141,724	513,589	187,629	513,589	7%	220,415	514,250	12%
IA	216,504	1,202,769	317,218	1,202,770	7%	460,637	1,211,646	18%
ID	134,906	464,616	235,620	464,616	17%	311,348	471,551	31%
IL	405,168	5,251,628	468,404	5,251,628	1%	1,547,788	5,369,902	22%
IN	621,452	2,330,686	728,286	2,330,686	4%	1,008,499	2,367,867	14%
KS	121,745	1,136,929	135,052	1,136,929	1%	323,920	1,150,308	17%
KY	387,604	1,474,683	436,786	1,474,683	3%	769,118	1,495,233	22%
LA	255,053	1,561,763	308,748	1,561,763	3%	715,461	1,613,671	28%
MA	19,520	2,276,118	203,552	2,276,506	8%	628,438	2,450,401	34%
MD	217,560	2,080,518	529,791	2,080,575	14%	940,197	2,201,983	37%
ME	109,339	550,625	163,509	550,625	8%	183,695	551,765	11%
MI	636,095	4,232,660	943,801	4,232,666	6%	1,431,883	4,266,469	17%
MN	226,333	2,180,219	264,055	2,180,220	2%	604,106	2,191,656	16%
MO	328,293	2,307,270	386,947	2,307,270	2%	836,461	2,348,142	21%
MS	241,562	980,110	249,421	980,110	1%	484,727	984,904	20%
MT	66,775	307,598	76,746	307,598	3%	167,966	316,302	29%
NC	676,812	2,998,459	1,142,207	2,998,472	13%	1,688,555	3,056,040	29%
ND	34,150	253,861	36,004	253,861	1%	86,926	259,887	20%
NE	81,174	671,256	85,171	671,256	1%	217,563	681,158	19%
NH	36,502	555,705	44,107	555,705	1%	113,391	572,312	16%
NJ	20,328	2,393,267	143,123	2,394,234	5%	651,233	2,390,306	26%
NM	240,329	637,256	263,614	637,256	3%	394,608	641,027	18%
NV	168,948	814,555	203,814	814,556	4%	416,470	827,394	26%
NY	121,626	6,753,047	959,629	6,754,186	12%	2,091,675	7,424,117	38%
OH	642,890	4,579,871	1,087,247	4,579,882	9%	1,749,139	4,632,293	22%
OK	209,904	1,208,503	236,684	1,208,504	2%	567,520	1,253,494	28%
OR	252,405	1,218,744	663,293	1,218,748	28%	781,156	1,234,513	37%
PA	675,705	4,853,335	1,024,798	4,853,343	6%	1,469,815	4,882,293	15%
RI	88,707	434,862	121,903	434,862	6%	140,049	435,349	10%
SC	225,440	1,395,668	237,629	1,395,668	1%	596,097	1,458,417	27%
SD	29,777	271,233	33,408	271,233	1%	88,288	283,700	24%
TN	401,215	1,948,370	463,574	1,948,371	3%	1,022,969	2,022,284	30%
TX	1,398,432	8,361,776	1,745,464	8,361,778	4%	3,672,305	8,647,868	26%

(Continued)

TABLE 8
Continued

State	Status Quo		National Market			National Market & SOTU 2008		
	Individual	Group	Individual	Group	% Change	Individual	Group	% Change
UT	371,112	876,221	387,514	876,221	1%	500,439	877,486	10%
VA	616,541	2,688,648	1,141,492	2,688,661	16%	1,548,180	2,745,801	30%
VT	48,290	252,989	74,587	252,989	9%	82,316	253,538	11%
WA	555,371	2,288,192	1,028,021	2,288,209	17%	1,320,419	2,377,662	30%
WI	276,530	2,239,075	297,050	2,239,075	1%	683,167	2,273,089	18%
WV	116,710	578,129	219,305	578,134	15%	368,536	602,469	40%
WY	35,246	177,949	43,078	177,950	4%	92,970	184,686	30%

TABLE 9
Long-Term Impact of National Insurance Market on Share of Chronically Ill Population Insured Compared With Status Quo

Year	% of Chronically Ill Insured Status Quo	% of Chronically Ill Insured National Market
0	29.5%	35.3%
1	27.8%	34.2%
2	27.3%	33.0%
3	26.4%	32.1%
4	25.5%	31.3%
5	24.8%	30.7%
Long-term %change (Years 0-5)	-15.9%	-13.0%

who prefer a less regulated environment to purchase there and subsequently raise premiums in more regulated markets. Over time, as the young and healthy leave for less regulated markets, rates in more regulated states will rise and coverage for the older, sicker population is likely to fall. Because the purpose of many of the regulations discussed in this article is to protect the ability of these more vulnerable populations to obtain affordable coverage, we examined the longer-term impact of a national marketplace in contrast to the current status quo.

