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ADDRESSING INSURANCE MARKET REFORM IN NATIONAL HEALTH REFORM (ROUNDTABLE DISCUSSION)

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

ON

EXAMINING ADDRESSING INSURANCE MARKET REFORM IN NATIONAL HEALTH REFORM

MARCH 24, 2009

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ADDRESSING INSURANCE MARKET REFORM IN NATIONAL HEALTH REFORM (ROUNDTABLE DISCUSSION)

TUESDAY, MARCH 24, 2009

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10:05 a.m. in Room SD–430, Dirksen Senate Office Building, Hon. Jeff Bingaman presiding.

Present: Senators Bingaman, Harkin, Brown, Casey, Hagan, Merkley, Burr, Hatch, Coburn, and Roberts.

OPENING STATEMENT OF SENATOR BINGAMAN

Senator BINGAMAN. OK. Why don't we get started? We have a few people here, and we thank everybody for coming.

Senator Enzi, I am told, is snowed in Appropriations Wyoming and is not able to be here. Senator Roberts is going to fill in for him and is on his way. But since we have several Senators here, why don't we go ahead and get started?

Let me make a few comments here and then ask any other Senator that wants to make comments to do so. Then we will turn to our witnesses, and we have sort of set this up as a roundtable discussion so that we don't have it as formal as usually is the case with hearings.

This is the second in a series of hearings that were designed to explore key issues surrounding legislation to provide meaningful and affordable health insurance for all Americans. Today's hearing focuses on the insurance market reforms that are needed to achieve that goal. Particularly, it is focused on small group and individual insurance markets, and we thank all the panelists for being here.

Approximately 60 percent of Americans receive their coverage today, their private insurance coverage from large employers. That is employers with 50 or more employees. Insurance offered through these employers include many protections, such as requirements that insurance companies provide coverage to all interested employees, the creation of large risk pools to spread the cost of coverage, and prohibitions on excluding coverage for specific pre-existing conditions.

In contrast, the coverage in the individual market is much less predictable, and regulations governing this market vary considerably from State to State. Individuals may or may not have impor-

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tant protections to ensure that coverage is meaningful and affordable.

For example, individuals may have critical health conditions that are excluded from coverage, or they may have very high cost-sharing requirements or be excluded from coverage altogether based on broad nonmedical characteristics. For example, older individuals on average are charged six times more for a policy than younger individuals, and women may be charged as much as 50 percent more for coverage than their male counterparts.

The National Women's Law Center indicates that it is still legal in nine States for insurers to reject individual applicants on the basis of having experienced domestic violence. In the end, about 30 percent of individuals applying to the individual insurance market are either denied a policy or are forced to pay significantly more for coverage, and only about 15 million to 17 million Americans purchase policies on the individual market.

As to the small business or small group market, that is, frankly, a market very relevant in my State, where most of the employers are small employers. In this market, like in the individual market, it is more difficult to spread risk because of the small size. Similarly, small employers have less bargaining power to negotiate affordable and meaningful coverage.

In many cases, small businesses have found it difficult to find affordable and meaningful coverage and have chosen not to provide health insurance to their employees. According to the Kaiser Family Foundation, less than two-thirds of small businesses offer health benefits to their employees, and this problem is apparently getting worse. Ninety percent of the decline in employer-sponsored coverage has been attributed to small businesses.

So we want to explore these issues with this group of panelists. I was told that Senator Roberts was going to come and stand in for Senator Enzi here. He is not here. Let me just see if Senator Hatch—excuse me? Oh, here. He arrives right now. OK.

Senator ROBERTS. What are you doing down there?

[Laughter.]

Senator BINGAMAN. Come on down here. We are waiting for you to tell us what you know on this subject.

While I am doing that, I will just call on Senator Hatch and any other Senator who wants to make any initial statement here before we get into this.

Senator HATCH. Do you want me to go?

Senator BINGAMAN. Go right ahead.

STATEMENT OF SENATOR HATCH

Senator HATCH. Well, we welcome all of you experts here today. It is very important because we know that insurance is one of the most important issues that we have in all of healthcare, and I don't believe you can do a healthcare bill without resolving some of the problems that exist in the insurance industry.

You folks, you do a lot of good for the industry, but there are also a lot of things that are challenges and problems that we have got to work out. Insurance market reform, there is no question about it, is a critical piece of any kind of healthcare reform if we are going to do it at all.

I think virtually everybody agrees that reform is necessary, and the question is what reforms should be implemented, both on the State and Federal levels? I am going to be very interested in what you have to say here today. We have chatted with a number of you in the past, and we are very, very impressed with this panel.

We welcome you to the Senate. We look forward to hearing from you.

Thanks, Mr. Chairman.

Senator BINGAMAN. All right. Senator Roberts, did you want to go ahead?

STATEMENT OF SENATOR ROBERTS

Senator ROBERTS. Yes, sir. Thank you very much.

I apologize to the group for being late. I was just finishing up finally reading the entirety of the stimulus bill. That is a joke. That is not—well, it is not a joke.

Senator BINGAMAN. Please continue to tell us whenever you do tell a joke.

Senator ROBERTS. Yes. OK.

[Laughter.]

OK. Mr. Chairman, I want to thank you for holding this roundtable today, and I want to pass on Senator Enzi's thanks as well for the members of the committee. I know he would like to be here with us today, but the weather in Wyoming is not a very good situation. The weather had other ideas. He is starring in that movie, "I Am Snowed In In Wyoming."

I understand the staffs worked very closely to plan today's roundtable, as well as set an agenda for two additional roundtables in the future. This is a very good thing. I appreciate that. I know Senator Enzi does as well, as does the chairman.

I think we have a stellar panel. I am looking forward to hearing from our experts and getting into the details of insurance market reforms. I believe it is very helpful to hear from people that have actually enacted policies in the real world. This is called reality, a reality hearing. You can tell us what you did right, what you did wrong, and how you would improve things moving forward.

As a Senator from the State of Kansas, I could not be more proud that one of these experienced people on our panel today is Kansas insurance commissioner, former Kansas legislator, and my very good friend Sandy Praeger.

Commissioner Praeger was first elected as the Kansas insurance commissioner in 2002, went on to re-election in 2006. Her health insurance expertise and her leadership abilities have also been recognized at the national level. She is the most immediate past president of the National Association of Insurance Commissioners.

In addition, she has experience as a past mayor of the city of Lawrence, no small task. Lawrence, that is the home of the Jayhawks, right? Right. That comes from a Wildcat, Mr. Chairman. You would have to understand that if you were from Kansas.

A past member of both chambers of the Kansas legislature. I am so pleased that Sandy could be here today to share her considerable experience with health insurance market regulation with this committee.

Thank you, Sandy, and thank you to all of our panelists for taking time out of your very valuable schedule to be here today. I look forward to hearing from you.

I hope the members of this committee can learn from all of our witnesses and use that knowledge to better inform their decisions on healthcare reform legislation. Healthcare reform will be difficult. There will be tradeoffs with any policy we devise. Insurance reforms all result in tradeoffs.

Rating rules are a perfect example. We must be cautious when considering reforms that may result in unaffordable prices for our young and healthy. We need those folks to participate because they help keep costs down. However, ensuring access to quality insurance for those struggling with health conditions is, I hope, our top priority.

Our job here is to find a balance that accomplishes our goals but doesn't create a disruption in our insurance marketplace. While it is critical we get the policy of insurance market reform right, I would be remiss if I didn't at least mention the perils of the process. Without the right process, we can't move forward on the best healthcare reforms for the American people. I doubt seriously if we can do this in 100 days.

If those in the majority attempt to use the budget reconciliation process to put healthcare reform through the Senate—or a better word would be "jam"—they will be sending a clear signal that they are not interested in a truly bipartisan effort.

With that, I look forward to our witnesses to make recommendations on how we should shape policies of healthcare reform.

Mr. Chairman, thank you again for holding this roundtable.

Senator BINGAMAN. Well, thank you again. Thank you.

Let me just see if Senator Brown or Senator Coburn or Senator Hagan wish to make any statement?

STATEMENT OF SENATOR BROWN

Senator BROWN. Just a few comments. Thank you, Mr. Chairman, for your leadership.

Thank you all, members of the panel, for your distinguished service to our country and for being here today.

Recently, a couple of weeks ago, my office conducted a seminar, if you will, for the five new Ohio House members elected last year, bipartisan, some in both parties—new House members from my State—to talk about case work and to sort of help them work their way through these first months in office in dealing with all the problems that people bring to our offices. And obviously, one of the issues that comes up so frequently is how do you deal with health insurance companies?

I think we all—our offices, if we are paying attention—all of our offices spend an awful lot of time fighting with insurance companies on behalf of our constituents. Insurance companies that often, and probably the perception of many, discriminate based on age and gender or medical history. Insurance companies that seem to put restrictions on treatments and prescription drugs that patients get, the wait for reimbursement, the wait to pay claims, and preexisting conditions. All of the issues that we have disagreements on

and that it is our job as elected officials to fight for our constituents to be treated fairly.

Let me share one real quick story about all of this that may bring this home in some sense. A woman named Deborah from Summit County, Ohio—the city of Akron is the county seat there—she is one of the 50 million Americans left out of our healthcare system because she lacks insurance, she can't get insurance.

Her income is too high for Medicaid. Her pre-existing condition—she has had two heart attacks. She has a spinal injury. Those conditions disqualify her from finding private insurance in the private market, her inability finding affordable insurance in the private market—no surprise there.

She wrote to me,

> "My only option is to start paying for my funeral. While everyone on Capitol Hill argues the point, people are suffering and dying. America proclaims itself the wealthiest and most powerful Nation in the world. If that is the case, why do we have people suffering and dying for lack of simple healthcare?"

We know what we need to do this year, and I think Deborah's words speak it certainly more persuasively than any of us could.

Last point, Mr. Chairman, I think that the President is right when he said there should be an option like the original Medicare, some public option to bring competition. Competition, as we hear from our friends in the insurance industry and hear from people on all sides of political debates, competition is the American way. It is healthy for our society.

I think competition in healthcare with a public option, whether it takes the form of FEHBP in some case, some sense, or a public, more Medicare look-alike option is a good thing, I think, for the insurance industry. It is a good thing for the country, and it is something that this committee I think should and will pursue.

I again thank the chairman for having this hearing today.

[The prepared statement of Senator Brown follows:]

PREPARED STATEMENT OF SENATOR BROWN

I want to first thank the Senator from New Mexico for holding this important hearing. He has been doing a great job leading the HELP working group on coverage and I look forward to working closely with him as our committee's effort to reform the health care system moves forward.

I think we can all agree that the private health insurance market in this country is broken.

Every day I hear from constituents who are frustrated:

- with health insurance that is nearly impossible to afford;
- with health insurance that fails to protect them from catastrophic health costs;
- with health insurance that openly discriminates based on their age, gender, location, or medical history;
- with health insurance that puts onerous restrictions on which providers patients can see and on which treatments and prescription drugs they can get;

• with health insurance that waits literally months to pay claims, or requires enrollees to fight for every penny the insurer owes;

• and with health insurance that doesn't respond to customers' questions, problems, and appeals.

Take, for example, Debra from Summit County, Ohio. She is one of the nearly 50 million Americans locked out of our health care system because she lacks insurance. Her income is too high for Medicaid, and her pre-existing conditions—she has a spinal injury and is recovering from two heart attacks—disqualify her from finding affordable insurance in the private market. As a result, she has piled up thousands of dollars in unpaid bills and is in constant pain.

She writes, "My only option [is] to start paying for my funeral. . . .While everyone on Capitol Hill argues the point, people are suffering and dying. . . . America proclaims itself the wealthiest [and] most powerful Nation in the world. If this is the case, then why do we have people suffering and dying for lack of simple health care?"

Or then there are those, like Barbara and Allen from Lyndhurst, Ohio, who have what is considered very good insurance, but it was not enough to protect them from a rash of bad luck.

Barbara was diagnosed with a rare form of muscular dystrophy 15 years ago. She has insurance, but the payments for the chronic disease management she needs are not sufficient to ensure access. In fact, the local hospital sometimes refuses to admit her because it would rather fill its beds with more lucrative patients.

Allen developed stage 4 Non-Hodgkin's lymphoma while working as a physician for a medical center in Cleveland; though he recovered from the disease he was forced out of his job and now is discriminated against by potential employers because his medical status skews the risk pool that insurers use to price their plans. Unfortunately, these stories are not unique. They represent the experience of thousands of Ohioans and millions of Americans who are being ill-served by the private health insurance market.

And it is because of stories like these that I am skeptical of any health reform proposal that relies solely on the private insurance market to solve all of our problems.

It is private insurers who decided to experience-rate enrollees and apply pre-existing condition exclusions, which has skewed risk pools, forced Federal and State Governments to cover more Americans, and enriched insurers by allowing them not to do their jobs.

It is private insurers who have set "reasonable and customary" reimbursement rates so low that balance billing has become the norm and "participating" providers an endangered species.

It is private insurers who instruct their claims personnel to deny claims first so they can hold on to premium dollars for as long as possible.

Private insurers have helped to create a system of winners and losers, a system in which insured individuals can still be bankrupted by health expenses and uninsured individuals can die far too young because they can't get the care they need.

There are good insurers and bad insurers, but the private insurance system is not, by any stretch, the complete answer to any question in health reform.

Insurance reform is positive, insurance reform is essential, but insurance reform is only a piece of the health reform puzzle.

There are those who believe that health reform can be achieved by tightening insurance regulation.

When the Medicare Advantage program was launched, private insurers promised that taxpayers would get better coverage at a lower price.

Medicare remains far more popular, with far fewer complaints, than Medicare Advantage, and taxpayers are paying significantly more for Medicare Advantage than they are for Medicare.

Private insurance reform isn't a panacea. Regardless of what insurance reforms we apply, President Obama is right that there should be an option like original Medicare for Americans to choose—the competition will be healthy, and those Americans who want to avoid health plans tethered to profit targets should have another choice.

I am looking forward to today's testimony and know it will be helpful. Health reform is a puzzle we can solve; this is one of the pieces that will help get us there.

Thank you, Mr. Chairman.

Senator BINGAMAN. Senator Coburn.

Senator COBURN. I will pass.

Senator BINGAMAN. Senator Hagan.

STATEMENT OF SENATOR HAGAN

Senator HAGAN. Thank you, Mr. Chairman.

I would like to welcome all of the panelists here.

I think this issue is one of the biggest issues facing the Nation right now, the affordability, accessibility, and in particular, the portability of insurance so that people can change jobs, especially those with pre-existing conditions. I think this roundtable will help bring some of this to light.

It is certainly a huge issue facing our country today, and I am thrilled to be at the table.

Thank you.

Senator BINGAMAN. Well, thank you.

Let me just very briefly introduce this distinguished group of witnesses we have here.

Janet Trautwein is the executive vice president and CEO of the National Association of Health Underwriters in Arlington, VA. Thank you for being here.

Ronald Williams is chairman and chief executive officer of Aetna, a leading diversified health insurance company.

Karen Pollitz is a research professor at the Health Policy Institute at Georgetown University. Thank you for being here.

Karen Ignagni—am I pronouncing that right? OK. President and CEO of America's Health Insurance Plans, a trade association that represents the Nation's health insurance organizations.

Len Nichols directs the health policy program at the New America Foundation and has a distinguished background in these issues as well.

Katherine Baicker is a professor of health economics at the Department of Health Policy and Management at Harvard School of Public Health. Thank you very much for being here.

And Ms. Praeger was just introduced, Commissioner Praeger. So we welcome you as Kansas's 24th commissioner of insurance, and we appreciate you all being here.

I guess the idea here was to have you each take a couple of minutes and tell us the most important things you think we need to be aware of in trying to understand the issue and how to proceed. I think that, at least from my perspective, the real issue is what are the most critical reforms that we need to try to enact in these areas?

Ms. Trautwein, why don't you go ahead? Then we will just go down the panel, and after we have heard from all of you, then we will have questions.

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

Ms. TRAUTWEIN. Thank you, Mr. Chairman.

I really am very pleased to be here today. This is a very, very important topic. The rising cost of health insurance is a problem that is driven by the rising cost of healthcare itself. As a part of any health reform package, I just want to stress that it is essential that we do everything possible to lower healthcare costs.

Keep in mind that of every premium dollar, 88 percent nationwide goes to cover claims, which is healthcare itself. I do also believe and NAHU believes that any health reform package should also include some very important health insurance reforms and that we can do this in a way that is both effective and affordable.

Now our members are benefit specialists. They help individuals and businesses purchase coverage on a daily basis. After the coverage is purchased, they also work with them through any problems that come up, and we are very familiar with what kinds of problems those are.

In fact, this service aspect of their jobs is the biggest part of their jobs, and it is something that most people are not aware of. There is a lot to do with not only getting coverage in place, but keeping it in force.

It gives us kind of a unique ability, this very frequent interaction with consumers, to understand what the greatest issues are. I will share what some of those are very briefly.

The biggest response that we get from most people who are covered by employer-sponsored plans, as you indicated, is that they love their employer-sponsored plans. I would just start off saying that we strongly believe that any reform package should include employer-sponsored coverage as its core. That is for large and small employers.

We do have, today already, about 14.5 million Americans that are already in the private individual health insurance market because either they choose to purchase individual coverage or employer-sponsored coverage is just not available to them. It is for this reason that we have looked very, very carefully at the individual market, which we think is a key place to start with reforms.

We have put together 10 very specific policy recommendations, which I am happy to go through during the course of our discussion today. But in general, what those recommendations do is ensure that coverage is available to everyone regardless of their health status, that everyone can afford coverage that is not only there and available to them, but they can pay for it, that it is affordable to them. I have included a lot of detail in my written statement.

I would also say that some of our recommendations also have to do with portability, and greater portability than what people have today. They have to do with what happens when they leave a group plan, and let us say they are going to start their own business and what faces them and what are the options in the event that they have a chronic health condition, but they still are going to start this business? What is available to them?

This is what our recommendations revolve around, and I do just want to applaud you for putting this together. I think this discussion is so important, and I think we have a lot of—my fellow panelists are just excellent, and I think that we will have a good discussion this morning.

[The prepared statement of Ms. Trautwein follows:]

PREPARED STATEMENT OF JANET STOKES TRAUTWEIN

EXECUTIVE SUMMARY

The National Association of Health Underwriters (NAHU), a professional trade association representing more than 20,000 health insurance agents, brokers and benefit specialists nationally, whose members help individuals and businesses purchase private health insurance coverage on a daily basis, feels that we must keep private individual health insurance coverage accessible and affordable for all Americans. Although we strongly feel that any health reform effort should be centered on employer-sponsored plans, it is critical that we look first at the individual market to be certain that it functions effectively and affordably for those who purchase coverage there. Since each State's individual market is uniquely regulated, consumers in some States are faring better than in others, but no State's individual health insurance market is problem-free.

Americans deserve to see what can be done at the Federal level to provide better access to individual coverage for everyone who needs it, and great care needs to be taken when implementing these market reforms on a national level so that coverage is affordable. No matter how "fair" a market-reform idea might seem on its surface, it's not at all "fair" if it also prices people out of the marketplace.

NAHU has developed 10 specific policy recommendations to ensure that all people, regardless of their health status and pre-existing medical conditions, have the ability to purchase affordable private individual coverage. It should be noted that some of these requirements may need to be present only during a transition process to complete guaranteed issuance of coverage. However, they still are quite important to achieving the affordability of coverage so crucial to getting everyone in the system. Our proposed requirements could either be enacted as part of a transition process to complete guaranteed issuance of coverage or they could be stand-alone requirements. Our recommendations are to:

1. Require guaranteed access to individual coverage and with State-level financial backstops for catastrophic risks.
2. Give pre-existing condition credit for prior individual market coverage to ensure true health insurance portability from one individual market policy to another.
3. Standardize State requirements regarding the consideration of pre-existing conditions.
4. Improve Federal group-to-individual coverage portability provisions so that people can transition directly from employer coverage to individual coverage without hurdles.
5. Stabilize individual market rates by requiring more standardization as to how individual market carriers determine pricing.
6. Increase consumer protections regarding individual market coverage rescissions.

7. Make it easier for employers to help people purchase individual health insurance.

8. Provide Federal financial assistance to keep individual health insurance coverage affordable, including enhanced deductibility, subsidies for low-income individuals, and Federal financial support for qualified State financial backstop programs.

9. Ensure that all Americans have health insurance coverage.

10. Allow State implementation of enhanced consumer protections with a Federal fallback enforcement mechanism.

NAHU urges Congress to carefully consider these ideas and we look forward to working with policymakers to fill the gaps in our Nation's coverage system and to make private individual health insurance coverage more affordable and accessible for all Americans.

NAHU'S SOLUTIONS TO CREATE ACCESSIBLE AND AFFORDABLE INDIVIDUAL HEALTH INSURANCE COVERAGE NATIONWIDE

The National Association of Health Underwriters (NAHU), a professional trade association representing more than 20,000 health insurance agents, brokers and benefit specialists nationally, feels that American policymakers must do everything they can to keep private individual health insurance coverage accessible and affordable for all Americans.

As an association of benefit specialists who help individuals and businesses purchase private health insurance coverage on a daily basis, we know that the vast majority of Americans are happy to receive their health insurance coverage through the employer-based system. Our association believes that any health insurance market reform effort should include the employer-based system as its core. But even though it works well for many people, the employer-based system isn't an option for everyone. Approximately 14.5 million Americans have private health insurance coverage that is not connected with an employer-sponsored plan.[1]

BACKGROUND ABOUT INDIVIDUAL HEALTH INSURANCE COVERAGE

Since the individual market is so small nationally (only about 5 percent of the non-elderly population has such coverage) and each State's individual market is separate, the ability of an insurer in any given State to spread costs and risks across a large pool is very limited. Individual-market risk spreading is even more complicated because that market is prone to a phenomenon known as adverse selection. Adverse selection occurs when a person delays buying an insurance product until he or she anticipates an immediate need for the benefit. Since individuals always know more about their own health status than anyone else does, and because all of the cost of buying individual health coverage is generally borne by the insured, the amount of adverse selection and poor risk spreading occurring in the individual market is very high. This has a direct impact on the pricing of individual-market policies.

The States are the primary regulators of individual health insurance policies. This is in contrast to the group health insurance market, where fully insured plans are governed primarily by State law but self-funded health plans are governed federally under the Employee Retirement Income Security Act of 1972 (ERISA). Since each State's health insurance regulatory requirements vary, State-specific regulations often impact the types of individual policies available in each State and their cost. The cost variance from State to State is dramatic. Some of the States that have gone to the greatest lengths to ensure equal insurance access actually have the highest coverage costs.[2]

Our States have proven to be an excellent laboratory for health reform and have given us some great examples of what does and does not work when it comes to providing choice and affordable premiums for individual health insurance buyers. Unfortunately, the great innovations provided by the States have not produced

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[1] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements) *http://www.statehealthfacts.org/comparebar.jsp?ind=125&cat=3*.

[2] For example, a PPO individual health insurance policy for a 37-year-old male living in Haddonfield, NJ, (a suburb of Philadelphia) with a $1,000 deductible and 80/20 percent coinsurance would be $514/month for coverage beginning on February 1, 2009. New Jersey guarantee issues all individual health insurance policies and prices them based on a modified community rate. A comparable policy could be issued to the same male living in Wayne, PA, (also a Philadelphia area suburb 22 miles away from Haddonfield, NJ) for $170 a month. Pennsylvania medically underwrites its individual policies and imposes pre-existing condition look-back and exclusionary periods.

much consistency. Furthermore, State-level consumer protections have sometimes proven to be inadequate, resulting in some people not being able to obtain the coverage they need at all or at an affordable price.

COVERAGE FOR EVERYONE

One of the greatest problems with individual health insurance today is that not all Americans are able to purchase coverage. In some States, people with serious medical conditions who do not have access to employer-sponsored plans cannot buy individual coverage at any price.

One of the simplest ways to address the access issue in the individual market would be to require that all individual health insurance policies be issued on a guaranteed-issue basis without regard to pre-existing medical history. However, in addition to being accessible to all Americans, individual coverage also must be affordable. It would be unwise to require insurers to guarantee-issue individual coverage to all applicants unless a system where nearly all Americans have coverage and full participation in the insurance risk pool has been achieved. Due to their small size and the propensity towards adverse selection, State individual health insurance markets are very fragile and price-sensitive. Also, there currently is no controlled means of entry and exit into the individual health insurance market independent of health status, like there is with employer-group coverage. Without near-universal participation, a guaranteed-issue requirement in this market would have the perverse effect of encouraging individuals to forgo buying coverage until they are sick or require sudden and significant medical care. This, in turn, would undermine the core principle of insurance: spreading risk amongst a large population. The result would be exorbitant premiums like we currently see in States that already require guaranteed issue of individual policies but do not require universal coverage or have a financial backstop in place.

Great care needs to be taken when implementing market reforms on a national level to not inadvertently cause costly damage to the existing private-market system. No matter how "fair" a market-reform idea might seem on its surface, it's not at all "fair" if it also prices people out of the marketplace.

RECOMMENDATIONS TO ACHIEVE NEAR-UNIVERSAL COVERAGE

To bring everyone into the health coverage system, NAHU believes that Congress would be wise to look at our existing system for holes and examine what the States have done to successfully fill those coverage gaps. A few simple reform measures would go a long way toward extending health insurance coverage to millions of Americans. State small-group health insurance markets and consumers ultimately benefited from the passage of Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA); a similar measure that preserves State regulation and consumer protections for individual-market consumers but would also make coverage options more consistent and affordable is warranted.

Such requirements could either be enacted as part of a transition process to complete guaranteed issuance of coverage or they could be stand-alone requirements. In either case, NAHU believes that the following policy recommendations would have a profoundly positive impact on individual health insurance market access and affordability nationwide.

Recommendation 1: Require Guaranteed Access to Individual Coverage with Qualified State-level Financial Backstops for Catastrophic Risks to Keep Coverage Affordable

Federal access protections in HIPAA ensure that small-group health insurance customers and individuals leaving group health insurance coverage under specified circumstances must have at least one guaranteed-purchasing option. But these Federal protections do not apply to everyone. People purchasing coverage in the traditional private individual health insurance market who are not transitioning from an employer's plan do not have Federal guaranteed-issue rights. That means right now, in a number of States, there are people with serious medical conditions who cannot buy health insurance at any price.

Furthermore, in many of the 45 States[3] that have independently established at least one mandatory guaranteed-purchasing option for individual-market consumers with serious health problems, there are still access problems due to design flaws. For example, some States have required that all people be guaranteed access to all

[3] The States without a guaranteed-access mechanism are Arizona, Delaware, Georgia, Nevada and Hawaii. Furthermore, Florida's high-risk pool has been closed to new applicants since 1992, so it effectively also has no access mechanism for new medically uninsurable individuals.

coverage on an immediate basis, without regard to health status. Unfortunately, merely requiring guaranteed issuance of individual coverage has led to adverse selection and, consequently, very high premium rates that create a barrier to entry for most consumers. On the other hand, in some States that allow for the consideration of health status, there can be a great deal of inconsistency in what types of risks are deemed to be uninsurable by individual carriers. Also, States with a high-risk health insurance pool often have funding difficulties that can result in high premiums and pool instability, both of which can be a barrier to entry.

While the mechanism for access to health care coverage may vary from State to State, access should not be denied to any American. The Federal Government should *immediately* require that all States have at least one guaranteed-purchasing option for all individual health insurance market consumers. But, beyond that, the Federal Government should also stipulate that a guaranteed-issue mandate, a designated carrier of last resort or a high-risk health insurance or reinsurance pool alone may not be a sufficient means of providing guaranteed access.

The best solution is a partnership between the private individual market and the mechanism for guaranteed access. A State's high-risk pool or reinsurance mechanism could serve as a backstop to insulate the traditional market against catastrophic claims costs. The Federal Government should establish broad guidelines for qualified State-level financial backstops (i.e., capped rates for high-risk individuals) to allow for State innovation but also ensure consistency of access and affordability.

Several States have been able to successfully combine a guaranteed-issue approach with universal underwriting criteria for all carriers and either a traditional high-risk pool or a reinsurance mechanism. When establishing State guaranteed-access requirements coupled with a financial backstop, four States in particular should be looked at as potential models:

Idaho.—One of the most interesting arrangements is from Idaho. It is a hybrid arrangement—the only one of its kind—known as an individual high-risk reinsurance pool. Although the idea of reinsurance isn't new, Idaho is using it in a manner that is different than what has been done before. In Idaho, if a person's health status (based on a uniform medical questionnaire that all carriers use) meets a certain threshold, the carrier can cede a large part of the financial risk for the individual to the reinsurance pool. Individuals who are insured in this manner are still issued a policy through the insurer they applied for coverage with, but must select one of four standard options. The coverage is still comprehensive, but the more limited benefit choices make administration of the reinsurance mechanism simpler. The carrier pays a premium to the pool in exchange for the pool taking on the risk of the individual's high claims. The individual consumer pays premiums to the insurer and has coverage issued by that insurer, not the pool itself. So the reinsurance mechanism is largely invisible to the consumer, although the premium is somewhat higher than the consumer would have otherwise paid. This program is funded through several mechanisms. First, the State's premium tax, paid by all insurers in the State, is the primary funding source and this is considered a stable funding source since it is not a State appropriation. In addition, when a carrier cedes risk to the pool, it pays a premium to the pool. Finally, the pool has the ability to assess insurance carriers for funding but, so far, it hasn't needed to do so. The Idaho pool is one of the few State programs that has more than enough funds to operate on a consistent basis.

Utah.—In Utah, health insurance carriers in the individual market must offer coverage to everyone who applies, but if an individual's medical costs are deemed to potentially exceed a set threshold ascertained through a medical questionnaire, the carrier can refer the person instead to the State high-risk pool. Of importance here is that every insurance carrier uses the same medical questionnaire, so the pool gets only the most serious health risks and the regular market keeps other applicants. The current downside of the Utah arrangement is that the excess funding for the pool comes from the State so, while the benefits are extremely comprehensive, State budget limitations have resulted in the need for an annual cap on benefits that are troublesome. But the mechanism is interesting and could be replicated and otherwise works well, if the funding issue could be resolved to something more stable.

Washington.—The Washington State high-risk pool and guaranteed-issue requirements work similarly to those in Utah although, in addition to the consistent underwriting requirements, carriers are limited to a set percentage of individual business that can be referred to the pool. Since Washington's pool isn't State-funded, it does not have an annual benefit maximum. It's another example of a partnership with the private market and a public guaranteed-access mechanism that works and could be replicated elsewhere.

New York.—Another twist on the reinsurance concept is New York with its Healthy New York program. Small employers, sole proprietors and uninsured working individuals, regardless of health status, who meet set eligibility criteria and participation rules can purchase a limited range of comprehensive coverage options offered through private carriers and backstopped with a State-level reinsurance pool for extraordinary claims. This is a different kind of reinsurance than in Idaho, since it works on a retrospective basis, but it is a great example of why a backstop can increase affordability. Although New York is a guaranteed-issue State, it still uses this mechanism to spread the risk of higher risk participants. If we compare the rates for similar coverage in New Jersey, also a guaranteed-issue State but with no financial backstop, it becomes clear that, although premiums are higher than in non-guarantee issue States, the financial backstop provided by the reinsurance mechanism has improved affordability there.

Recommendation 2: Give Pre-existing Condition Credit for Prior Individual Market Coverage to Ensure True Health Insurance Portability

The issue of pre-existing conditions and individual market coverage portability has been repeatedly identified as a problem. It's not just a problem for people who have a serious medical condition when they apply for coverage. People who have obtained individual coverage when healthy and then acquired medical conditions over time can be limited in their ability to switch coverage plans due to pre-existing conditions and medical underwriting requirements.

HIPAA does provide individual-market consumers some protections, but they don't go far enough. Current law requires that all health insurance policies be guaranteed renewable unless there is non-payment of premium, the insured has committed fraud or intentional misrepresentation, or the insured has not complied with the terms of the health insurance contract. In addition, most States require that individual health insurance policies be renewed at class average rates and prohibit the practice of re-underwriting (making people fill out a new health questionnaire at renewal), provided that the policyholder sticks with the same product.

The flaw in HIPAA is that it does not protect individuals who want to change carriers or health insurance products within the individual market. This is not only a problem for the individuals who want to make a change, but it also stifles individual market carrier which in turn has a significant impact on price.

To solve this problem, States should be required to adopt a qualified access program so that no individual will be denied a private health insurance option because of a pre-existing condition, as described in Recommendation 1. In addition, individual market health insurance carriers should be required to give individual health insurance market consumers credit for prior individual coverage when changing insurance plans, if there is no greater than a 63-day break in coverage, just as is required in the group market by HIPAA. This means that existing individual-market consumers who wanted to switch health insurance products and/or health insurance carriers would be given credit against any pre-existing condition look-back or exclusionary periods equal to the amount of prior coverage they have. Furthermore, NAHU believes that the 63-day coverage window provisions should be amended to specify credit should be granted as long as the individual *applies* for coverage within 63 days, to protect individuals in cases where coverage cannot be issued immediately upon application.

However, to protect against adverse selection, a provision would also need to be included to address situations where individual-market consumers were substantially changing their level of coverage and/or benefits. In these cases, while credit for prior coverage would be applicable, carriers would still be able to assess for insurable risk when determining initial premium rates.

Recommendation 3: Standardize State-Level Requirements Regarding the Consideration of Pre-existing Conditions

Right now, State exclusionary and look back periods for pre-existing conditions in the individual market range from none at all to 5 years. NAHU believes greater standardization could easily be achieved in a similar way as was done relative to the small-group market in HIPAA when a Federal maximum look-back window of 6 months and a 12-month exclusionary period was established for the States. Having a pre-existing conditions rule that is consistent in both the individual and group model would also be much simpler for consumers to understand.

In the absence of a *fully implemented* and *enforceable* individual purchase mandate, plans and high-risk options must be able to look back at a new applicant's medical history and impose reasonable waiting periods in order to mitigate adverse selection. Until implementation is complete, greater standardization of limitations is necessary and warranted.

Recommendation 4: Improve Federal Group-to-Individual Coverage Portability Protections So That People Can Transition Directly From Employer Coverage to Individual Without Hurdles

HIPAA attempts to provide individuals who are leaving group health insurance coverage with portability protections to make it easier for them to purchase coverage in the individual market. Unfortunately, the protections are confusing and many consumers unintentionally invalidate their HIPAA guaranteed-issue rights without realizing it and then risk being denied coverage when they apply for individual coverage.

Under current law, individuals who are leaving group coverage must exhaust either COBRA continuation coverage or any State-mandated continuation of coverage option if COBRA is not applicable before they have any group-to-individual rights under HIPAA. Once the consumer exhausts these options if available, then he or she can purchase certain types of individual coverage on a guaranteed-issue basis, provided that there is no more than a 63-day break in coverage. Each State was required under HIPAA to develop a mechanism for providing this coverage. The two most common State elections are to either allow HIPAA-eligible people to purchase coverage through a State high-risk health insurance pool, or to require all individual market carriers to guarantee-issue HIPAA-eligible consumers at least two products, which are often priced higher than traditional individual coverage.

Most people who leave group coverage are unaware of all of the stipulations required to receive Federal portability-of-coverage protections. Faced with high COBRA or State-continuation premiums, many individuals decline such coverage either initially or after a few months. Then, depending on their health status or a family member's, they may experience extreme difficulty obtaining individual market coverage. To solve this problem, the HIPAA requirement to exhaust State continuation coverage or COBRA before Federal guarantees are available should be rescinded, and individuals leaving group coverage should be able to exercise their Federal group-to-individual portability rights immediately, provided that there is no more than a 63-day break in coverage.

Recommendation 5: Stabilize Individual Market Rates by Requiring More Standardization as to How Individual Market Carriers Determine Pricing

Another inconsistency among State individual health insurance markets is the way that premium rates are determined at the time of application. In a few States they are determined merely by geographic location (pure community rating) and in several others rating factors are determined by the State but are limited in nature (i.e., age, gender, industry, wellness, etc.), which is known as modified community rating. However, even with States with modified community rating, the rating factors and how they may be applied vary significantly by State. It is NAHU's view that State individual health insurance markets would benefit from greater standardization as to how premium rates are determined.

The first step to greater standardization would be for States to adopt a uniform application for applying for individual insurance coverage. A clear and understandable uniform application would assure full disclosure of accurate and consistent information when individuals apply for coverage. It would also be easier for consumers when applying for coverage with several different insurance carriers at one time.

In the vast majority of States, no specific rating structure is required in the individual market, and carriers can assess for insurable risk at the time of application and discount or increase rates based on health status with few limitations. Full, accurate and complete risk assessment has proven to be the most effective rating mechanism because it has been demonstrated to lower overall premium cost. However, the unlimited rating structure used in most State individual markets is in contrast to most State small-group health insurance markets and can create anti-selection issues between the two markets. Most State small-group carriers are also allowed to assess for insurable risk but have limitations on the amount of premium adjustments based on health status. In addition to these initial limitations, most State small-group laws require that premium increases are limited on renewal. This means that the amount each small group's premium can go up annually is based on the overall health experience of the carrier's entire small-group pool and is limited by the State to usually 10–15 percent plus an additional amount for inflation.

The Federal Government could require that States meet a minimum standard of rate stabilization by imposing maximum rate variations for initial applicants, as well as a cap on renewal premium increases, as most States do for their small-group market. Another option would be to allow a modified community rate. However, in order to protect against runaway costs, the Federal Government should ensure that wide-enough adjustments may be made for several key factors. At a minimum, variations need to be allowed for applicant age of at least five to one (meaning that the

rate of the oldest applicant may be no more than five times the rate of the youngest applicant). In addition to age, variations in premium rates should also be allowed for wellness factors, smoking status, gender and geography. Since we know that up to 50 percent of health status is determined by personal behavior choices,[4] in order to have effective cost containment, we need to be able to reward healthy behavioral choices.

Recommendation 6: Increase Consumer Protections Regarding Individual Market Coverage Rescissions

Under very rare circumstances, individual health insurance carriers rescind an insurance policy based on a submission of fraudulent information on an application or an intentional omission of required information. Surveys of individual health insurance plans indicate this happens to far less than 1 percent of individual market consumers annually,[5] but all individuals buying individual coverage deserve assurances that they will not be subject to unfair policy rescissions or pre-existing condition determinations.

All States should be required to develop an independent medical review process to resolve disputes concerning policy rescissions and/or pre-existing condition determinations. In addition, health plans should be required to limit rescissions to only material omissions and misrepresentations on the uniform insurance application. Health plans should be responsible for reviewing all applications received for clarity and completeness at the time of application and not after the policy is issued. If a carrier does not conduct a review of listed medical conditions on the application upon submission, it should not be allowed to use any subsequently obtained health information as a standard for a rescission, unless fraud or deceit has occurred. Health plan consumers should be clearly informed of their rights relative to rescissions and pre-existing condition determinations. Consumers also should be informed of their obligation to provide complete and accurate responses on health plan applications and to provide additional information at the time of application upon request of the health plan.

Recommendation 7: Making it Easier for Employers to Help People Purchase Individual Coverage

One of the biggest complaints about the individual market is that coverage is too difficult to purchase independently, and one of the greatest advantages of employer-group coverage is its ease of enrollment and payment. Many employers would like to offer their employees traditional health insurance coverage but simply can't afford to do so under current economic conditions. Also, some employers have an employee base that is difficult to cover under a traditional group scenario. As an alternative, employers should be allowed to work with licensed insurance agents and brokers to help employees purchase and pay for individual coverage by setting up a Section 125 plan, deducting premiums from wages, aggregating premiums and sending them to the insurer, and possibly providing a defined contribution. This would be a particularly appropriate coverage option for certain types of businesses that are rarely able to offer benefits to all employees (for example, restaurants and some small retail establishments) and for employees who may not be eligible for an employer's group plan, such as part-time or contract workers. This could help to draw many uninsured individuals into the private health coverage system. In addition, it could expand the size of the individual market, making it less fragile and, therefore, less costly.

However, current Federal law requires that all individual health insurance policies sold in a group setting are subject to ERISA and all of the HIPAA consumer protections relative to *group* health insurance plans, including the group guaranteed-issue and pre-existing requirements and all nondiscrimination provisions. Under current market conditions, practically no individual-market policies can meet all of the HIPAA small-group protections since they are not designed for a product that is marketed to individual consumers. In addition, the sale of list-billed policies, which are individual policies where the employer agrees to payroll-withhold individual health insurance premiums on behalf of its employees and send the premium payments to the insurance carrier but does not contribute to the cost of the premium, is specifically prohibited by some States.