To examine the longer-term impact of a national insurance market we extended our 1-year simulation model to run out over multiple years. For this extension we assume real premium growth rate of 6 percent per year.¹² In Table 9, we provide a 6-year set of microsimulation results where we compare differences in insurance take-up among the chronically ill and nonchronically ill for a status quo environment and the national

¹²This assumption is based on the Congressional Budget Office's estimate of 8 percent insurance premium inflation discounted by a productivity growth rate of 2 percent to yield a 6 percent real premium inflation rate.

market option where people choose the least costly state to purchase individual health insurance. The table describes the proportion of chronically ill individuals in the status quo and national insurance markets getting any insurance coverage. At time period 0, 29.5% of the chronically ill get insurance coverage in the status quo compared with 35.3% coverage of this population in the national marketplace. It is important to note that the national marketplace will, from its start, improve coverage for the chronically ill compared with the status quo. Keep in mind, however, that the chronically ill pay higher premiums in the status quo except in a few regulated states.

Over time, as premiums increase, the chronically ill get less coverage in both the status quo simulation and the national marketplace simulation. By the fifth year of the simulation, this population has seen a decline in coverage of 13 percent (from 35.3 percent to 30.7 percent) in the national marketplace. Even so, coverage for the chronically ill is greater in the national marketplace than in the status quo. This example points to the fact that unchecked premium increases over time are the greatest threat to insurance coverage in both the status quo and the national marketplace.

DISCUSSION

Our results suggest that significant reductions in the level of uninsured can result if consumers are permitted to purchase insurance across state lines. These results are driven by the impact on premiums from different states' regulations. The impact of regulations on the probability of being uninsured has been explored by Sloan and Conover (1998) and Zuckerman and Rajan (1999). Although our microsimulation approach is novel and the policy question different from prior research, the underlying model can be used to generate comparable estimates to previous research as a test for robustness.

Prior studies tested the impact of mandated benefits and community rating in isolation. We completed a robustness check focused on New York as a large state with community rating, guaranteed issue, and 54 individual mandates already in place. Since 1993, New York has had community rating and guaranteed issue regulations. Using the plan choice model in this article combined with a telephone survey of approximately 1,000 New York respondents in the individual insurance market completed by Zogby International, we found similar results to prior analyses. Specifically, Sloan and Conover (1998) estimated that each additional mandated benefit raises the probability of an adult being uninsured by 0.004. Our New York predictions yield an individual mandate effect on the probability of being uninsured of 0.0022. With respect to the guaranteed issue, Zuckerman and Rajan (1999) estimated that guaranteed issue raises the uninsurance rate by 0.0277 compared with states that do not have guaranteed issue. In New York, we estimate guaranteed issue alone raises the uninsurance rate by 0.057. While this estimate is twice as high, New York may be a special case because of the very high premium costs in the state—about twice the national average. Our estimates have the same direction as those of Zuckerman and Rajan (1999).

Studies examining the impact of changing the McCarran-Ferguson Act also are relevant for consideration because of the congressional precedent. In this study, we are proposing that health insurance companies be subject to interstate commerce laws and regulations. Another part of McCarran-Ferguson is the limited exemption of

insurers from federal antitrust laws. As discussed by Harrington (2010), repealing that exemption is not likely to improve competition in the health insurance market. Recently, the U.S. House of Representatives passed H.R. 4626 (The Health Insurance Industry Fair Competition Act) to repeal the limited antitrust exemption. This bill is now in the U.S. Senate. Legislative attention directed at McCarran-Ferguson demonstrates that the policy can be changed if there is sufficient political consensus. This analysis suggests there is more empirical evidence to allow interstate purchase of insurance than to repeal the limited antitrust exemption.

CAVEATS

Our analysis has three major limitations. The first is that the simulations assume that regulations affect the demand for coverage exclusively through their effect on premiums. It is undoubtedly true, however, that some of these regulations add value as well. The decline in price from removing certain mandates, for example, will not garner the same demand response as a decline in price that keeps the original benefits intact.