Congress should overturn State bans of the sale of list-billed policies and clarify that individual health insurance policies purchased by employees are not the same

[4] Mercer Management Journal 18. "The Case for Consumerism in Health Care" *http://www.oliverwyman.com/ow/pdf_files/MMJ18_Case_Consumerism_Healthcare.pdf.*

[5] America's Health Insurance Plans. Comprehensive Health Insurance Policy Rescissions in the Individual Health Insurance Market Reported by AHIP Member Companies, 2007 Survey.

as group health insurance policies and are not subject to the group insurance requirements specified in HIPAA or ERISA but rather the newly reformed rules for the individual market. In particular, the Federal requirements regarding individual policies sold on a list-bill basis need to be clarified, since even minimal involvement on the part of the employer could trigger group health plan requirements.

Congress should also establish that all individual health insurance policies sold under a list-billed arrangement are subject to all insurance regulations governing the issuance of traditional individual insurance policies in the State in which the policy was sold. This would include rating requirements, issuing requirements and the requirement that such products only be sold by licensed health insurance producers, among other consumer protections.

Recommendation 8: Provide Federal Financial Assistance to Keep Individual Health Insurance Coverage Affordable

The most critical problem that we see in State individual health insurance markets is affordability, particularly for those individuals who have medical conditions. The high cost of coverage for these people often doubles as an access barrier.

There are clear broad-scale solutions that NAHU supports relative to coverage affordability. The most important of these is acting on the true underlying problem with our existing system: the cost of medical care. Health care delivery costs are the key driver of rising health insurance premiums, and they are putting the cost of health insurance coverage beyond the reach of many Americans.[6] Addressing the cost of care and its impact on the cost of coverage is critical in every market.

However, there are other affordability reforms that could be crafted that would specifically help individual market health insurance purchasers.

TAX EQUITY—ENHANCED DEDUCTIBILITY OF PREMIUMS

The most important step toward making individual coverage more affordable would be extending tax equity to individuals and families purchasing health insurance coverage on their own and equal tax treatment for the self-employed. NAHU believes Federal tax laws should be updated to provide the same Federal tax deductions to individuals and the self-employed that corporations have for providing health insurance coverage for their employees, although not at the expense of the existing employer exclusion. Specifically, NAHU feels Congress should take action to:

- Remove the 7.5 percent of adjusted gross limit of medical expenses on tax filers' itemized deduction Schedule A form.
- Allow the deduction of individual insurance premiums as a medical expense in itemized deductions.
- Equalize the self-employed health insurance deduction to the level corporations deduct by changing it from a deduction to adjusted gross income to a full deductible business expense on Schedule C.
- Clarify in statute that employers implementing list-billing arrangements for their employees may also establish Section 125 premium-only plans for their workers. This would enable employees to pay for their individual policies on a tax-favored basis. If an individual participated in a section 125 plan for a list-billed policy, those premiums would not be eligible for deduction as a medical expense under Schedule A.

SUBSIDIES

NAHU also supports targeted premium-assistance programs for low-income individuals purchasing private coverage, and we feel that the Federal Government should finance such programs. A subsidy program could be national in scope or each State could be required to create one that suits the unique needs of its citizens in partnership with the Federal Government. Several States have already created successful subsidy programs and their existing structures could be used as a model framework for a national reform. I have included a chart at the end of this statement that itemizes some of the State subsidy programs that provide us with some good models on creative ways to help both employers and their employees with the cost of health insurance coverage. Two States in particular should be looked to as models:

Oregon.—The Oregon Family Health Insurance Assistance Program (FHIAP)[7] is one State program that could serve as a model. FHIAP is an innovative State cov-

[6] PricewaterhouseCoopers. "The Factors Fueling Rising Health Care Costs, 2008." *http://www.americanhealthsolution.org/assets/Uploads/risinghealthcarecostsfactors2008.pdf*.

[7] *http://www.oregon.gov/OPHP/FHIAP/*.

erage initiative that subsidizes both employer-sponsored coverage and individual insurance coverage. Eligible families making over 150 percent FPL who do not receive cash assistance must participate if employer coverage is available, and others can participate on a voluntary basis. Licensed health insurance professionals help both employers and individuals with enrollment and participation. The program subsidizes coverage on a sliding scale according to income. Subsidies range from 50 percent to 95 percent of the premium. Individuals and families use FHIAP subsidies to pay for insurance at work or to buy individual health plans if insurance is not available through an employer. FHIAP members pay part of the premium. They also pay other costs of private health insurance such as co-payments and deductibles. Once approved for FHIAP, members are eligible to remain in the program for 12 months. Three to four months before the member's eligibility ends, FHIAP sends a new application and members may re-apply. FHIAP provides direct premium assistance through the insurer for people who use its benefits to purchase individual coverage. For those with employer coverage, FHIAP reimburses employees for the cost of their premium within 4 days of receipt of a valid pay stub denoting the employee contribution. This program has been around for a number of years and struggles each year with funding, but many have benefited from it and it is a streamlined approach with little administrative cost.

Oklahoma.—Oklahoma's Employer/Employee Partnership for Insurance Coverage (OEPIC or Insure Oklahoma)[8] is another very successful State subsidy program that works with both employer-sponsored and individual health insurance coverage for self-employed people, certain unemployed individuals, and working individuals who do not have access to small-group health coverage. In 2008, 9,923 employees and dependents were directly subsidized by Insure Oklahoma, which is a 234 percent increase from the previous year.[9] Licensed insurance agents and brokers help identify applicable participants and enroll people and employers in the plan. Through the program, the employer pays only 25 percent of the premium of the low-wage worker, the employee pays up to 15 percent of the premium and the State pays the remainder. The program's passage was supported by insurers, small employers, agents and brokers and providers. It is funded by a State tobacco tax and Federal funds based on a Medicaid Health Insurance Flexibility and Accountability waiver. Twenty insurers participate, offering dozens of qualified products that meet simple specified coverage standards.

FEDERAL FINANCIAL SUPPORT FOR QUALIFIED ACCESS MECHANISMS

Finally, we support even more targeted means of providing Federal affordability assistance to individual market consumers, particularly to individuals with serious medical conditions. Since in any insurance pool of risk a small number of insureds incur the majority of claims. NAHU's access solutions alone, by guaranteeing that the highest-risk individuals are covered in a financially separate private-market pool, will help lower costs for all consumers. But even more could be done to help lower costs.

Funding for high-risk health programs is a continual problem in some States. When a pool consists of only sick people, there is no spreading of risks, so premiums charged to policyholders are never enough to cover expenses and additional funding mechanisms must be created. A variety of funding sources are currently being used, including using State premium taxes, direct State appropriations, assessments to carriers that operate in the State, hospital taxes, or a mixture of several sources. Current limited Federal grant funds for high-risk pools have enabled a number of State high-risk pools to lower premiums and even start low-income subsidy programs. NAHU believes this funding should not only continue, but it should also be increased and expanded to the new qualified access mechanisms outlined in Recommendation 1.

The issue of affordability is key. A State should be required to demonstrate that the funding source for whatever high-risk option it elects will be both *broadly distributed* over as much of the marketplace as possible and *stable* over time. CMS could develop broad criteria, and this program could be administered easily with the career employees already dedicated to the current high-risk pool grants. It would be important when establishing criteria not to hinder State innovation relative to funding sources as this is a key factor of ensuring affordability. Furthermore, due to the high-needs population being served, premiums alone cannot be considered a stable funding source.

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[8] *http://www.oepic.ok.gov/*.

[9] Blue Cross Blue Shield Association. "Insure Oklahoma: Overview and Impact." *http://www.bcbs.com/issues/uninsured/background/insure-oklahoma-overview.html*.

Funding could be conditional upon a State's ability to meet federally established broad criteria regarding the framework of a qualified program. This may be the biggest bargain for Federal dollars that exists. A small amount of funding will go a long way. The current $75 million grant funding for high-risk pools has helped many pools establish low-income subsidies, disease-management programs and other important benefits for pool participants. New funding would be used to help subsidize premiums for the high-risk beneficiaries because, regardless of the backstop option the State creates, premiums alone in a State high-risk option will never be enough to satisfy claims, and premiums for participants in these programs must be at reasonable levels to ensure adequate participation. Funding could also be used as an additional backstop to State high-risk options that meet specified requirements for those rare individuals whose medical expenses are so great they would exceed high-risk pool lifetime caps.

Recommendation 9: Getting Everyone Covered

NAHU believes that implementing recommendations 1 through 8 will bring our country much closer to all Americans having health coverage. But an additional way to achieve the standard of near-complete coverage that is necessary for stand-alone guaranteed issuance of coverage as well as controlled entry and exit into the individual insurance market is through the implementation of an enforceable and effective individual mandate.

NAHU has historically approached the idea of an individual mandate to obtain health insurance coverage with great caution. Similar mandates for auto insurance coverage have failed to reduce the number of uninsured motorists.[10] Also, subsidies, as well as benefit standards and enforcement mechanisms, would need to be created to fairly implement such a mandate. However, if such barriers could be overcome, enough people would be covered to mitigate the problem of adverse selection and its resulting cost consequences.

If the Federal Government were to require an individual mandate to obtain coverage, NAHU feels that it must be structured appropriately. The following elements are crucial to an effective and enforceable individual mandate:

- While the mandate may need to be phased in over time, starting with perhaps select populations like children age 25 and under, ultimately it must apply to all populations equally.
- An individual mandate must be accompanied by a national qualified guaranteed-access mechanism *with a financial backstop* as described in Recommendation 1 so that all individuals have cost-effective private health coverage options available to them. This is especially critical during the transition period when the mandate is being put into place and the entire population is not yet insured.
- An individual mandate should not be accompanied by overly rigid coverage standards that would make coverage unaffordable and inhibit private plan design innovations.
- Subsidies in the form of direct private coverage premium assistance or refundable advanceable tax credits for the purchase of private coverage must be made available to low-income consumers.
- An effective coverage verification system must be created, with multiple points of verification.
- An effective enforcement mechanism would need to be implemented with multiple enforcement points and effective penalties for noncompliance.
- Each State must be responsible for enforcement of the mandate for its own population. The United States is too large and diverse a country for such a mandate to work otherwise.

Recommendation 10: Allow State Implementation with a Federal Fallback Enforcement Mechanism

States should be given a finite timeframe of several years to achieve these reforms through legislative or regulatory means. If a State cannot adopt the necessary reforms in the timeframe allotted, Federal enforcement through CMS should be the fallback, similar to the way CMS serves as the Federal fallback enforcement authority for HIPAA's small-group market requirements.

[10] Insurance Research Council. "IRC Estimates That More Than 14 Percent of Drivers Are Uninsured." *http://www.ircweb.org/news/20060628.pdf.*

CONCLUSION

NAHU members work on a daily basis to help individuals and employers of all sizes purchase health insurance coverage. We also help clients use their coverage effectively and make sure they get the right coverage at the most affordable price.

All of this experience gives our membership a unique perspective on the health insurance marketplace. Our members are intimately familiar with the needs and challenges of health insurance consumers, and they have a clear understanding of the economic realities of the health insurance business, including both consumer and employer behavioral responses to public policy changes. We have had the chance to observe the health insurance market reform experiments that have been tried by the States and private enterprise, and we have based these individual-market health reform policy recommendations on what we believe would be the most beneficial changes for individual health insurance consumers.

The NAHU membership urges Congress to carefully consider these ideas to improve individual health insurance coverage options for consumers nationwide. Our private health insurance plans are innovative, flexible and efficient, and our marketplace is up to the task of responding to well-structured reforms. We look forward to working with Federal and State policymakers to fill the gaps in our Nation's coverage system and to make private individual health insurance coverage more affordable and accessible for all Americans.

We appreciate this opportunity to participate in today's hearing and look forward to the discussion with the committee and other panelists.

Addendum: Chart on State-Level Private Health Insurance Subsidy Programs for Low-Income Individuals

Senator BINGAMAN. Thank you very much.

Mr. Williams, please.

STATEMENT OF RONALD A. WILLIAMS, MS, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, AETNA, INC., HARTFORD, CT

Mr. WILLIAMS. Good morning, Mr. Chairman and members of the committee. It is a pleasure to be here and to see so many of my colleagues I have had the privilege to work with over the past few years.

I am Ronald A. Williams, chairman and chief executive officer of Aetna, a leader in providing diversified healthcare benefits.

As the healthcare system hurtles toward $4.3 trillion in annual spending in 2017, we have an opportunity and an obligation to achieve meaningful reform that guarantees access and makes health insurance more affordable for all. You have my commitment to work with you to transform the healthcare system.

It is worth noting at the outset that our industry, my company, and the expectations of our customers and members have changed a good deal over the past several years. Health insurance is not about just paying claims anymore. At Aetna, our spending on technology and innovation, more than $1.8 billion since 2005, and the composition of our workforce of 35,000, nearly 40 percent of whom are clinical and technology professionals, are much different than they would have been just 10 years ago.

Transforming our healthcare system will require us to work collaboratively to address the key roadblocks that stand in our way and build a sensible path to reform. That means building on an employer-based healthcare model that already works for more than 177 million Americans and accelerating our efforts to harness the power of health information technology and confronting the challenges associated with rising healthcare costs.

In our view, the following are critical components of reform. First, we need to get all Americans covered through an enforceable individual coverage requirement combined with subsidies and other

changes to make coverage affordable. It must be coupled with sliding-scale subsidies to ensure that income is not a barrier for any individual, and we should offer tax credits for small businesses to encourage them to offer and subsidize employee coverage.

Second, we need to take steps necessary to bring affordable coverage within reach for everyone. This begins by using health information technology as a tool to bend the cost curve and addressing our country's pervasive quality issues. We also need payment reform because the traditional fee-for-service payment structure often rewards physicians and hospitals for the volume of services they deliver rather than the value of quality of care they provide.

Third and finally, we need to engage consumers in their own healthcare, focusing on prevention and wellness, and provide them the tools to be good consumers. The healthcare system needs fundamental reform, and that will require unprecedented determination and collaboration across the healthcare system.

We are ready and willing to work with you because we know that success will be rooted in a public-private cooperation to create and implement practical solutions that drive systemic change.

Thank you.

[The prepared statement of Mr. Williams follows:]

PREPARED STATEMENT OF RONALD A. WILLIAMS, MS

Good morning Chairman Kennedy, Ranking Member Enzi and members of the committee. Thank you for the opportunity to be here today. I am Ronald A. Williams, Chairman and Chief Executive Officer of Aetna Inc., one of the Nation's leading diversified health care benefits companies. I appreciate the opportunity to share my views with this committee and to continue working with you to transform our health care system, which we can all agree is in urgent need of reform. I believe our health care system must provide affordable, high quality coverage for all Americans.

My company is committed to taking part in the development of meaningful, broad-based solutions, and I am convinced that we can help move reform forward. Our views are shaped by our experience with the 36.5 million unique individuals to whom we provide products and services in all 50 States; the 894,000 health care professionals with whom we interact daily; and the thousands of employers for whom we devise benefits solutions regularly and the 50 States and multiple Federal entities that regulate our products.

Our industry, my company and the expectations of the people who are our customers and members have changed a good deal over the past several years. Insurance is not just about paying claims anymore. Increasingly, our stakeholders expect us to be their partner, to add value and to innovate. Employers want affordable, high-quality products and services to enhance the health and productivity of their employees. Doctors and hospitals want to give their patients access to medical innovations and new technologies, with fewer administrative barriers. Our members want access to our network of health care professionals, tools to make informed decisions, transparency of price and quality data, and access to the expertise of nurses and trained professionals on issues ranging from chronic disease care to wellness and prevention.

At Aetna, our business model has changed significantly over time as we work to meet these new expectations. We have been at the forefront of bringing the information age to health care. That is why we have spent more than $1.8 billion on technology and innovation since 2005. Our innovations mean that we no longer simply process and pay claims; now we have sophisticated systems that scan hundreds of millions of interactions between our members and their doctors, hospitals and pharmacies to alert them and their physicians to sometimes dangerous interactions caused by errors or omissions.

Our workforce has changed also. Today, nearly 40 percent of our workforce are clinical professionals or work in information technology. The focus of all our employees is to improve health and ensure our consumers get the best, most appropriate treatment possible, including wellness and preventive care and managing their com-

plex diseases. If you are an Aetna member, you can reach a health care professional at any time of the day or evening who can respond to your health care needs.

As the health care system hurtles toward $4.3 trillion in annual spending by 2017, we have an opportunity and an obligation to achieve meaningful reform and improvement. Our experience and perspective tell us that we are a nation and culture unique from the rest of the globe, and we require a uniquely American solution that will enable the health care system to meet the Nation's expectations for health care quality, access and affordability.

To transform our current healthcare system into what it should be, we need to work collaboratively to address the key roadblocks that stand in our way and build a sensible path to reform:

• **It is essential that we realize real reform while preserving and building on the employer-based health care model that works for most Americans.** We should avoid systemic disruption to the 177 million Americans who have employer-sponsored coverage, and instead build upon the strengths and innovations of private health coverage for the good of other populations. Together, employers and insurers are driving innovations that are helping many Americans better maintain their health, take advantage of helpful health care technology and access safe, quality health care.

• **We need to accelerate our efforts to harness the power of health information technology (HIT), which is so critical to addressing cost and quality issues.** Congress made a significant investment in HIT in the American Recovery and Reinvestment Act, but the United States still lags behind other countries in the use of electronic medical records (EMRs). If 90 percent of all providers in the United States were using EMRs, we could see savings of about $77 billion within 15 years.[1] With the advent of sophisticated clinical decision support capabilities, those savings, coupled with lives saved, could exceed current expectations. At Aetna, we have made significant investments in health information technology, and we are not finished. Our investments are designed to help patients and doctors take action on their health conditions and help patients get the standard of care they expect and require.

• **We need to confront the challenges associated with the rising cost of health care.** Costs will rise from $8,000 per person this year to more than $13,000 per person in the next decade. There is an important, but often overlooked connection between health care costs and the premiums people pay for health insurance coverage. Health insurance premiums reflect the underlying cost of health care. So unless we, as a nation, are successful in "bending" the cost curve, we will see premiums continue to rise at a pace far faster than either wage growth or inflation—which puts health insurance out of the financial reach of a growing number of U.S. residents. If we do not address the issue of costs, reforms made today to improve access will not be sustainable. We all have a significant role to play in this complex problem. This includes our industry, which is committed to achieving new levels of simplification and reduced administrative costs.

A SOLID FOUNDATION FOR REFORM

Many are questioning whether we can achieve meaningful health care reform. I believe the answer is that we can reform our system and simultaneously achieve the dual goals of improving access and making healthcare more affordable. All of the players in health care—health insurers, hospitals, physicians, employers, pharmaceutical companies, consumers, legislators and regulators—will need to focus on achieving both of these goals together.

As you consider how to structure reform, I urge you to build upon the current employer-based system that today covers 177 million people—60 percent of the American population. When given the choice, 82 percent of workers who are eligible for employer-offered coverage participate in their employers' health plans.[2]

Leveraging the strengths of the employer-based system would enable people to keep the health coverage they have if they are satisfied. It would also continue the innovation that has resulted from employers and health plans working together over decades to improve quality and value. We recognize that maintaining the basic structure of health care coverage through the employer-based system is not enough. Our customers are demanding that we make sound health care investments that positively impact their physical and financial health. We have responded to this imperative by:

[1] Modern Healthcare, "By the Numbers," 2006–2007 Edition, December 17, 2006, p. 66.

[2] Pickreign, Jeremy et al. "Employer Health Benefits 2008 Annual Survey," Kaiser Family Foundation and Health Research and Education Trust, September 2008.

• Developing products and services that improve the quality of health care and help control rising benefits costs;
• Providing members with access to convenient tools and easy-to-understand information that can help them make better-informed decisions about their health and financial wellbeing;
• Introducing new levels of transparency to the health care system; and
• Pioneering new ways to focus on wellness and prevention programs.

We recognize that maintaining the current structure is not enough. Reform efforts need to focus on access and affordability of insurance for the 45 million uninsured Americans and those seeking coverage in the individual and small group markets. A growing number of people, nearly 18 million under age 65, are accessing insurance through the individual market. In addition, coverage is often expensive and unstable for the millions accessing coverage through the small group market.

CRITICAL COMPONENTS OF REFORM

Getting all Americans Covered

Covering all Americans is imperative for fixing our Nation's health care system. An enforceable individual coverage requirement, combined with subsidies and other changes to make coverage affordable, is the best way to ensure that all Americans have continuous access to insurance coverage and high-quality health care. Since 2005, we at Aetna have been speaking out in support of an individual coverage requirement, as we believe it is the critical step for achieving universal coverage.

One of the great, and often painful, challenges in our system is that too many individuals often have difficulty accessing coverage in the individual market. Insurers have relied on tools like medical underwriting and pre-existing condition exclusions to maintain the solvency of the current system, which lacks universal participation. Insurance works best when everyone participates in the system continuously, whether they are healthy or sick. Today's individual market system does not reflect these principles and insurers face adverse selection, wherein people enter the insurance marketplace when they need coverage and healthcare services.

An enforceable individual coverage requirement solves this problem better than any other proposed policy, because it allows us to bring everybody—both healthy and unhealthy—into the insurance pool. By using an individual coverage requirement to address the challenge of adverse selection, we can transform our system into one where private insurance is provided on a guaranteed-issue basis with no pre-existing condition exclusions and a rating system that does not include health status. We support allowing insurers to provide discounts on premiums for those who engage in healthy behaviors to help increase incentives for good health. These reforms would allow all Americans access to coverage and would help people keep their health coverage as they go through life transitions, allowing true portability.

An individual coverage requirement must, of course, be coupled with sliding scale subsidies to ensure that income is not a barrier for any individual's fulfillment of this requirement. In addition, we must offer tax credits for small businesses to encourage them to offer (and subsidize) employee coverage. We must create a rational regulatory structure that is conducive to creating affordable coverage options. I would encourage greater uniformity of State laws and regulations and the development of a new Federal charter. Insurers with a multi-state presence face costly administrative burden to comply with divergent State laws and regulations, and these higher administrative costs are passed onto the market at large through higher insurance premiums. A national entity would need to determine a standard benefit package and determine what types of actuarially equivalent plans could be offered. Under a national framework, plans could cross State boundaries and be offered through national, State or regional insurance exchanges that create new pooling mechanisms.

We believe an individual coverage requirement, subsidies and insurance market reforms create the best framework for addressing our country's access challenge. Others believe a new public plan is the silver bullet for the uninsured. I would submit that, for a number of reasons, a public plan is not the best way to fix our system.

First and foremost, insurers bring innovation, value and choices that allow individuals to choose a tailored approach to their individual needs that a one-size-fits-all public plan just could not achieve. With our unique capabilities in the realm of encouraging wellness and prevention, providing care coordination and chronic disease management, and empowering consumers and providers with health information technology, we can offer health care that responds to the specific needs of individuals. Health care is one area in which we must leverage the agility of the private sector to provide continued innovation and customization of health care plans.

Beyond recognizing the added value that private insurers can provide, we must also be aware of the challenges a new public plan would impose on the rest of the system. A public plan would most likely employ the payment rates used in Medicare, which are far lower than the rates paid by private payers. In fact, the average family of four with private insurance spends an additional $1,788 on health care each year because of Medicare and Medicaid underpayments to providers. On an aggregate level, commercial payers incur approximately $89 billion more in costs than they would if public and private payers all paid equivalent rates.[3] Expanding the use of low public payment rates would mean expanded cost-shifting for our health care system.

There is no doubt that getting all Americans into the health care system is of the utmost importance. The best solution for our country will not be to shift us over to a system for which the public sector gradually takes more and more responsibility and competes with the private market, but rather to engage in a public-private partnership that allows each sector to focus on what it does best. Aetna is fully committed to active participation in this partnership to create a better system in which no one is left out.

Bringing Affordable Coverage Into Reach

If we want to ensure that all Americans have access to high-quality, affordable health coverage, we must both slow the growth of health care costs and get greater value out of our health care spending.

The cost of health care in the United States is growing at an unsustainable rate. National health spending will reach $2.5 trillion in 2009 and by 2018, it is expected to reach $4.4 trillion and comprise just over one-fifth (20.3 percent) of Gross Domestic Product (GDP). This year, we can expect the top three cost drivers—hospitals, physicians and prescription drugs—to comprise 73 percent of health care spending.[4]

If we fail to effectively address our Nation's health care cost problem, which is ultimately driven by the increasing illness burden borne by our population, we will find that access expansions will be unsustainable. A case in point is Massachusetts, where the absence of payment reform and more effective utilization threatens to undermine the ultimate success of truly commendable access reforms. Investments in health information technology and tackling payment reform are both necessary to slow the cost growth and improve quality.

HIT can live up to expectations: The use of health information technology will not only be a powerful tool to bend the cost curve, but will also help address our country's pervasive quality issues. The United States continues to lag behind its peers globally in embracing HIT solutions necessary to yield cost reductions and quality gains. Compared to other developed nations the United States trails in its overall use of electronic medical records (EMR), with an adoption rate of only 28 percent.[5] A *New England Journal of Medicine* survey suggests that 83 percent of U.S. doctors have still not adopted EMR technology.[6] Consequently, Aetna continues to strongly support the President's initiatives to accelerate HIT adoption and commends the Congress' recent work to invest up to $22 billion to promote the use of electronic health records that have clinical decision support capacity as recommended by the Institute of Medicine.

Over the past 4 years, Aetna has invested more than $1.8 billion in deploying health IT solutions that improve both the quality and cost-efficiency of the care that is delivered to our members. In making these investments, Aetna recognized from the outset that beyond its other claims and care management technologies, robust clinical decision support capabilities are essential to yielding the desired quality and cost returns necessary to produce a return on HIT investment. This was a key reason for Aetna's 2005 acquisition of Active Health Management and its innovative Care Engine® technology.

This unique technology provides a truly integrated solution for providers to extend clinical decision support beyond the electronic records platforms that may be contained in a physician's office or hospital. Care Engine® scans millions of lines of pharmacy, lab, diagnostic, claims and other clinical data and matches them up to the latest available medical literature. It can scan disease management members' data for opportunities to improve care through enhanced diagnostic and therapeutic

[3] Milliman, *Hospital & Physician Cost Shift*, December 2008; figures reflect 2006 and 2007 data.

[4] Centers for Medicare and Medicaid Services, "National Health Expenditures Projections: 2008–2018."

[5] The Commonwealth Fund, "2006 International Health Policy Survey of Primary Care Physicians in Seven Countries," November 1–2, 2006.

[6] The New England Journal of Medicine, "National Survey on Physician Adoption of Electronic Health Records," July 2008.

precision, and then notify physicians and patients with actionable information that can lead to improved outcomes at the point of care. Among the providers and plan sponsors now utilizing Care Engine®, it has demonstrated that the technology's use can generate a meaningful return on investment by measurably improving quality outcomes (e.g., 19 percent reductions in overall hospitalizations)[7] while producing overall cost savings (e.g., eight-fold ROI or 6 percent reduction in average charges).[8]

As we look ahead to ensure the public also receives a strong ROI for this new national HIT investment, it will be important for the Secretary and the Office of the National Coordinator within the Department of Health and Human Services to reinforce expectations in regulation and other guidance that: (1) providers meet measurable targets focused on quality outcomes in their use of publicly financed health information technology; and (2) that these technologies measure up to standards that ensure their capability to assist providers with clinical decision support that integrates pertinent data from all of the critical points within the health care system.

Addressing Health Care Costs and Quality: A Critical Foundation

On an annual basis, the United States spends $650 billion more on health care than peer OECD countries, even after adjusting for wealth.[9] The vast majority ($436 billion) of this "excess" spending results from outpatient care. There are other factors that contribute to the "excess," including technological innovation, high levels of utilization, misaligned incentives for providers, lack of transparency and consumerism, higher prices and population health challenges.

We need to tread carefully when it comes to some of these cost factors, as we do not want to stifle the innovation that drives improvements in our ability to improve and save lives. We can, however, work to ensure that technology is used appropriately to improve the standard of care and drive better patient outcomes. We can also re-align incentives in our system to ensure that quality and value serve as the primary motivators for choosing specific treatments.

The American health care system is wrought with inefficiencies, wasteful duplicative spending and poor performance. Understandably, there is a strong concern that our inputs in health spending are not yielding high enough quality output in care and outcomes, and the impact of these quality disparities is brought to bear in very real terms. In fact, between 35,000 and 75,000 avoidable deaths and $2.7 billion to $3.7 billion per year in avoidable medical costs can be attributed to unexplained variations in care,[10] underscoring the need for widespread dissemination of evidence-based medicine and standards. The guidelines must ultimately be applied at the individual member level to mitigate variation and wasteful spending.

Payment reform will also be a critical tool to improve quality and bending the cost curve: The traditional fee-for-service (FFS) payment structure often rewards physicians and hospitals for the volume of services they deliver rather than the value or quality of care they provide. Aetna supports transforming the payment system into one that aligns provider reimbursement incentives with the pursuit of high-quality outcomes for patients. We need a payment system that works for the patient, bringing them value—high quality at the right cost.

Reform needs to focus on promoting patient-centered care that integrates the multiple aspects of the health care delivery system and shifts the model from episodic, acute care to comprehensive, evidence-based care. Yet equally important is that any attempts to enact comprehensive payment reform include the input and support of the multiple stakeholders that make up the system, including providers, patients, employers and health plans. The managed care backlash of the 1990s taught us the valuable lesson that in order for payment reform to succeed, providers need to participate in the agenda-setting and metric-development process and patients need to know their interests are being served.

We believe engaging consumers in their own health care is also of critical importance in achieving greater value within our health care system. As the leader in consumer-directed health plans (CDHPs), we continue to help plan sponsors with empowering their employees to make informed decisions about their medical care. In fact, the average large employer saved more than $7 million per 10,000 members over the course of 5 years when an Aetna Health Reimbursement Arrangement

[7] The American Journal of Managed Care, "Using a Claims Data-Based Sentinel System to Improve Compliance With Clinical Guidelines: Results of a Randomized Prospective Study," 2005;11:93–102.

[8] The Journal of Health Economics, "Information Technology and Medical Missteps: Evidence From a Randomized Trial," 2008; 585–60.

[9] McKinsey Global Institute, "Accounting for the cost of U.S. health care: A new look at why Americans spend more," December 2008.

[10] National Committee for Quality Assurance, "The State of Health Care Quality," 2007.

(HRA) or Health Savings Account (HSA) was offered as a plan option. We also found that Aetna customers with CDHPs were much more likely to use online consumer tools and information—a leading indicator of employee engagement. They were also more likely to use preventive services than those enrolled in traditional health plans.

Congress has taken some important steps forward: I applaud the members of this committee, the Senate and the House for their success in passing several key reforms that will start to slow the growth of our Nation's health care costs while improving healthcare quality. The inclusion in the American Recovery and Reinvestment Act of 2009 of $1.1 billion in funding for comparative effectiveness research will help ensure that we invest in treatments that truly offer added benefit to the right patients. The commitment of $22 billion to investments in health information technology infrastructure and Medicare and Medicaid incentives for providers to electronically exchange patient health information will not only help to advance quality of care, but will help us to achieve long-term savings.

CONCLUSION

I believe that President Obama and this Congress have charted a course of change, and I want to make clear that we too are committed to expanding access, controlling costs and improving the quality and value of care people receive. I hope this committee and the Nation as a whole will view Aetna and our industry peers as partners in advancing these shared goals. Our experience and effectiveness in developing and using technology to drive quality improvements, for example, can inform the larger discourse about health information technology and comparative effectiveness. We will support those efforts aimed at addressing access and affordability as well as the quality and value of health care in America. Over the past several years, Aetna has tried to lead by harnessing innovation and utilizing technology to serve people, and by stepping out front on issues that we believe can truly make a difference to our country.

The health care system needs fundamental reform, and that will require determination and collaboration across the health care system that is unprecedented. We are ready and willing to work with you—because we know that success will be rooted in public/private cooperation—to create and implement practical solutions that drive systemic change.

Working together, I believe that the path forward is achievable and that we will be able to bring a new approach to health care that efficiently and safely gets people to their desired destination—optimal health.

Thank you.

Senator BINGAMAN. Thank you very much.

Ms. POLLITZ.

STATEMENT OF KAREN POLLITZ, M.P.P., RESEARCH PROFESSOR, HEALTH POLICY INSTITUTE AT GEORGETOWN UNIVERSITY, WASHINGTON, DC

Ms. POLLITZ. Good morning, Mr. Chairman, members of the committee.

I am Karen Pollitz, and I direct research on private health insurance at Georgetown University.

Very briefly, I think the challenges facing this committee are daunting, but doable. I think the first thing that you need to do to get health insurance to work the way you want it to is to stop it from discriminating against people based on their health status, their age, their gender. The cherry-picking, lemon-dropping activities that are common in the insurance market today need to end.

You also need to stop the sale of health insurance that is inadequate. We have 57 million Americans who are struggling with medical debt today, and most of them have health insurance. Twenty-two percent of insured cancer patients nonetheless burn through their life savings paying medical bills.

These practices are defended because they make health insurance cheaper, but it is not really a good kind of cheaper because

it makes protection flimsier. So we need to make insurance affordable by providing subsidies for good coverage and dependable coverage that is always there. To make sure that these prohibitions on these kinds of bad practices are followed, you are going to need an unprecedented level of accountability and transparency in market practices so that you can ensure that they actually stop.

Then I think you need to reorient the market and organize it to compete in ways that we want it to. And in particular, I think introduction of a public plan, a public health insurance plan option in health insurance markets is a good thing. It can cue the market to compete in the ways that you want it to, to be a tough price negotiator, to be an innovator, and to share those innovations widely, not just bottle them up as trade secrets.

I think there will be a lot of talk about a public health insurance plan today and sort of whether that is a fair thing or not, and I would just encourage you not to get too caught up in that. I don't think a public plan should be there to bully private insurers, but I don't think it is there to prop it up either.

I think you want the market to have very specific goals and have an entity out there that is cueing the market to get it to move in the direction of those goals.

Thank you.

[The prepared statement of Ms. Pollitz follows:]

PREPARED STATEMENT OF KAREN POLLITZ, M.P.P.

Mr. Chairman and members of the committee, thank you for inviting me to testify on opportunities to strengthen health insurance markets in health care reform. My name is Karen Pollitz. I direct the study of private health insurance and its regulation at Georgetown University's Health Policy Institute.

A program of health reform to guarantee universal coverage including through private health insurance will need to address several key shortcomings of private markets today. These include:

1. Discrimination based on health status and risk selection;
2. Inadequate coverage;
3. Affordability challenges for low- and middle-income people;
4. Rising costs; and
5. Lack of transparency and accountability.

Part of the solution to these problems will lie in strengthening and reorganizing private health insurance markets to produce the coverage results we seek. A health insurance Exchange—sometimes referred to by other names, such as "Connector"—can be established to pursue the goals of reform and to hold markets accountable for progress toward those goals.

PROMOTE RISK SPREADING AND STABILITY

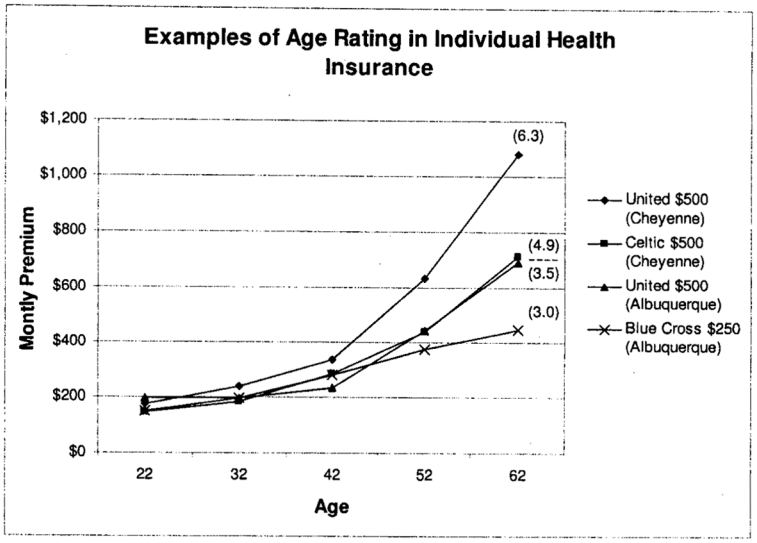
It has long been true that approximately 20 percent of the population accounts for 80 percent of health spending. The sickest 1 percent account for nearly one-quarter of health expenditures. We rely on health insurance to spread costs more evenly across the population and protect all of us from the risk that we may find ourselves in need of expensive care in any given year. Unfortunately the distribution of medical care needs creates a powerful economic incentive to avoid risk, not spread it. Discrimination based on health status is a problem for all health insurance purchasers, although most pronounced in the individual market today. Even consumers with mild conditions may be turned down, charged more, or offered a policy with permanent coverage exclusions. More expensive health conditions such as cancer, diabetes, pregnancy, will always render a person uninsurable in medically underwritten individual markets.

Risk avoidance practices continue even after coverage is issued. Last summer, the House Committee on Oversight and Government Reform studied problems relating to post-claims underwriting and rescission. Individual market policyholders who make claims in the first year of coverage may be investigated for evidence their

health condition was pre-existing or not fully disclosed during the initial medical underwriting process. Claims may be denied or coverage cancelled or rescinded as a result. Although these practices are intended to protect against fraud, abuses have also been documented.[1]

Stability and long term affordability of coverage is also highly problematic in the individual market today. Typically people remain enrolled in policies for less than 2 years.[2] High rates of turnover result from several factors. In general, the individual market today is a residual market and unsubsidized, so participants tend to leave as soon as they regain eligibility for subsidized job-based or public coverage. However, for those who must remain longer, various market practices encourage churning or make it increasingly unaffordable to remain covered.

Age rating makes it difficult to afford coverage over time. Insurers typically charge people in their early sixties three to six times the premium for people in their early twenties. The slope of this age climb varies, but often age adjustments are modest for young adults, becoming more pronounced for people in their fifties and early sixties, not coincidentally, when the incidence of many high-cost medical conditions also increases.



Parenthetical number by 62-year-old premium indicates multiple of 22-year-old premium
Source: ehealthinsurance.com. Quotes for male, non-smoker, March 18, 2009

Durational rating is used by many insurers to increase premiums based on the tenure of the policyholder. The predictive power of medical underwriting wears off over time; policyholders who were young and healthy when they first applied for coverage tend not to remain that way. By applying tenure surcharges, insurers encourage those enrollees who are still healthy to apply for new coverage, and resubmit to medical underwriting, in order to hold premiums down. This practice has the effect of segregating policyholders who have gotten sick, forcing their premiums even higher.

In a related practice, insurers may introduce new policies into the marketplace every few years, leaving older policies in force but no longer actively marketed. With freshly underwritten applicants diverted to new policies, the claims experience of the "closed" policies deteriorates, driving up premiums. People healthy enough to leave the closed block will do so, further escalating premiums for those with health problems who are stranded.[3]

A recent health insurance survey of family farm and ranch operators, who rely disproportionately on the individual health insurance market, found high rates of financial burden due to these kinds of market practices.[4]

How reform can help.—Congress can and must change the rules of the health insurance marketplace so that insurers no longer compete on the basis of risk selection, but instead, on the basis of efficiency and customer service. All policies should be sold on a guaranteed-issue basis.

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Premiums should be determined based on community rating.* Pre-existing condition exclusions should end. Federal minimum standards for health insurance should be strengthened so that these protections apply to all types of health coverage. Vigorous oversight to ensure compliance is also essential.

ASSURE COVERAGE ADEQUACY

Under-insurance is a serious and growing problem. In 2007, 57 million Americans lived in families struggling with medical debt—a 33 percent increase since 2003—and 75 percent of them had health insurance.[5] Policies that fail to cover key benefits, such as prescription drugs, maternity care, and mental health care, can leave people under-insured. Likewise, caps on covered benefits leave patients at risk for catastrophic medical expenses. High deductibles, co-pays, and other cost sharing are also problematic.