We believe this concern is warranted but it may not be significant enough to bias the outcome of our approach. Consider the following. Suppose the demand for health insurance coverage Q can be written as a function of the premium P and mandates M , where the premium depends on the number of mandates

$$Q = Q(P(M), M). \quad (2)$$

Mandates have two effects on demand: one that reduces demand through higher premiums and another that increases demand because mandates increase the value of coverage, holding premiums constant. We ignore the second effect, which is equivalent to assuming that consumers do not regard the mandate as increasing the value of coverage. By differentiating (2), we get

$$dQ/dM = \partial Q/\partial P * dP/dM + \partial Q/\partial M. \quad (3)$$

If we divide both sides of (3) by Q and let $dM = 1$ (i.e., imagine that one additional mandate is imposed), we get

$$dQ/Q = \eta * dP/P + \partial Q/Q, \quad (4)$$

where η is the price elasticity of demand for coverage. Sloan and Conover (1998) have estimated that each additional mandate would reduce the probability of an adult being covered by any private health insurance by 0.004, given the baseline probability of 0.82. We also use an estimate of the price elasticity of demand for private health insurance coverage equal to -0.67 from Parente and Feldman (2007). Our assumption that the value of one additional mandated benefit (the $\partial Q/Q$ term)

is equal to zero implies that the “pure” price effect of that benefit is

$$dP/P = (-0.004/0.82)/(-0.67) = 0.0072. \quad (5)$$

Comparing this estimate to the midpoint value of $dP/P = 0.0065$ derived from Table 2, we suggest that ignoring the demand-increasing effect of an additional mandate causes very little error. In fact, the mandate appears to have negative value, although we acknowledge that this estimate involves considerable uncertainty.¹³ Congdon, Kowalski, and Showalter (2008) also found that consumers in states with more mandates tend to purchase policies with larger deductibles and higher coinsurance—a sign that mandates increase the “pure” price of health insurance.

A second limitation is that removing regulations will not affect all plans equally. For example, removing AWP laws should reduce premiums more for managed care plans than for plans that had broad provider networks in the first place. Unfortunately, none of our sources can provide estimates with enough detail to identify the plan-specific impact of AWP laws or other regulations. This should not be a problem in the individual market because managed care plans are quite rare in this market (see the status quo probabilities in Table 4). Thus, the effects of AWP laws that have been estimated for the individual market should apply to the same degree, more or less, to all plan types in this market. However, we would expect to see more heterogeneity in the effects of laws and regulations in the small-group market, where managed care plans are more commonly offered. Modeling the effects of interstate shopping in the small-group market is beyond the scope of our simulations.

A third limitation that can complicate our simulations is that reforms are often correlated, so our estimates may be biased. We agree that the effects of individual regulations may be overstated if the regulations are imposed or removed as a package. This is why we tried three distinctively different scenarios to test the differential impact of the insurance reform options. The greatest credibility probably should be given to our intermediate-impact scenario. To investigate this further would require more data from natural experiments to see how specific changes in regulations would affect health plan choice and the decision to be uninsured.

CONCLUSION

We find evidence of a significant opportunity to reduce the number of uninsured under a proposal to allow the purchase of individual health insurance across state lines. The best scenario to reduce the uninsured, numerically, is competition among all 50 states with one clear winner. This idea is not without precedent outside the health care industry, where Delaware has become the most favored state for incorporating a firm. The most pragmatic scenario, with a good impact, is one winner in each regional market. This is a compromise since the U.S. health insurance industry is only “half-way” national (through national employers contracting with insurers that

¹³See Auerbach and Ohri (2006) for another recent estimate of the price elasticity of demand for health insurance. They found the price elasticity for all single workers who were ineligible for a group policy was -0.592 ; for workers at less than 200 percent of the federal poverty limit, the price elasticity was -0.873 .

offer national provider panels), and this could provide a practical, more politically palatable approach. The “five large state” scenario is the least effective policy for increasing the number of insured people. This is likely due to the fact that only one state of the five, Texas, had a combined regulatory burden that is less than the 50th percentile of all states.

Under any scenario, there will be significant implementation issues. In general, these issues need to address the relationship between the state where the policyholder lives and the state that is “exporting” insurance. Miller (2002) refers to the division of regulatory powers between the “primary state” (the one designated by the insurer as the state whose laws govern the sale of coverage) and the “secondary state” where the insurer does business. H.R. 2355—Rep. Shadegg’s (R-AZ) Health Care Choice Act of 2005—exempted the policy from coverage laws in the secondary state but left the insurer with some obligations to the secondary state, such as obligations to pay premium taxes and to comply with state laws regarding fraud and abuse. These policies might form the basis for legislated or contractual agreements to divide regulatory powers between primary and secondary states. Of course, adequate disclosure to consumers of the primary and secondary states’ obligations will be paramount for this to work.

One possible outcome is that consumers who buy insurance in one state, but live in another, could have two insurance regulators looking out for them rather than just one. This would address a substantial concern that “demanding” the market could leave consumers without adequate protection. At the same time, if the effect of mandates on premiums substantially reduces the probability that someone would buy insurance, one must ask: which is the worse outcome, lack of coverage for a given service or no coverage at all due to higher premiums?

Although we have modeled the person-level impact of a national market on coverage, we are unable to assess the impact of such a migration on provider access or quality of care. Nevertheless, a national market would lead to substantially more health insurance coverage, which should improve access to health care among the vulnerable populations who currently find health insurance unaffordable. In addition, development of a national market requires no additional federal resources other than support for legislation to permit the development of such a change.

APPENDIX: STATE-SPECIFIC IMPUTATION OF MEPS

The state-specific imputation of the Medical Expenditure Panel Survey (MEPS) was a critical element of this simulation. Below, we summarize the four-step process that resulted in the creation of 51 synthetic state populations from the 2005 MEPS-HC.

First, we used the 2005 American Community Survey (ACS) to define the strata that would be used to generate the sample.¹⁴ The final strata included four variables: age (18–34, 35–44, 45–54, and 55–64), income (1 if household income is in the lowest quartile, 0 if not), male (1 if male, 0 if not), and white (1 if white, non-Hispanic, 0 if not). All possible combinations of these strata resulted in 32 cells per state. The unit of

¹⁴We used the ACS because it gave us state-specific distributions that were required to create the synthetic state markets for the analysis.

TABLE A1
2005 Regional MEPS Sample Size by Region

Region	Sample Size
Northeast	2,874
Midwest	3,734
South	7,520
West	5,132

analysis for data construction is the person, not the household. Using person weights in the ACS, we tabulated the population frequencies for each of these strata by state.

Second, we divided the 2005 MEPS into four regions—Northeast, Midwest, South, and West. The District of Columbia is in the South region. We selected only 18- to 64-year-olds to match the ACS selection criteria. The regional MEPS sample sizes are reported in Table A1.

The strata were defined within each of these regions. We then wrote a STATA computer program to draw a random sample with replacement of 1,000 (approximately, given rounding) observations from the region containing a particular state.¹⁵ The frequency of observations by strata was matched to represent the population (e.g., if 10 percent of the state is age 18–34, low-income, male, and nonwhite, then 100 of the 1,000 observations would be drawn from MEPS individuals of this type). After all of the random samples were drawn, the data were appended to form a national data set.

In the third step of the process, we validated our state assignments. While we know that the state samples match the sociodemographic criteria with respect to the strata, additionally we wanted to check to see how our samples looked with respect to insurance holding. To do this, we computed state-specific estimates of uninsurance from the 2006 Current Population Survey (CPS). We compared the uninsurance estimates generated for our synthetic state populations with the CPS estimates. This comparison fares pretty well. There are only two notable issues: (1) we tended to underestimate the amount of uninsurance in synthetic Northeast states due to the small MEPS sample and the population heterogeneity in the Northeast, and (2) uninsurance was overestimated in Washington, D.C., because the sample is drawn from the entire South region and there is no easy way to account for the concentration of federal government workers in D.C.

In our fourth and final step, we merged several other variables into the file and selected the sample to mimic the one we have used previously in simulations (Feldman et al., 2005). In particular, we deleted cases of adult dependents who did not have an ESI offer but had a spousal offer ($n = 8,609$), those who reported having public insurance at any point during round 1 of MEPS ($n = 4,725$), and full-time students ($n = 892$).

¹⁵The sample size for Hawaii had to be reduced to 600 because the MEPS sample from the Western region of the United States did not have enough representation among certain strata to accommodate the sociodemographics of Hawaii. STATA does not allow one to draw a random sample from a stratum that is larger than the population, even with replacement.

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