In an effort to offset rising premiums and stem coverage loss, the content of coverage under many health insurance plans and policies has eroded steadily. However, this strategy has proven to be ineffective. Coverage erosion leaves the under-insured in circumstances very similar to the uninsured—they forego or delay needed medical care due to costs, experience poorer quality care, and suffer financial burdens.[6]

Coverage adequacy is particularly important for patients with chronic conditions. Even modest co-pays for services can accumulate to burdensome levels for patients who need medical care and prescriptions on a regular basis. For example, a study of the effect of doubling prescription drug co-pays—from $6 to $12 for generic drugs and from $12 to $25 for brand name drugs—found that patients with diabetes, hypertension, and depression reduced use of their respective medications by nearly one-quarter.[7] Failure to properly manage chronic conditions often leads to the development of more serious and expensive medical complications. Under-insurance among the chronically ill should be viewed as a threat to public health. There is also evidence high-cost sharing is exacerbating collections problems and fueling bad debt for hospitals and doctors.[8]

How reform can help.—A key goal of health reform must be to ensure that all people have adequate coverage. Minimum standards for what health insurance covers must be developed and explicitly take into account what insured patients will be left to pay out-of-pocket when they need medical care. Research finds that when out-of-pocket spending for health care services exceeds just 2.5 percent of family income, financial pressures on families from medical bills increase dramatically. Financial burdens arise for low-income families at even lower levels of out-of-pocket spending.[9] Accordingly, the design of all health insurance plans and policies must consider the care needs of patients with cancer, diabetes, heart disease and other serious medical conditions. Coverage for care needs of people when they are healthy—primary and preventive care services and maternity care—must also be included. Cost sharing must be held to modest levels and further subsidized for low-income individuals.

A condition of insurer participation in a health insurance Exchange must be the offering of policies that meet minimum coverage standards. The elimination of substandard coverage options will not only address the problem of under-insurance, it will reinforce risk spreading. When all policies provide adequate coverage, people will not sort themselves by risk status across plans that offer widely varying levels of insurance protection.

ASSURE AFFORDABILITY

Overwhelmingly, the uninsured lack coverage today because they cannot afford it. Most uninsured have incomes below twice the Federal poverty level. Significant assistance is needed to make coverage affordable. As just discussed, artificially depressing premiums by offering substandard policies will not help.

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*As an alternative, some have suggested modified community rating that would allow premium adjustments for age but not health status. Because income generally increases with age, it is argued, age adjustments would be more equitable. However, income does not rise nearly as fast with age as do health insurance premiums. For example, median household income at age 55 is only 30 percent higher than for age 25. By contrast, under age rating, a 55-year-old's health insurance premium could be surcharged by a factor of 2 to 5. If modified community rating is adopted and income equity is a goal, premium subsidies will need to reach farther up the income scale for individuals as they age. Age rating is also problematic because age strongly correlates to health status. The incidence of many chronic conditions increases steadily with age. As a result, age rating will tend to disproportionately surcharge premiums for people with heart disease, cancer, and other conditions. If age rating is permitted, at a minimum, its impact on affordability of coverage for the chronically ill will need to be closely monitored.

Affordability must be measured against the cost of comprehensive coverage. Job-based group health plans offered by large employers today suggest one benchmark for the likely cost of adequate coverage. Such plans currently cost approximately $4,800 per year for self-only coverage and $13,000 for family coverage.[10]

How reform can help.—Subsidies are essential to make coverage affordable for millions of uninsured Americans. Defining affordability will certainly entail some subjective judgments. However, economic studies of consumer spending suggest health insurance may be affordable for middle-income families as long as premiums do not exceed 4 to 8 percent of household income, with lower affordability thresholds for lower income families.[11] A similar standard has been adopted by the State of Massachusetts in determining its premium subsidies and affordability index, and as a result, subsidies for both premiums and cost sharing are available for individuals and families with income to 300 percent of the poverty. Residents with income to 500 percent of poverty are ineligible for subsidies but may receive a waiver of the requirement to buy health insurance on grounds of affordability.

COST CONTAINMENT

Since 1999, employer-sponsored insurance premiums have more than doubled, well outpacing inflation and the rise in earnings.[12] In 2007 total national health expenditures reached $2.2 trillion, or more than $7,400 per capita and more than 16 percent of GDP.[13] All indications are that unless we take action through health care reform, health spending will continue to rise at levels beyond what families, employers, and taxpayers can afford.[14]

In today's private health insurance markets, competition between carriers does not help control costs. Quite the opposite, data show there is a high degree of concentration among insurers, with just a handful of carriers accounting for the majority market share in most States. Insurers have not used their market power to negotiate favorable provider rates or otherwise control costs as might be expected; rather, they've passed on health care costs to consumers while increasing profitability at the same time.[15]

How reform can help.—Health insurance markets can be better organized to generate new forms of competition and more effective cost containment strategies. First and foremost, once all policies meet standards for comprehensive coverage, it will be easier for consumers to shop on the basis of price prompting insurers to behave more cost effectively.

As is the case in Massachusetts, the Exchange could also be given authority to negotiate with health insurers over premiums and to exclude the least efficient and effective carriers from participation. The Exchange might also adopt minimum loss ratio targets, adopt standards for broker commissions, and institute other expectations of efficiency to lower health insurance administrative costs.

Importantly, a public health insurance plan option should also be offered to heighten competitive pressures to contain costs. A public health insurance plan can substantially influence market innovation by investing in new approaches to disease management or more effective use of information technology. Such innovations should be freely shared with other insurers so they could adopt them at lower cost. A public health insurance plan also could induce other insurers to be tougher price negotiators with providers.

The issue of a public health insurance plan option has prompted concern that it would constitute unfair competition with private insurance companies, and might even result in the elimination of private insurers over time. However, experts suggest a different outcome seems as or more likely because a public health insurance plan will face other unique constraints. In particular, health care providers have been formidable in their exercise of political pressure to oppose payment rate cuts under Medicare, as evidenced by Congress' vote to prohibit Medicare from negotiating prescription drug price discounts under the Part D program. While a public health insurance plan will likely enjoy some cost advantages over private insurers, political constraints will prevent it from exploiting those advantages.[16]

In addition, it is important to remember how private insurers have benefited from public programs by shifting costs to them. Thanks to Medicare, the private market no longer finances most medical care for the elderly and disabled, nor for patients with ESRD and ALS. Medicaid eligibility categories now include women with breast and cervical cancer who are under-insured for this care. Three-fourths of States have opened high-risk pools for uninsurable residents whom private insurers refuse to cover. In 2000, Minnesota's attorney general found private health insurers were shifting to taxpayers the cost of mental health care it contracted to provide its beneficiaries by forcing policyholders, through claims delays and denials, to turn to public programs for mental health care.[17] Offering a public health insurance plan option

also ensures that the sickest patients will always have a source of affordable, adequate health coverage in the event that some private insurance companies do not immediately cease cost avoidance activities.

TRANSPARENCY AND ACCOUNTABILITY

Finally, transparency of information is critical in a competitive market where consumers have choices. Lack of transparency promotes inefficiency and bias in consumer choices.[18] Health insurance policies are complex and confusing for consumers, who often do not understand what type of coverage they have or how it works.[19] One industry survey found that less than one-fourth of consumers understand the terminology in their health insurance contracts; and rather than try to read their policy, most would prefer to prepare their income taxes or go to the gym.[20]

Greater transparency in market behaviors will also be needed to ensure accountability. Compliance with market rules must be closely monitored and enforced if we want insurers to cease competition on the basis of risk selection.

How reform can help.—In an organized marketplace, there can be rules to ensure that insurance products are understandable. One important task of an Exchange must be to provide more and better information about health insurance than most consumers have today. The Commonwealth Connector, for example, designates types of health insurance plans as gold, silver, and bronze to make it easier for consumers to compare across option. In addition, the Connector makes available plan comparison tools that highlight differences in key plan features such as deductibles, co-pays, and benefit limits.[21] Members of Congress and other participants in the Federal Employees Health Benefits Program (FEHBP) have on-line access to full health insurance policy language for each available plan option. Under health reform, the Exchange should require all health insurance policies to be available for public inspection at all times in order to promote transparency.

If a goal of reform is to encourage health insurers to compete on the basis of efficiency, this information must also be readily available. In Washington State, for example, the Office of the Insurance Commissioner (OIC) makes available a Health Carrier Information Comparison tool with information about carrier loss ratios, profit margins and other characteristics to help consumers see how much of their premium dollars are spent on medical claims vs. administrative costs.[22] Health insurers should be required to disclose plan loss ratios including detailed information about administrative costs by type and amount. In addition, price transparency will help consumers and providers see and compare variation in prices (charged and allowed) for different health care services.

The Exchange should also collect data to hold health plans accountable for compliance with nondiscrimination rules. Insurer marketing, rating, and plan administration practices that might be used to evade such rules must be monitored. Disclosure must include data on applications, enrollment and disenrollment by plan, including demographic and health status characteristics. Rating of policies at issue and renewal must also be monitored. In addition, it will be important to track claims handling practices, including payment denials and delays, with detail disclosed on type of service and patient diagnosis. Data on grievance and appeals procedures and outcomes will also be needed.

In recent months, accountability and transparency have become watchwords in our effort to strengthen financial markets and the economy generally. These themes must also apply to health insurance and guide your efforts on health care reform.

END NOTES

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Senator BINGAMAN. Thank you very much.

Ms. IGNAGNI.

STATEMENT OF KAREN IGNAGNI, M.B.A., PRESIDENT AND CEO, AMERICA'S HEALTH INSURANCE PLANS, WASHINGTON, DC

Ms. IGNAGNI. Thank you, Mr. Chairman, members of the committee. It is a pleasure to be here.

Our members are providing health insurance services to over 225 million people through a diversified product mix. We are committed to reform, as Mr. Williams indicated. He is a member of our board of directors and has been a leading member of the committee on the board that has worked to propose solutions to the problems that you are talking about today.

Our members believe that health insurance reform needs to be done this year. We want to participate with you in helping to get legislation passed. We believe that the legislation needs to have three parts—universal access, cost containment, and modernization—to bring us into the 21st century and begin to pay for value,

not volume. We have offered very specific proposals in each of these areas that are outlined in our testimony.

In addition, as to the matter before you this morning, we took the responsibility to look at the issues that affect our industry. We have considered them very carefully, and we have proposed major changes that can be made to ensure that no one will fall through the cracks, that no one is discriminated against because of a pre-existing condition, and that there is guaranteed issue.

Second, today we have sent a letter to the committee to outline jointly with the Blue Cross Blue Shield Association a package of solutions that, if implemented together, can phase out the practice of varying premiums based on health status. We are committed to giving Americans health security.

There have been certain aspects of the market that has caused it to work the way it does. We are very much interested in engaging with you about what those issues are, how we believe we can solve them, and how we can demonstrate to the committee and to the Nation that our members can be counted upon to offer transparent, equitable, safe, fair health insurance products. We are delighted to be here this morning.

Thank you.

[The prepared statement of Ms. Ignagni follows:]

PREPARED STATEMENT OF KAREN IGNAGNI, M.B.A.

SUMMARY

AHIP's members believe that health care reform legislation needs to be enacted and signed into law this year. Our Board of Directors has devoted hundreds of hours to the development of policy proposals for building a stronger health care system. From the outset, we have committed to a series of proposals that would transform the health care system. Our Board has made it clear that it does not view the status quo as acceptable, and it is deeply committed to helping this committee, the Congress, and the Administration achieve workable reforms.

In December 2008, the AHIP Board announced a comprehensive proposal for restructuring the health care system with these cornerstone goals: achieving universal coverage, reducing the future growth rate of health care costs, and improving quality of care. To ensure that no one falls through the cracks of the U.S. health care system, our proposals include insurance market reforms addressing guaranteed coverage for people with pre-existing medical conditions, portability of coverage, continuity of care, and other solutions for addressing the concerns we heard during a nationwide listening tour we conducted last year as part of AHIP's "Campaign for an American Solution." Our written testimony outlines specific proposals addressing three major priorities:

Insurance Market Reforms to Provide Affordable, Portable Coverage to All Americans:

- Improving the individual market.
- Helping small business.
- Strengthening the small group market.
- Establishing an essential benefits plan.
- Confronting cost-shifting.
- Improving public programs.
- Protecting Americans from bankruptcy.

Containing Health Care Costs:

- Setting a goal for reducing the future rate of growth in health care costs.

Steps for Creating a High-Value Health Care System:

- Incentives for more effective and coordinated delivery of care.
- Prevention, early treatment, and coordinated care for chronic conditions.
- Uniform standards for quality, reporting, and information technology.
- Comparative effectiveness research.
- Targeted investments in public health infrastructure.

I. INTRODUCTION

Senator Bingaman, Senator Enzi, and members of the committee, I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We appreciate this opportunity to testify on solutions for achieving health care reform and how insurance reforms are integral to this effort. We believe that legislation needs to be enacted and signed into law this year, and we are committed to playing a meaningful role in this debate. To that end, we have worked hard to bring tangible strategies to the discussion that will address market issues, make the system more affordable, and facilitate the modernization that needs to occur in the delivery of health care services.

In December 2008, the AHIP Board announced a comprehensive proposal for restructuring the health care system with these cornerstone goals: achieving universal coverage, reducing the future growth rate of health care costs, and improving quality of care.

The AHIP proposal is the culmination of 3 years of policy work by our Board of Directors, which has focused on developing workable solutions to the health care challenges facing the Nation. It also responds to the concerns and incorporates the ideas that were raised by the American people during a nationwide listening tour we conducted last year as part of AHIP's "Campaign for an American Solution." This listening tour included roundtable discussions involving Americans from all walks of life, including people with and without insurance, small business owners and their employees, union leaders and members, elected officials, and community leaders.

Since June 2008, our Board has held eight in-person meetings and 11 conference calls, devoting hundreds of hours to the development of policy proposals for building a stronger health care system. From the outset, our community has committed to a series of proposals that would transform the health care system. Our Board has made it clear that it does not view the status quo as acceptable, and it is deeply committed to helping this committee, the Congress, and the Administration achieve reforms that work and become the building blocks on which a uniquely American system can be built.

II. INSURANCE MARKET REFORMS TO PROVIDE AFFORDABLE, PORTABLE COVERAGE TO ALL AMERICANS

As this debate moves forward, we believe all participants in the health care system have a responsibility to play a leadership role in identifying strategies in their sectors that will allow the Congress to pass health care reform legislation that will work and that can be sustained.

Rather than build on the existing regulatory structure, we are proposing a fundamental overhaul that would bring all individuals into the system, and allow major changes to be made that would ensure that all Americans can obtain affordable health insurance and do so irrespective of their health care history. We are proposing a series of policy changes which, if implemented together, will ensure that no one falls through the cracks, that coverage will be portable, and that information will be given to consumers that they need and want. To achieve these goals, the following steps are necessary:

Helping to Ensure Portability and Continuity of Coverage for Consumers in the Individual Market

• **Ensuring that no one falls through the cracks by combining guarantee-issue coverage (with no pre-existing condition exclusions) with an enforceable individual mandate:** For guarantee-issue to work, it is necessary for everyone to be brought into the system and participate in obtaining coverage. Achieving this objective will require specific attention to the mechanisms for making the mandate enforceable and will require coordinated action at multiple levels of government.

Indeed, the importance of combining guarantee issue with an enforceable individual mandate is borne out by research and experience from the States. For example, a report by Milliman, Inc. found that States that enacted guarantee-issue laws in the absence of an individual coverage requirement saw a rise in insurance premiums, a reduction of individual insurance enrollment, and no significant decrease in the number of uninsured.

• **Ensuring fairness in the tax code:** Currently, individuals purchasing insurance on their own cannot deduct expenses for health insurance coverage unless total health care expenses exceed 7.5 percent of adjusted gross income. This should be corrected to promote tax equity and help make health care more affordable whether coverage is obtained through an employer or the individual market.

• **Ensuring a stable market for consumers:** A broadly funded mechanism which spreads costs for high-risk individuals across a broader base needs to be put in place to ensure premium stability for those with existing coverage.

• **Ensuring that coverage is affordable for lower-income individuals and working families:** Refundable, advanceable tax credits should be available on a sliding scale basis for those earning less than 400 percent of the Federal Poverty Level (FPL), as discussed below.

Helping Small Business Provide Health Care Coverage More Affordably

Small business owners find themselves in an increasingly difficult marketplace for health insurance because of constantly rising health care costs and the limited ability of most small businesses to bear risks, contribute a substantial share of costs, or support administrative functions. On March 9, AHIP's Board of Directors approved a policy statement outlining solutions to help small business based on the following three core principles:

Affordability

• **Essential Benefits Plan:** As discussed below, we propose the creation of new health plan options that are affordable for small employers and their employees. These "essential benefits plans" would be available nationwide and provide comprehensive coverage for prevention and wellness as well as chronic and acute care. In addition, these plans would be subject to State regulation, but would not be subject to varying and conflicting State benefit mandates that result in increased costs to small businesses (and that do not apply to the generally larger employers that enter into self-funded health care coverage arrangements).

• **Tax Credits or Other Incentives to Assist Small Business:** We support the establishment of tax code incentives or other types of assistance that encourage both small business owners to offer coverage to their employees and employees to take up coverage. We recognize the special challenges, both administrative and financial, that small businesses face in offering contributions toward their employees' coverage. Providing assistance can encourage these contributions and help enable employees to take up coverage which improves predictability and stability in the small group market.

• **Improving Coordination of Private and Public Programs Strengthens Small Group Coverage:** Premium or other assistance offered to low-income individuals and working families can be applied to and work with employer-sponsored coverage. This is important whether the assistance is provided through Medicaid, the Children's Health Insurance Program (CHIP), or other expanded programs designed to help individuals and families obtain coverage. Improved coordination allows workers to take up coverage offered by small businesses by leveraging both public and private sources of assistance, and benefits the firms' employees as a whole by increasing rates of participation in the small group plan.

Flexibility

We are committed to working with the small business community to ensure that small businesses have access to a range of options and tools that better assist them in helping their employees obtain health care coverage. One-size-does-not-fit-all, as the needs of diverse small firms vary greatly.

• **Micro-firms:** As an example, "micro-firms" (those with fewer than 10 employees) face special challenges in offering coverage. Statistics show that only about one-third of these firms offer coverage. This reflects the administrative, financial, and logistical challenges many micro-firms face in setting up and establishing plans and offering and contributing to their employees' coverage. To help these firms meet these challenges, enhanced tools could be developed that would allow those micro-firms that have found it impractical to offer coverage, to contribute to coverage purchased on a pre-tax basis by individual employees. As part of comprehensive health care reform, employees could then use these contributions to help purchase coverage in a reshaped health care system that combines an individual requirement to obtain coverage with reforms in the individual market.

• **One-stop information source:** All small firms will benefit from collaborative efforts between health plans and the public sector (e.g., insurance commissioners) to ensure that small employers and individuals have one-stop access to clear, organized information that allows them to compare coverage options. This one-stop shop

could also allow individuals to confirm eligibility for tax credits or other assistance and even provide a mechanism to aggregate premium contributions from multiple sources. By providing a mechanism to combine even modest contributions from multiple sources (public and private), this new one-stop shop could be especially helpful to employees who may hold multiple jobs.

Simplicity

Small businesses may find the current system difficult to navigate with a lack of simple, streamlined information about multiple coverage and care options and related assistance programs. We propose modifications to introduce greater simplicity to the system through technology and regulatory reform and the creation of a one-stop information source as described above. These proposed efforts will benefit all participants in the health care system, including the small business community.

• **Technological advances:** In our December 2008 Board statement, we emphasized that any health care reform proposal should include recommendations to streamline administrative processes across the health care system. Success will require advances in automating routine administrative procedures, expanding the use of decision support tools in clinical settings, and implementing interoperable electronic health records. Using technology to help streamline administrative processes will improve care delivery, enhance the provider and patient experience, and speed claims submission and payment. Done right, streamlining can also help reduce costs systemwide, leading to improved affordability.

• **Regulatory reform:** Regulatory structures should be rethought so that they work better and provide for a more consistent approach in areas such as external review, benefit plan filings, and market conduct exams. In a reformed market, policymakers should be driven by striking a balance between the traditional roles of the Federal Government and the States, and the objectives of achieving clearer and "smarter" regulation that promotes competition and avoids duplication of existing functions. Greater consistency in regulation and focusing on what works best will enhance consumer protections across States and help improve quality, increase transparency, and increase efficiency leading to reduced administrative costs.

Strengthening the Large Group Market

We support building upon the existing employer-based system, which currently covers 177 million Americans according to the U.S. Census Bureau. It is a key part of our economic fabric. Although the employer-based system faces challenges, more than 90 percent of employers report that offering high-quality coverage is important to their ability to recruit and retain valuable workers and enhance employee morale. Thus, as a first priority, the Nation's reform agenda should be committed to a policy that "first does no harm" to that system and limits strategies that would reduce employer coverage. Focus should be placed on retaining a national structure for the large group market that continues to promote uniformity and ensures the smooth functioning of the employer-based system.

At the same time, the Nation's economic uncertainties and job losses underscore the need for new strategies to assist individuals who become unemployed or are transitioning from job to job. While a Congressional Budget Office (CBO) study found that nearly 50 percent of the uninsured go without coverage for 4 months or less, additional protections are still needed. We propose ensuring that tax credits are available to individuals on an advanceable basis to help them through job transitions along with access during these times to more affordable coverage options consistent with our proposal for a basic benefits plan.

Establishing an Essential Benefits Plan

Individuals and small businesses should have access to an affordable "essential benefits plan" available in all States that provides coverage for prevention and wellness as well as acute and chronic care. To maintain affordability, the essential benefits plan should not be subject to varying and conflicting State benefit mandates.

An essential benefits plan should include coverage for primary care, preventive care, chronic care, acute episodic care, and emergency room and hospital services. Alternatively, it should include coverage that is at least actuarially equivalent to the minimum Federal standards for a high-deductible health plan sold in connection with a health savings account, along with the opportunity to include enhancements such as wellness programs, preventive care, and disease management.

Allowing benefit packages to vary based on actuarial equivalence is crucial to ensure that any package can evolve based upon new innovations in benefit design and the latest clinical evidence.

Confronting the "Cost-Shifting Surtax" Currently Imposed On Employers And Consumers Purchasing Health Care Coverage

As part of any national health care reform initiative, Congress must address the fact that reducing outlays in one area inevitably means shifting costs elsewhere. Underpayment of physicians and hospitals by public programs shifts tens of billions in annual costs to those with private insurance. A December 2008 study by Milliman, Inc. projects that this cost shifting essentially imposes a surtax of $88.8 billion annually on privately insured patients, increasing their hospital and physician costs by 15 percent. This study concluded that annual health care spending for an average family of four is $1,788 higher than it would be if all payers paid equivalent rates to hospitals and physicians. The transfer of these costs to those with private coverage cannot be sustained and is critical to addressing concerns over affordability.

The impact of cost-shifting is dramatically illustrated by the tables below, which use real data showing that hospitals in California recorded significant losses in 2007 by serving Medicare and Medicaid beneficiaries. These losses are offset, however, by higher costs charged to commercial payers. This cost shifting translates into higher premiums for working families and employers.

Hospital Net Income Figures in California

[In millions]

Year	Medicare and Medicaid		Commercial		Total	
	DSH	Non-DSH	DSH	Non-DSH	DSH	Non-DSH
2001	256	(1051)	137	1621	(825)	853
2007	(914)	(4292)	790	6230	(1450)	1852

Hospital Payments to Non-DSH Hospitals Relative to Costs in California

[In Percent}

Year	Commercial	Medicare	Medicaid
2001	117	98	67
2007	142	85	56

Non-DSH Hospital Margins in California

[In Billions}

Year	Commercial	Medicare	Medicaid
2001	2.0	(0.2)	(0.9)
2007	6.2	(2.4)	(1.9)

In addition, the U.S. currently spends approximately $50 billion each year to provide health services to those without coverage, leading to high levels of uncompensated care. This too results in cost-shifting to those with coverage in the form of higher premiums and other related costs. According to a 2005 Families USA study, the cost-shift due to uncompensated care adds $922 annually to family premiums. When these costs associated with uncompensated care are combined with the cost shifting that results from the underfunding of Medicare and Medicaid, the impact for families with private coverage is an overall surtax of $2,710 annually due to cost-shifting.

Improving Public Programs

For health care reform to succeed, we also need to improve the public safety net. We strongly supported the funding that is committed to this priority by H.R. 2, the "Children's Health Insurance Program Reauthorization Act of 2009" (CHIPRA). We also support extending Medicaid eligibility to all individuals with incomes at or below 100 percent of the FPL. In addition, adequate support should be provided to community health centers, recognizing the critical role they play in providing access to services for vulnerable populations and to ensure they can continue this role in the future.

Protecting Americans from Bankruptcy

To guard against medical bankruptcy, a system of tax credits should be designed for lower-income individuals and working families that would cap their total health care expenses (to include spending on premiums and cost-sharing) as a proportion of income. Achieving the goal of universal coverage is also critical to preventing medical bankruptcies, as research shows medical expense related bankruptcy is most prevalent among those without health insurance coverage.

III. CONTAINING HEALTH CARE COSTS

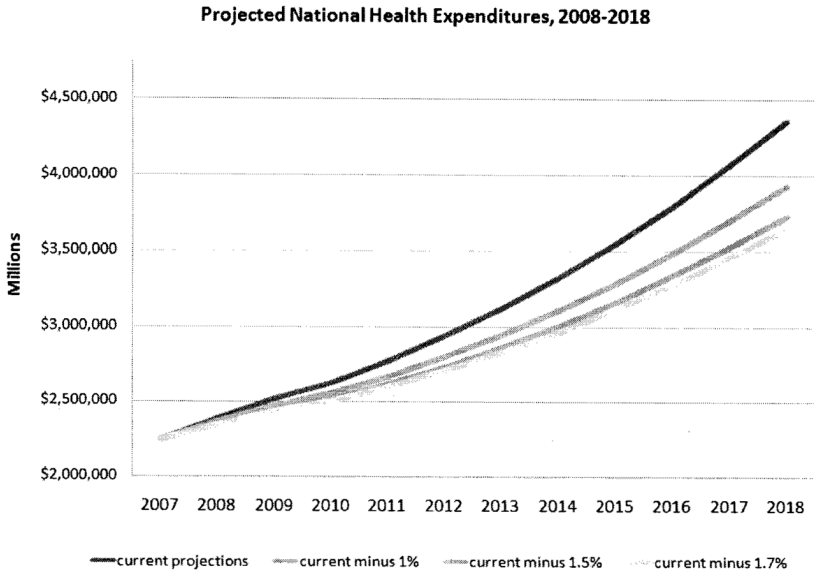
A broad consensus is emerging that reform of the system—that covers all Americans and provides safer and more effective care—is possible *if* we can contain the future growth in health care costs. At present, U.S. health expenditures are rising at an unsustainable rate, placing unaffordable burdens on families and small businesses, and hampering our competitiveness as a nation. In order to confront these issues, all stakeholders need to be challenged to innovate, perform better, and come to the table with solutions.

Health plans are leading the way by pioneering disease management and care coordination programs, promoting prevention, wellness and early intervention, and implementing innovative payment strategies that reward performance and outcomes. We are committed to working with the Administration, Congress and other stakeholders to advance strategies that promote effective, efficient, and high value health care.

At the same time, efforts to make our health care system more affordable for the long run will succeed only if the Nation as a whole makes a strong commitment to reducing the future rate of increase in health costs and we all work together to achieve it. The critical link between reducing costs and increasing quality should help guide this effort. Spending more on health care does not necessarily equate to better quality; rather, the opposite has been shown. In particular, many regions of the Nation with higher spending actually have poorer quality of care and exhibit wide variations in practice and treatment patterns.

Recognizing the need for bold action, we are encouraging Congress to consider setting a goal for reducing future health care costs over a 10-year period and designate a public-private advisory group to develop a roadmap to reduce projected growth by 1.5–1.7 percentage points. The importance of such an effort cannot be overstated, nor can the responsibility that each stakeholder group must assume. Leaders in each sector know best about how to reduce future cost trends, and we are proposing a strategy where each of the key groups would be expected to take the lead in outlining a blueprint to reduce future cost growth in their sector.

The value of launching such an effort is illustrated by the chart below, which shows the dramatic impact of reducing annual increases in the projected growth of national health expenditures by 1 percentage point, 1.5 percentage points, or 1.7 percentage points. The aggregate cost savings under any of these scenarios would be very large, with the third scenario—achieving a reduction of 1.7 percentage points—yielding savings of $3.5 trillion over 10 years, or more than $700 billion in 2018 alone.



Reducing cost trend in this manner would strengthen the Nation's economic position relative to the global economy, provide significant relief to individuals and employers, and improve the solvency of the Medicare trust fund. Moreover, cost savings of this magnitude could go a long way toward ensuring that every American has access to affordable, quality coverage and care. These savings could help finance part of the costs of providing coverage to the uninsured, as well as reduce costs for those who are currently covered.

The impact on the U.S. economy is particularly important, as the chart below shows. Modest reductions in cost trends would have a dramatic effect in holding down future projections of national health care spending as a percentage of our Nation's gross domestic product (GDP).

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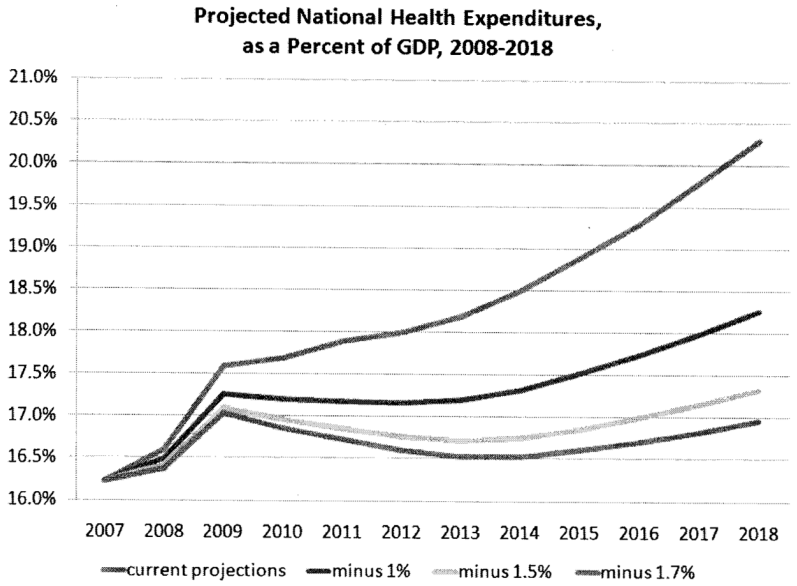

A financially sustainable and affordable health care system can only be achieved by bringing underlying medical costs under control. If health care costs are allowed to continue rising at rates far exceeding economic growth, they will stall all efforts to expand coverage and improve care. Meeting specific affordability goals will require leadership from all stakeholders. Health plans are prepared to step up and meet that challenge and participate in a fast-track process with other stakeholder groups.

IV. CREATING A HIGH-VALUE HEALTH CARE SYSTEM

The goal of containing costs can only be realized if it is coupled with parallel efforts to improve the ability of our health care system to deliver high-quality care that is in line with best practices and addresses the disparities in care experienced by cultural and ethnic minorities.

The fragmented U.S. health care delivery system is wasteful and unsustainable. Patients across the Nation fail to receive high quality care on a consistent basis, while the system overpays and encourages the overuse of costly specialty care, yet underpays primary care which fosters care coordination and chronic care management. About 18 percent of Medicare hospital admissions result in re-admissions within 30 days of discharge, accounting for $15 billion in spending and $12 billion in potentially preventable re-admissions.

The total costs of preventable medical errors that result in injury are estimated to be between $17 billion and $29 billion—of which over half represent health care costs. Additional research demonstrates that there is an alarming gap between what is recommended by scientific evidence and what is actually practiced, including a 2003 RAND study which found that only 55 percent of patients receive treatments based on best practices.

To address these challenges, we need to focus on several critical areas to create a high-value health care system.

• **Updating and recalibrating the Medicare physician fee schedule.** The current process for determining physician payment across different specialties under the Medicare program should be overhauled, and a transparent, public process should be created. Payment levels should be adjusted for cognitive and procedural services as well as account for gains in efficiency and provider productivity. Recalibrating the value of professional services will create renewed interest in important areas such as primary care.

• **Setting standards and expectations for the safety and quality of diagnostics.** The 2001 Institute of Medicine's landmark report, *Crossing the Qual-*

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ity Chasm, recommended setting and enforcing explicit professional and facility standards through regulatory and other oversight mechanisms, such as licensure, certification and accreditation, that define minimum threshold performance levels for health care organizations and professionals. Standards will hold providers accountable for ensuring a safe environment in which patients receive care.

• **Promoting care coordination and patient-centered care by designating a medical home as well as supporting other primary care delivery models.** The patient-centered medical home is a promising concept that would replace fragmented care with a coordinated approach to care. By providing physicians with a periodic payment for a set of defined services, such as care coordination that integrates all treatment received by a patient throughout an illness or an acute event, this model promotes ongoing comprehensive care management, optimizes patients' health status, and assists patients in navigating the health care system. Other models which utilize nurses and other professionals to coordinate and manage patients' care also should be explored.

• **Linking payment to quality.** Payment incentives which reward physicians that practice both efficiently and consistently with clinical practice guidelines should continue to be promoted. The next generation of pay-for-performance models will move beyond the current focus of ensuring that processes of care are followed and performance metrics are reported, and instead, reward providers for achieving results including better clinical outcomes, improved patient experience, and lower total cost of care. Similar incentives which apply to hospitals also may have potential benefits.

• **Bundling payments for better management of chronic conditions across practitioners and facilities.** Bundled payments could allow for better management of chronic conditions by providing a single prospective payment for all providers involved in the management of a patient's condition. Under this model, providers would have shared accountability and responsibility, and thus be motivated to individually provide quality care in more efficient ways as well as work with other professionals to improve collective performance.

• **Redesigning acute care episodes.** Global case rate models—which typically provide an all-inclusive payment for a defined set of services, regardless of how much care is actually provided—may be a beneficial payment approach for procedures and conditions which have a relatively clear beginning and end.

• **Refocusing our health care system on keeping people healthy, intervening early, and providing coordinated care for chronic conditions.** Additional proactive steps need to be taken to identify individuals at risk for chronic conditions, help them access care, and encourage them to maintain healthy lifestyles. A proactive approach that keeps people healthy and productive needs to: (1) address the growing shortage of physicians and nurses in selected disciplines, including primary care and general surgery; and (2) reward providers for spending time with patients and coordinating their care.

• **Improving care nationwide by adopting uniform standards for quality, reporting, and information technology.** AHIP strongly supports the investments in health information technology that were enacted as part of H.R. 1, the "The American Recovery and Reinvestment Act of 2009." This legislation lays the groundwork for steps that must be taken to ensure that health care providers, consumers, payers, and policymakers have access to consistent and useful data on the quality of care delivered.

• **Investing more in research to better understand which treatments and therapies work best.** We need to close gaps in research, organize information on practices yielding the best outcomes for patients, and diffuse this information among practitioners and patients. H.R. 1, the "American Recovery and Reinvestment Act of 2009," provided $1.1 billion in Federal funding—which we strongly supported—to support research that will advance these important priorities.

• **Creating accountability for consistently delivered, high-quality care based on the best evidence.** All stakeholders should promote the delivery of the best clinical outcomes and patient experience while ensuring the most effective and appropriate utilization of health care services. To accomplish this objective, investment in the development of new and improved measures that assess episodes of care and efficiency must be fast-tracked as part of health care reform.

• **Making targeted investments in our public health infrastructure.** Our public health infrastructure needs to be better positioned to implement strategies that prevent or ameliorate health care concerns and promote well-being and healthy lifestyles as part of health care reform. We advocate a new, targeted national initiative to increase public awareness of the links between preventable conditions and chronic illness and to support new and existing prevention programs in our schools, worksites, and communities. Health plans are committed to working directly with

communities to promote safe and healthy living and provide models for targeted investments in public health across the Nation.

The visual on the following page shows that many of the initiatives that have been implemented in the private sector today are paving the way for future innovations under a reformed health care system. Existing programs listed in the left column provide a valuable foundation for the tools and strategies of tomorrow's health care system.

Cost/Quality Improvement Strategies

Private Sector Today	Future
• Speed and innovation • Identification of patients at risk for disease • Access to health information • Wellness and health promotion (productive workforce) • Disease management/care coordination • Aggressive primary care promotion • Tiering • Pay for performance • Centers of Excellence • High quality service facilities (e.g. radiology) • Patient-centered medical homes • Bundled rates/case rates • "At-risk arrangements" with manufacturers and providers of specialty services	• Targeted DM and care management programs (personalized medicine) • Clinical decision making at point of care based on latest medical evidence • Paying for outcomes • Enhanced episode payments and case rates • Enhanced medical homes • Payment models that encourage integration and personal responsibility • Risk arrangements with specialists • Device formularies • Expanded gain sharing • Integration of administrative and clinical data across health care system • Public disclosure of performance

V. CONCLUSION

AHIP appreciates this opportunity to outline our suggestions for enacting meaningful health care reforms. We are doing our part to advance new strategies, and we are strongly committed to working with committee members and other stakeholders to develop solutions for ensuring that all Americans have access to high quality, affordable health care coverage.

Senator BINGAMAN. Thank you very much.

Dr. Nichols.

STATEMENT OF LEN M. NICHOLS, Ph.D., DIRECTOR, HEALTH POLICY PROGRAM AT THE NEW AMERICA FOUNDATION, WASHINGTON, DC

Mr. NICHOLS. Mr. Chairman, it is a real honor to be before you and to work with this storied committee today.

My name is Len Nichols, and I direct a health policy program at the New America Foundation.

I am here to say that our insurance markets are failing us. They lead to inefficiency, unnecessary human suffering, death, and loss of productivity from that premature death and prolonged morbidity. But it is important we recognize that the fault lies not with the people who run the insurance companies. The fault lies in the rules we have set for them.

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By and large, they follow the rules, and those rules are stupid. We need to acknowledge that smart rules can make markets more efficient and work better. They can make markets more efficient and more fair.

The role of policy, in my view, is to set rules that channel self-interest to serve the public interest. Our goal should be to create marketplaces wherein insurers that adopt socially responsible business models will thrive.

The obsolete business model that has led to all this inefficiency and human suffering is centered on aggressive underwriting and risk selection. So the simple thing to do is outlaw it. We want insurers to compete on price, clinical value-added, and consumer satisfaction, not on avoiding the sick and strategically denying valid claims.

Therefore, to that end, I think it is very clear you need to think about rules that would end discrimination based on health status. You have heard a lot about that. Sounds like we got a consensus. Let us just do it this afternoon. End discrimination based on health status.

Guaranteed issue. Sell to all comers. Guaranteed renewal. Some kind of modified community rating so you don't use health as a discriminating factor.

Then I would say you need to avoid adverse selection. You have to have an individual mandate to require people to purchase that insurance. If you are going to ask insurers to take all comers, you have to make sure the population they are covering is the full population and not just the sick.

Thank you very much.

[The prepared statement of Mr. Nichols follows:]

PREPARED STATEMENT OF LEN M. NICHOLS, PH.D.

Chairman Kennedy, Ranking Member Enzi, Senator Bingaman and other distinguished members of the committee, thank you for inviting me to testify today on this central topic of health reform and how best to organize insurance markets. My name is Len M. Nichols. I am a health economist and direct the Health Policy Program at the New America Foundation, a non-profit, non-partisan public policy research institute based in Washington, DC, with offices in Sacramento, CA. Our program seeks to nurture, advance, and protect an evidence-based conversation about comprehensive health care reform. We remain open-minded about the means, but not the goals: all Americans should have access to high-quality, affordable health insurance and health care that is delivered within a politically and economically sustainable system. I am happy to share ideas for your consideration today and hereafter with you, other members of the committee, and staff.

Insurance markets are a great place to focus on early in your inquiries. We know that having quality health coverage is literally a matter of life and death. The Institute of Medicine (IOM) estimates that over 18,000 Americans die every year because they do not have access to the timely and necessary care that health insurance affords.[1] Many of us in this room take this kind of seemingly routine care for granted, yet I know that securing access to health insurance for all is a moral obligation that many members of this committee share.

The truth is many insurance markets do not work very well for many of our fellow citizens. Small employer groups with fewer than 50 or 100 members lack bargaining power, administrative economies of scale, and the ability to self-insure. As a result, they pay very high prices for coverage.[2] Perfectly healthy and higher income individ-

[1] Institute of Medicine, *Coverage Matters: Insurance and Health Care*, (National Academies Press: Washington, DC, 2001).

[2] The "price" of insurance is the "load," the difference between the premium paid and the amount of money paid to medical providers for health services. Individuals pay loads between 30–40 percent, small groups pay 25–30 percent, and large groups pay 6–15 percent.

uals do satisfactorily well in the non-group market most of the time. However, those with health conditions, even fairly minor ones, often encounter carriers who refuse to sell to them at all or only at a greatly inflated price.[3] The non-group market can never work well for those with serious health conditions and modest incomes.[4]

Even large group markets are not working all that well. Large employers are increasingly focused on cost and quality issues as much as and in some cases more than everyone else. Most large employers self-insure because they concluded long ago that they were not getting value for the risk-bearing services they were buying from insurers. Today, many large employers just buy claims processing and provider contracting services. Furthermore, many employers actually engage in benefit design and care management efforts themselves, sometimes in concert with insurers acting as third-party administrators, but often alone.

Thus, insurance markets need to be reformed—and some people must be given substantial subsidies—for us to reach the goal of covering all Americans in a sustainable way.

I will get specific in short order, but I prefer to start with a big picture perspective. To reform our health system generally and our insurance marketplaces specifically, we must re-align incentives quite profoundly. The role of policy is to set the rules so that *self-interest* is channeled to serve the *social interest*. We have not done this very well with regard to insurance regulation, either at the Federal or State levels. We can do far better.

Our goal should be to create marketplaces wherein insurers who adopt socially responsible business models will thrive. The obsolete business model that has inflicted so much inefficiency and human suffering on so many is centered on aggressive underwriting and risk selection. Under this model, insurers compete to insure the best risks and avoid the sick at all costs. Americans will be much better served by rules that make it unprofitable and illegal to continue these strategies.

It is necessary to institute rules that will encourage insurers to: interact with enrollees efficiently, respectfully, and transparently; help us get and stay healthier; identify outstanding and efficient providers and use information tools and incentives to help them deliver better care; and, structure payments to providers so that continuous quality improvement is embedded in every care process, regardless of whether the care is being delivered in the physician's office, the hospital, or elsewhere. In other words, we want to create markets wherein insurers compete based on price, clinical value-added, and consumer satisfaction, rather than on avoiding the sick and strategically denying claims.

NECESSARY REFORMS

The following reforms are necessary to create an insurance market that is accessible and affordable for all:

A new marketplace that extends the advantages of large group purchasing—large, balanced risk pools and administrative economies of scale—to all. This new marketplace or "exchange" could be organized nationally. But insurance markets, like health service markets, are inherently local. The conditions on the ground vary quite a bit across the country and even within States. For example, integrated health systems, large multi-specialty physician groups, and effective and responsive local non-profit health plans are not as widespread as most of us would prefer. Therefore, creating several marketplaces or exchanges on a regional, State, or sub-state level (or some combination), would be preferable to a single national marketplace.

However, and this should be made abundantly clear, the most important rules that govern the new marketplace must be uniform across the country. We cannot serve all Americans well with a regulatory patchwork that reflects local lobbying disparities more than good policy sense.

The responsibility for enforcing the new insurance regulations should remain with the States. As a result of their current role, States have more functional knowledge about regulating insurance companies and of the local nuances of local markets than the Federal Government. However, the Federal Government will need to invest in back-up regulatory authority if States fail to act consistently with the intent of Federal legislation.

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[3] Karen Pollitz and Richard Sorian, "Is the Individual Market Ready for Prime Time?" *Health Affairs* Web Exclusive, October 23, 2002; Karen Pollitz, Richard Sorian, and Kathy Thomas, "How Accessible is Individual Health Insurance for People in Less-Than-Perfect Health?" *Kaiser Family Foundation*, June 2001.

[4] Mark V. Pauly and Len Nichols, "The Nongroup Insurance Market: Short On Facts, Long On Opinions And Policy Disputes," *Health Affairs* Web Exclusive, October 23, 2002.

Initially, the new exchanges should subsume today's small group and non-group markets. This will enable people who are not eligible for Medicaid (or Medicare) who work in small firms or are without access to employer-sponsored coverage to enter right away. No residual market outside the exchange should be allowed for these small groups and individuals. This will eliminate risk selection once and for all. Over time, large (currently self-insured) groups might be allowed to enter into the market, perhaps starting with State and Federal employees. Care must be taken to protect against risk selection, however, so large groups should be allowed to come in only as a result of employer choice, not the choice of individual employees.

The marketplaces should be governed by a balanced, non-profit board of directors appointed by political leaders. Insurers will need to meet specific standards in order to participate. They should be required to report data (for comparative performance purposes) and abide by the marketing rules and open enrollment period policies set by the board.

Prohibit discrimination based on health status. No American should be denied coverage or charged differential premiums because of their health status or family history. To achieve this goal, the following reforms are absolutely necessary: guaranteed issue (all insurers must sell all products to all people within the exchange and outside the exchange large employers must allow all workers to join their plans at group rates), no exclusions based on pre-existing conditions (once virtually all Americans are covered), guaranteed renewability (plans cannot refuse to continue covering individuals or differentially change their premium as a result of changes to health status), and modified community rating (premiums may not vary based on health status, but can vary by age, geography, and family size).

Minimum benefit package. All Americans should have coverage that protects their health and financial needs. Therefore, Congress or another authority should require a minimum level of benefits to guarantee the quality of coverage being offered in the marketplace and protect against adverse selection that could result from wide variations in product design.

The minimum benefit standard could be designed as a specific minimum benefit package or an actuarial value target. An actuarial value test, while not as effective for market competition as a specific benefit minimum package, would nevertheless preserve some flexibility for benefit and cost-sharing design and still guarantee quality coverage. If done carefully, this strategy could also protect against extreme adverse selection.

Risk adjustment (distributing payments to insurers based on differential risk profiles) will be necessary to help reduce the consequences of adverse selection as well. Insurers should also be permitted to sell supplemental products; however, these packages must be priced and described separately to allow consumers to easily compare different choices and create transparency regarding cost and value.

Subsidies. Health care costs have risen faster than wages for some time. As a result, health insurance and health care have become more unaffordable for more and more American families every day. Therefore, we will need to devote substantial subsidy dollars to make health insurance and health care affordable for all Americans. However, affordability has two dimensions—for households and for governments. Ultimately, the final definition of affordability will reflect political judgments about what households and governments can afford. This definition may evolve over time, as will delivery system efficiencies, demographic trends, and economic growth.

Reform proposals should include sliding scale subsidies for individuals and families who need help affording coverage (again, defined by the community). Subsidies could be available for both premiums and cost-sharing requirements (depending on the design of the minimum package) and made available directly or through the tax code.

We should keep in mind that the Federal Government already spends more than $200 billion per year subsidizing insurance through the tax treatment of employer-provided health coverage. Economists, analysts, and courageous policymakers have argued for years that the income tax exclusion for employer premium payments is both regressive and inefficient relative to other ways to subsidize insurance coverage. The current employer tax exclusion is a poorly targeted subsidy that we could and should use to make our health system both more efficient and more fair. Therefore, as we think about how to finance coverage expansion and necessary subsidies, we should remember that some of the resources we have dedicated already could be targeted far more efficiently.

Requirement to purchase coverage. No one suggests an individual mandate because they want to "make" people buy insurance. Rather, when combined with the reforms described above, a requirement to purchase coverage is necessary to make the insurance market function efficiently and fairly. Without a purchase requirement, insurers will legitimately fear that only the sick will buy health insurance

(adverse selection). That fear will produce higher premium bids, which will cost people and governments more money. Purchase requirements will guarantee that the population seeking care represents the entire population. As a result, insurers will bid lower in a competitive context. Massachusetts has seen this happen in real life.

Once insurance is accessible (through the newly reformed marketplace) and affordable (through subsidies), all individuals should be required to purchase coverage to make sure everyone pays their fair share and reduce the costs shifted to the insured by free riders. A free rider is an individual who could afford to purchase coverage, but does not enroll. Ten percent of the uninsured make more than four times the Federal poverty level.[5] Often when a free rider gets seriously ill they visit a hospital emergency room and indicate that they cannot pay for the services provided to them. Their costs are shifted to the insured in the form of higher provider prices and in turn higher private insurance premiums. Roughly 16 percent of our uncompensated care expenses for the uninsured go to people who make more than 400 percent of the poverty level.[6]

In addition, 25 percent of people eligible for public coverage at little to no cost do not enroll.[7] While these individuals are not free riders, they still contribute to the cost-shift or "hidden tax," which results in higher premiums for the insured. An individual mandate would necessitate effective outreach and enrollment efforts to minimize the number of people who are currently missed by the system and ensure this vulnerable population is taking advantage of available coverage. In the long run, this should help them get healthier and become more productive citizens.

Finally, as a condition of living in a community that helps individuals afford insurance and care, everyone has a personal responsibility to maintain their own health. Value-based design features in the minimum benefit package that encourage healthy eating, exercise, and lifestyle behaviors will help give Americans some of the tools they need to achieve this goal. In addition, part of taking responsibility for our own health includes a requirement to access appropriate health care services when necessary. This is possible only if a person is insured. Therefore, a requirement to purchase or enroll in available coverage represents one part of an individual's personal responsibility to the larger community.

Transparency for insurers. In general, we must increase transparency within our insurance markets to engender fair competition and give consumers the information they need to make informed choices about the insurance products that are right for them. Insurers should be required to report information on the quality of care their enrollees are getting, as well as patient satisfaction indicators that will be made public by the exchanges. The Healthcare Effectiveness Data and Information Set (HEDIS) measures, which are continually updated by the National Committee for Quality Assurance (NCQA), seems like a reasonable place to start. Also, exchanges will want to help the public compare administrative efficiency by making available the ratio of premiums collected versus dollars spent on patient care. The risk profiles of enrollees will need to be reported for exchange-wide risk adjustment as well.

OPTIONAL REFORMS

The reforms described above could achieve satisfactory performance from a market comprised exclusively of private health insurance plans. Yet, I admit that there are few real-world examples that prove this kind of system would function as anticipated, though reforms in Massachusetts are making great strides. (Since Massachusetts remains a work-in-progress I will not analyze it in detail in the written testimony but will gladly discuss my impressions of what we know so far in the hearing itself, or later). While my personal views lead me to believe that private insurers alone could enable our new marketplace to deliver excellent performance in the future, I understand profoundly that many advocates and citizens are skeptical that regulations or contracts will be able to ensure that private insurers actually comply with all reforms for all people.

Several leading reform proposals recommend allowing consumers to choose between public and private health plans. Therefore, it is worth exploring how to design an insurance marketplace wherein private and public plans can compete fairly.

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[5] Kaiser Family Foundation, "The Uninsured, A Primer: Supplementary Data Tables," October 2008.

[6] Sarah Axeen and Elizabeth Carpenter, "Who Receives Uncompensated Care," *New America Foundation*, March 2008.

[7] John Holahan, Allison Cook, Lisa Dubay, "Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Need Help Affording Coverage," *Kaiser Family Foundation*, July 2007.

Public plan. Let me be crystal clear: if the playing field is level, it is possible for public and private health insurance plans to compete and deliver value for consumers without distorting the insurance market. This policy question should not create an impasse or stall reform efforts.[8]

Fair competition, however, will require separating the oversight of the public plan from that of the managers of the marketplace or exchange(s). It will also require that all rules of the marketplace—benefit package requirements, insurance regulations, and risk adjustment processes—apply to all plans equally, whether public or private.

More than 30 State governments offer their employees a choice between traditional private health insurance products and a plan self-insured by the State. This experience combined with historic competition between public and private plans in both the Medicare program and California Public Employees Retirement System (CALPERS) serves as proof-of-concept: plans operating with politically appointed managers can compete with plans run by private managers if the rules of engagement are structured properly.

Again, State employee plans offer an excellent model for how we could structure a choice of a public health insurance plan. More than 30 State governments offer their employees a choice between traditional private health insurance products and a plan self-insured by the State. In the case of the self-insured product, the State or a third party administrator (TPA) negotiates provider contracts and performs administrative functions. While the State may pay a TPA (usually the resident "Blue" plan) to handle some tasks, the plan is publicly owned and the State bears the insurance risk. If claims outpace premiums in a given year, the State pays and is at risk for the difference. Likewise, if the TPA collects more premiums than it pays out in claims, the surplus dollars are usually allocated to a premium stabilization fund or remain with the State's general revenues. Neither the TPA nor the State plan's managers profit from stinting on care. This credible reassurance seems to be what most advocates for the choice of a public health insurance plan seek.

Therefore, I believe the type of public plan I describe above can achieve many of the goals of public plan advocates, while preserving fair and effective market competition, negating the risk of excess cost-shift, and avoiding any kind of inevitable progression toward a single payer health system. Yet, this approach will require us to systemically address delivery system reforms that can deliver more value and lower cost growth trajectories over time. But that is a subject for another day.

CONCLUSION

Insurance market reforms are an essential part of re-making our health system into one that works for all Americans in the 21st century. Comprehensive health reform must also include efforts to improve quality and reduce cost growth. But the foundation of a *health* system must be coverage. Without coverage, tens of millions of Americans will never have access to appropriate care and health-enhancing interventions.

There is a compelling collective interest in making sure coverage is a reality for all Americans: the economic loss we suffer as a result of the uninsured exceeds the cost of covering everyone.[9] Also, we must cover all Americans to allow the information system and quality innovations, that we desperately need, to work successfully. Therefore, making insurance markets work for all is a crucial step on the road to real reform, the kind of reform your committee has long sought and that our Nation desperately needs. I hope this testimony is useful and I remain, as always, eager to answer any questions.

Senator BINGAMAN. Thank you very much.

Dr. BAICKER.

STATEMENT OF KATHERINE BAICKER, Ph.D., PROFESSOR OF HEALTH ECONOMICS, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT AT THE HARVARD SCHOOL OF PUBLIC HEALTH, CAMBRIDGE, MA

Ms. BAICKER. Thank you.

[8] For further information on my thoughts about a competing public plan, *see*: Len M. Nichols and John M. Bertko, "A Modest Proposal for a Competing Public Insurance Plan," *New America Foundation*, March 2009.

[9] Health Policy Program, "The Case for Health Reform," *New America Foundation*, 2009.

It is an honor to be here to talk with you about the crucial issue of making our health markets work better. Our system should provide both high-quality care and high-value insurance, and those aren't necessarily the same thing, although they are surely related.

High-value healthcare would end the overuse of intensive procedures of questionable value and the under use of procedures of high health value and usually low intensity that we see in varying degrees across the country. There are parts of the country that spend two or three times as much money as other parts to deliver care that is of no higher value to the recipients.

High-value health insurance would deliver protection against the risk of needing expensive healthcare not only this year, but against the risk of developing conditions that would require much more expensive healthcare in years to come. Market reforms can make that kind of high-value health insurance more widely available to everyone, but they work best when everyone gets insured early because insurance is about that risk.

We don't need health insurance because healthcare is expensive. We need health insurance because healthcare is uncertain and expensive, and that is when we value health insurance the most.

Health insurance can do a good job in the private market of redistributing money. If you want to redistribute money to high health risk people, you need to also include a bundle of social insurance to wrap around private market insurance, and that social insurance need not be socialized. It can be a risk-adjusted voucher or other mechanism to ensure that vulnerable low-income, high-risk populations also have access to the lifesaving healthcare that their insured counterparts enjoy.

Thank you.

[The prepared statement of Ms. Baicker follows:]

PREPARED STATEMENT OF KATHERINE BAICKER, PH.D.

My name is Katherine Baicker, and I am a Professor of Health Economics in the Department of Health Policy and Management at the Harvard School of Public Health. I would like to thank Senator Kennedy, Senator Enzi, and the members of the committee for giving me the opportunity to speak today about how we can address the crucial policy challenge of health insurance market reform. This testimony is derived in large part from recent academic work with my colleague Amitabh Chandra that appeared in the journal *Health Affairs*. I summarize that work here.

This morning I would like to discuss several general principles about the nature of health insurance. Misunderstandings about these principles have the potential to impede the development of a much-needed consensus on how to engineer reform. Uncovering the kernels of truth that underlie these misperceptions can help focus reform efforts on the critical challenges facing our health system.

A key distinction should be made between health care and health insurance. Insurance works by pooling risks: many pay a premium up front, and then those who face a bad outcome (getting sick, being in a car accident, having their home burn down) get paid out of those collected premiums. The premium is the expected average cost of treatment for everyone in the pool, not just the cost of treating the sick. Because not everyone will fall sick at the same time, it is possible to make payments to those who do fall sick even though their care costs more than their premium. This is also why it is particularly important for people to get insured when they are healthy—to protect against the risk of needing extra resources to devote to health care if they fall ill.

Uncertainty about when we may fall sick and need more health care is the reason that we purchase insurance—not just because health care is expensive (which it is). Many other things are expensive, including housing and college tuition, but we do not have insurance to help us purchase them because they are not uncertain in the way that potentially needing very expensive medical care is. The more uncertainty there is, the more valuable the insurance is.

THE PROBLEM OF THE SICK AND UNINSURED

Insured sick people and uninsured sick people present very different issues of public policy. People who have already purchased insurance and then fall sick pose a particular policy challenge: insurance is not just about protecting against unexpected high expenses this year, but also about protecting against the risk of persistently higher expenses in the case of chronic illness. This kind of protection means that once insured, enrollees' premiums would not rise just because they got sick, but this is not always the case today. In fact, insurers have an incentive to shed their sickest enrollees, suggesting a strong role for regulation protecting them. Nor are insurers held responsible when inadequate coverage raises the costs of a future insurer, such as Medicare for those over 65. These problems highlight the limited availability of true long-run insurance offerings, a reform issue that is often glossed over in the conflation of health care and health insurance.

Uninsured Americans who are sick pose a very different set of problems. They need health *care* more than health *insurance*. Insurance is about reducing uncertainty in spending. It is impossible to "insure" against an adverse event that has already happened, for there is no longer any uncertainty. If you were to try to purchase auto insurance that covered replacement of a car that had already been totaled in an accident, the premium would equal the cost of a new car. You would not be buying car insurance—you would be buying a car. Similarly, uninsured people with known high health costs do not need health insurance—they need health care. Private health insurers can no more charge uninsured sick people a premium lower than their expected costs. The policy problem posed by this group is how to ensure that low-income uninsured sick people have the resources they need to obtain what society deems an acceptable level of care—and ideally, as discussed below, to minimize the number of people in this situation.

This highlights one of the many reasons that health insurance is different from car insurance: the underlying good, health care, is viewed by many as a right. Furthermore, we may want to redistribute money from the healthy to the sick, in the same way that we redistribute money from the rich to the poor. This kind of redistribution is fundamentally different from private insurance—it is social insurance, and it is hard to achieve through private markets alone.[1] Medicare, which insures the aged and disabled, is an example of a social insurance program. Private markets can pool risk among people starting out with similar health risks, and regulations can ensure that when some members of those risk pools fall ill, insurers cannot deny them care or raise their premiums, but transferring resources to people who are already sick and uninsured or transferring resources from lower health risk groups to higher health risk groups requires social insurance.

How then do we provide the sick and uninsured with socially acceptable care? Private health insurance alone is unlikely to achieve this goal: no insurer will be willing to charge a premium less than an enrollees' likely health costs. Instead, they could be provided with health care directly or a premium subsidy equal to their expected health care costs. Alternatively, we could force sick people and healthy people to pool their risks, such as through community rating coupled with insurance mandates (to preclude healthy people from opting out of subsidizing sick ones). These kind of transfers are based on social choices about redistribution.

The advantage of social insurance programs, including a nationalized health care system, is that they can achieve redistribution that private markets alone cannot. They may also provide benefits with lower administrative costs (although, in the case of moving to a single payer system, the size of administrative savings relative to overall health care cost growth is likely to be small).[2] There are, of course, costs associated with social insurance programs as well. First, there is the drag on the economy imposed by raising revenues to finance them. Second, there is the loss of competition, diverse offerings for diverse preferences, and market discipline that private provision brings—and that promote higher value and innovation. This means that the social insurance program may be both expensive and inefficient—and thus impose an even larger burden on already strained public budgets. These pressures have, perhaps unsurprisingly, spawned additional misconceptions that suggest that the costs of expanded insurance are lower and the benefits higher than the data support.

THE COST OF COVERING THE UNINSURED

A common and deceptively appealing argument for expanding insurance coverage is that we could both spend less and achieve better health by replacing the inefficient emergency room care received by the uninsured with an insurance plan. Unfortunately, this argument finds little empirical support. ER care for the uninsured is indeed inefficient and might have been avoided through more diligent preventive

care and disease management. Diabetes treatment is a good example; it is much cheaper to manage diabetes well than wait for a hospitalization which requires a leg amputation. Having health insurance may lower the costs of ER and other publicly provided care used by the uninsured through better prevention and medical management. But empirical research also demonstrates that insured people consume more care (and have better health outcomes) than uninsured people—so universal insurance is likely to increase, not reduce, overall health spending.[3]

Why does insurance cause greater consumption of health care? Insurance, particularly insurance with low cost-sharing, means that patients do not bear the full cost of the health resources they use. This is a good thing—having just made the case for the importance of the financial protections that insurance provides—but comes with the side-effect of promoting greater consumption of health resources, even when their health benefit is low. This well-documented phenomenon is known as "moral hazard," even though there is nothing moral or immoral about it. The RAND Health Insurance Experiment (HIE), one of the largest and most famous experiments in social science, measured people's responsiveness to the price of health care. Contrary to the view of many non-economists that consuming health care is unpleasant and thus not likely to be responsive to prices, the HIE found otherwise: people who paid nothing for health care consumed 30 percent more care than those with high deductibles.[4] This is not done in bad faith: patients and their physicians evaluate whether the care is of sufficient value to the patient to be worth the out-of-pocket costs. The increase in care that individual patients use because of insurance has even greater system-wide ramifications. R&D in new medical technologies responds to the changes in aggregate incentives driven by health insurance. While these technologies may improve welfare, they also raise premiums because of larger armamentarium of treatments available to the sick. There is evidence of these system-wide effects: when Medicare was introduced in 1965, providers made spectacular investments beds in high-tech care, and hospital spending surged over 25 percent in 5 years.[5]

Even increases in preventive care do not usually pay for themselves: in general prevention is good for health, but does not reduce spending. Some preventive care has been shown to be cost-saving—such as flu vaccines for toddlers or targeted investments like initial colonoscopy screening for men aged 60–64—but most preventative care results in greater spending along with better health outcomes. Indeed, some money spent on preventive care may not only cost money, but may be no more cost effective than some "high-tech" medical care. For example, screening all 65-year-olds for diabetes, as opposed to only those with hypertension, may improve health but costs so much (about $600,000 per Quality Adjusted Life Year) that that money might be better spent elsewhere.[6]

All of this suggests that insuring the uninsured would raise total spending. This doesn't mean that it would not be money well spent (which I believe it would be). Spending more to attain universal insurance is not a problem if it generates more value than it costs, and the view that health care is a right is not inconsistent with this framework. First, and sometimes overlooked, is the security that insurance provides against the uncertainty of unknown health care expenses. The value of this financial smoothing alone is estimated to be almost as much as the cost of providing people with insurance.[7] Second, much of the additional health care that the newly insured would receive is likely to improve health. (But this is by no means automatic, for as discussed below, being insured is not enough to guarantee good health care.) Extending health insurance coverage is worth it for these reasons—but not because it would save money.

GETTING HIGH-VALUE CARE

Having insurance may increase the quantity of care patients receive, but it is no guarantee that they will receive high quality care. A recent study found that Americans received less than 60 percent of recommended care, including preventive, acute, and chronic care, and including such low-cost interventions as flu vaccines and antibiotics for surgical patients.[8] Beginning with the work of John Wennberg at Dartmouth, an immense literature in medicine and economics has found that even among Medicare enrollees, there are enormous differences in the quality of care received: in fact, in areas where the most is spent on Medicare beneficiaries, they are the least likely to get high quality care. The use of mammograms, flu-shots, beta-blockers and aspirin for heart attack patents, rapid antibiotics for pneumonia patients, and simple laboratory tests to evaluate the management of diabetes are all lower in higher-spending areas.[9] Higher spending is not even associated with lower mortality, which suggests that more generous insurance provision does not necessarily translate to better care or outcomes.

When these results showing the lack of relationship between spending and quality were first reported there were two predictable responses by skeptics: that high spending areas had sicker patients who were (appropriately) less likely to receive these therapies, and that patients in high-spending had higher satisfaction even if their measurable health outcomes were the same. Neither claim is supported by the evidence.

What, then, do patients in high-spending areas get? Evidence suggests that this higher intensity is driven by greater use of procedures with questionable clinical value—that may even be associated with under-use of high value, less-intensive care. Patients in high-spending areas are no more likely to receive surgery, but see more specialists more frequently, have more diagnostic and imaging services, and get more intensive care in the end of the life—none of which has been shown through clinical trials to improve health.[10] "Coordination failures" in delivery may both raise costs and lower quality, even among the insured.

Thus, while health insurance increases the quantity of care patients receive, being insured alone is not sufficient to ensure high quality care. Insuring the uninsured will give them access to the sort of health care that the rest of us receive: a combination of valuable care, overuse of some costly interventions with little proven benefit, and under-use of some vitally important therapies, care that is sometimes coordinated but often fragmented. This is better than no care, but it highlights the problem of collapsing the entire debate about U.S. health care reform down to the issue of uninsurance: health insurance alone does not guarantee good health care.

THE ROLE OF EMPLOYERS

Employees ultimately pay for the health insurance that they get through their employer, no matter who writes the check to the insurance company. The view that we can get employers to shoulder the cost of providing health insurance stems from the misconception that employers pay for benefits out of a reservoir of profits. Regardless of a firm's profits, valued benefits are paid primarily out of workers wages.[11] While workers may not even be aware of the cost of their total health premium, employers make hiring and salary decisions based on the total cost of employment, including both wages and benefits such as health insurance, maternity leave, disability and retirement benefits.[12] They provide health insurance not out of generosity of spirit, but as a way to attract workers—just like wages. When the cost of benefits rises, wages fall (or rise more slowly than they would have otherwise), leaving workers bearing the cost of their benefits in the form of lower wages.[13]

The uncomfortable arithmetic of this wage-fringe offset is seen in other contexts—for example, workers bear the costs of workers compensation, and mandated maternity benefits primarily reduce the wages of women of child-bearing age.[14] When it is not possible to reduce wages, employers may respond in other ways: employment can be reduced for workers whose wages cannot be lowered, outsourcing and a reliance on temp-agencies may increase, and workers can be moved into part-time jobs where mandates do not apply. These adjustments are neither instantaneous nor one-for-one for every person (depending, for example, on wage rigidities, how much individuals value the insurance benefit, and how heterogeneous the employees' income and health are)—a fact that obscures the underlying connection. This also means that the claimed connection between health care costs and the "international competitiveness" of U.S. industry is murky at best: higher health costs primarily lower current workers' non-health compensation, rather than firms' profitability (although the same trade-off cannot operate in retiree health benefits, making their effects more complicated).[15]

Why, then, do we have a private health insurance system based primarily on policies offered through employers? There is a preference in the tax code for premiums paid by employers relative to premiums paid by individuals or direct payments for health care. This tax preference drives both the predominance of employment-based policies and the prevalence of policies with low cost-sharing, because care paid for in the form of higher employer premiums comes at a lower after-tax price than care paid for out-of-pocket. Of course, this tie between employment and insurance comes at a well-known cost: workers who leave or lose a job risk losing their insurance or facing much higher premiums, sometimes forcing them to stay in a job to retain health insurance.[16]

This is not to say that there are not important advantages to getting insurance through an employer instead of on the individual non-group insurance market (especially given the current state of individual market), including better pricing and risk pooling. The employer market is the primary mechanism for maintaining cross-subsidization from low-risk populations to high-risk ones, with tax subsidies adding an

element of social insurance (albeit one that is not particularly progressive).[17] It is these benefits that are the main advantages of access to employer policies, not the fact that employers nominally pay part of the premium.

EFFICIENT INSURANCE

Greater patient cost-sharing could help improve the efficiency of health care spending, but it is not a cure-all. It is certainly true that first-dollar insurance coverage (that is, insurance coverage for the first dollar of health care expenditures or insurance with very low cost-sharing more broadly) encourages use of care with very low marginal benefit and that greater cost-sharing would help reduce the use of discretionary care of questionable value. But there is also evidence that patients underutilize drugs with very high value when confronted with greater cost-sharing (whether because they lack resources or information). Worse, there is evidence that even $5–$10 increases in co-payments for outpatient care can result in some patients getting hospitalized as a result of cutting back too much on valuable care, offsetting the reduced spending.[18] Capping total insurance benefits is also shortsighted and imprudent: not only does evidence suggest that such caps result in adverse clinical outcomes, worse adherence, and increased hospital and ER costs, but the presence of caps means that patients are not insured against catastrophic costs—exactly what insurance is supposed to protect against the most.

There is no reason to think that the optimal insurance structure would look like the typical high-deductible plan. Rather, it might subsidize high-value care such as treatments to manage diabetes or asthma, while imposing greater cost-sharing on care of lower value, such as elective surgeries with limited health benefits. People would choose the insurance plans that offered them the best benefit mix—trading off higher premiums for plans that covered care of diminishing marginal value. Of course, what may be valuable to one patient could be wasteful for another, and the key challenge for "value-based insurance design" policies is to differentiate these cases. Many firms are experimenting with these plans.[19] Focusing exclusively on high-deductible plans that rely on a blunt structure of patient cost-sharing and perfectly forward-looking patients may forestall the development of even more innovative plans.

This does not mean that competition and cost-sharing have no role in driving higher value spending, however. Competition between insurers to offer plans that have the mix of benefits enrollees find most valuable could drive the kind of innovative plans described above. Increased cost-sharing such as that promoted by high deductible policies coupled with health savings accounts can also be an important tool for improving the value of care. As the evidence from the RAND HIE discussed above shows, the low-cost sharing plans fostered by the current tax treatment of health insurance (which look more like pre-paid health care than true insurance) promote the use of care that is of limited health benefit. While most spending is indeed done by people with very high total costs, well-designed cost-sharing programs could still have substantial effects on spending decisions. Most spending is not done in emergency settings, and even limited cost-sharing can have an effect on a substantial share of total spending.[20] This suggests that carefully designed incentives could have a big effect on improving the value of care delivered.

CONCLUSION

We know that our health care system is not delivering the consistently high-quality, high-value care that we should expect. While there are many open questions in the design of the ideal system, with millions uninsured and rising costs threatening to swamp public and private budgets alike, we cannot afford to wait to act.

Focusing on the underlying issues discussed here suggests that the fundamental problems facing our health insurance system are unlikely to be cured by the extremes of either a single payer system or an unfettered marketplace. On the one hand, the unregulated marketplace is unlikely to provide long-run stable insurance. Private insurers will always have an incentive to try to shed their highest cost enrollees, so without regulatory safeguards even the insured sick will be at risk of losing the insurance protections to which they are entitled. Private insurance fundamentally cannot provide the kind of redistribution based on underlying health risk or income that social insurance can. On the other hand, a single payer system does not automatically provide high quality care: the provision of low-value care is as pervasive in the single payer Medicare system as it is elsewhere. Single-payer systems are also slow to innovate—as suggested by the fact that it took Medicare 40 years to add a prescription drug benefit, long after most private insurers had done so. Nor do calculations of the costs of a single-payer system measure the utility loss from forcing people with different preferences into a monolithic health insur-

ance plan. The private facilities that have sprung up in Canada to meet the demands of those who want more health care than the public system provides fundamentally undermine the "single payer" nature of the system.

How one balances these trade-offs is likely driven as much by philosophy as economics, and any reform will involve tough choices between competing values. Serious reforms would focus not exclusively on lowering costs, but on increasing the value that we get from health insurance and health care.[21] Reforms that promoted higher-value insurance could both extend coverage so that more people benefit from the protections that insurance affords and ensure that those protections are secure for those who fall ill. These reforms would not be enough to achieve uniformly high-quality care, however. The frequent failure of the use of best practices and the tremendous geographic variation in the use of costly care of uncertain medical benefit are often obscured in the focus on the uninsured. That many nations, including both the United States and Canada, struggle with these challenges suggests that reforms of the payment system alone are unlikely to solve all of these problems. A comprehensive reform proposal that aimed both to extend insurance protections to those who lack them and to improve the value of care received by those who are insured would be more likely to succeed at each goal than proposals that focused on just one.

Thank you again for the opportunity to meet with you. I would be happy to answer any questions that you might have.

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Senator BINGAMAN. Well, thank you very much.

Ms. Praeger, go right ahead.

STATEMENT OF SANDY PRAEGER, HEALTH INSURANCE COMMISSIONER, STATE OF KANSAS, KANSAS CITY, KS

Ms. PRAEGER. Good morning. Thank you, Senator.

It is always a pleasure to see my own Senator Roberts, and thank you for that nice introduction.

And it is a pleasure to be here, representing the Nation's insurance commissioners. I am optimistic after what I have just heard from this very distinguished panel that there is an awful lot of agreement among the panel members about both the problem and I think some potential solutions.

I just have four points I want to make on behalf of our national association. First, any solution, as we have all said, must address the rising cost of healthcare, and you cannot expect the insurance mechanism, which is the payment system, to fully address the rising cost. I think that is going to require some aggressive action on the part of you all at the Federal level.

Whatever solutions are proposed, we certainly hope that consumer protections will still be in place and enforced at the State level. States have already taken great strides in putting in place patient protection legislation, solvency standards for companies,

fraud prevention programs, and oversight mechanisms that enable us to answer those questions that Senator Brown talked about in his opening comments.

When consumers feel that they are being unjustly treated by their insurance company, it is our insurance commissioners across the country that are on the ground day in and day out with those consumer protections. So we hope that any solution, first and foremost, recognizes those important elements of consumer protection.

It is easy, as we look at solutions, to create an opportunity for adverse selection. We would just obviously caution against that. I think rating reforms are necessary. I also agree that rating based on health status should be eliminated.

I think individuals should be required, all people should be required to have coverage, but there needs to be consistency across markets so that if you have different rating rules at the State level and you have a national plan that does eliminate health status rating, then you will get adverse selection into that national plan, which will make it eventually very costly and unaffordable. So avoiding adverse selection is critically important.

Again, I would just emphasize the importance of preserving a State role in the process. I think we recognize that States alone cannot solve the problem. It will require working collaboratively with the Federal Government on a number of issues—sliding-scale subsidies, for example, for low-income folks.

Assisting us with a reinsurance mechanism for the high-cost utilizers. We have in place the high-risk pools. Congress has helped us through grants back to the States for high-risk pools, but that is another area where certainly State and Federal cooperation and collaboration is important.

And I would point out that our national association has expertise here in Washington ready, willing, and able to assist in hammering out the details of any legislation that is put forward. We have been actively involved with Senator Durbin. His SHOP Act, I think, has some very good components. Several years ago, we were actively involved with Senator Enzi of this committee.

So we want to be a resource. We want to assist. We know the system is broken, and it is time to address it.

[The prepared statement of Ms. Praeger follows:]

PREPARED STATEMENT OF SANDY PRAEGER

INTRODUCTION

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

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

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

STATE EXPERIENCE

States led the way in requiring insurers to offer insurance to all small businesses in the early 1990s, and the Federal Government made guaranteed issue the law of the land in 1996[1] for all businesses with 2–50 employees. Federal law does not limit rating practices, but 48 States have supplemented the guaranteed issue requirement with laws that limit rate variations between groups, cap rate increases, or impose other limitations on insurer rating practices. These rating laws vary significantly in response to local market conditions, but their common objective is to pool and spread small group risk across larger populations so that rates are more stable and no small group is vulnerable to a rate spike based on one or two expensive claims.

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

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

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

KEYS TO REFORM

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

• **Address Health Care Spending.** Any effort to increase access to insurance will not be successful over time unless the overriding issue of rapidly rising health care costs is also addressed. While the health care challenge in this country is generally expressed in terms of the number of Americans without health insurance coverage, the root of the problem lies in the high cost of providing health care services in this country. According to the most recent National Health Expenditures data, health care spending reached $2.2 trillion in 2007, 16.2 percent of GDP and $7,421 for every man, woman and child in the United States.[2] This level is twice the average for other industrialized nations.

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

• **Protect the Rights of Consumers.** States already have the patient protections, solvency standards, fraud prevention programs, and oversight mechanisms in place to protect consumers; these should not be pre-empted by the Federal Government. As the members of this committee know all too well, the pre-emption of State oversight of private Medicare plans has led to fraudulent and abusive marketing practices that would have been prevented under State law, bringing considerable harm to thousands of seniors. In similar fashion, the Employee Retirement Income Security Act of 1974 (ERISA) severely restricts the rights of millions of employees

[1] 42 U.S.C. 300gg–12.
[2] Centers for Medicare and Medicaid Services, National Health Expenditures.

covered by self-insured plans. We urge Federal policymakers to preserve State oversight of health insurance and avoid pre-empting or superseding State consumer protections.

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

• **Preserve a Strong State Role.** Congress must carefully consider the impact of any new Federal reforms on the States' ability to be effective partners in solving the health care crisis. In developing a national direction for health insurance reform, we encourage Congress to preserve the role of the States in tailoring reforms to meet the specific needs of consumers and to promote a vibrant marketplace. We also note that States can, and should, play a key role in deciding how reforms will be phased-in to ensure the least amount of negative disruption.

In addition, the NAIC urges Congress to review current Federal laws and regulations that hinder State efforts to reform the health care system. For example, ERISA curtails consumer protections and supersedes State laws, and inadequate reimbursement payments in Federal health programs have resulted in higher overall costs and decreased access for many consumers. Such Federal policies can limit the ability of States to implement broad market reforms.

CONCLUSION

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

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

Senator BINGAMAN. Thank you all very much.

Senator Hatch has to go to the floor to manage a bill, and so why don't I call on him first for any comments or questions?

Senator HATCH. Well, thank you so much, Mr. Chairman.

We are delighted to have all of you here. You are just wonderful leaders in this area, and we appreciate the time that you have taken to come and discuss these matters with us.

Let me just ask one question before I leave, and that is although the term "enforceable mandate" is often mentioned in our healthcare reform discussions, I have a sneaking suspicion that the definition of the word "enforceable" varies depending upon the stakeholder group.

I would like each one of you to tell us your definition of the term "enforceable individual mandate," if you would?

Mr. WILLIAMS. I will go first. I think, simply put, it is a way by which the Congress, should it choose to implement such a law, would assure that we got everyone into the insurance mechanisms that were deemed appropriate. I think we can look at Massachusetts as one example of how it has been done through the tax system. I think there may be other models that people choose to do as a way to achieve it.

The notion, simply put, is that we have the ability to offer insurance to everyone on a guaranteed issue basis, as long as everyone is in the insurance pool.

Ms. POLLITZ. Senator Hatch, I think in its simplest form, an enforceable mandate is also an entitlement. People are entitled to coverage, and they are obligated to have it. You can certainly track

people's enrollment and have them report on their insurance status throughout the year and then assess a penalty for not complying with that.

I think, more importantly, a mandate is only enforceable if it is reasonable. So, to tell people that they need to go out and buy an insurance policy, which will be expensive, you need to make a lot of subsidy money available. Health insurance, good health insurance that covers people when they are sick is always going to be expensive, even if we succeed beyond our wildest dreams in cost containment.

It will always be expensive, and I have had cancer. It is expensive to be sick. And to have coverage that pays those bills will cost a lot of money. So people are going to need help to afford good coverage, and I think they are going to need assurances that the coverage will really take care of them.

That is why I think transparency and accountability throughout the marketplace, policies that are simple, that are understandable, that are straightforward, that behave, that pay claims when they are supposed to, that don't accidentally lose people along the way once they start making claims—all of that needs to be provided for as well for you to have an enforceable mandate.

Ms. IGNAGNI. Senator, I think Mr. Williams and Ms. Pollitz have said it exactly right. We need a mandate that is enforceable so that we can build a system, as you indicate in your opening remarks, that really meets the test of what every American wants, which is it is fair, it is equitable, it is transparent.

Ms. Pollitz is absolutely right that we need to think about subsidies to make sure that people have a helping hand so they can afford coverage. But at the same time, and I know we will get into this discussion, we also need to have a very specific strategy on containing underlying costs, in addition to providing subsidies.

So we agree with both comments that have been made, and we think that with those pieces in place, those building blocks, you can change the rules to be the kinds of rules that the American people are telegraphing they want. We have done a great deal of work, and we are looking forward to talking about that.

It is with that idea of taking responsibility to look at when you change the rules what is possible and under what circumstances, and that is the way our board has proceeded in its activity and a very significantly deep dive.

Mr. NICHOLS. Senator, I believe individual mandate is about having everyone pay their fair share, but no more than their fair share. So there have to be subsidies, as Karen said. But I also think it really is possible to use modern technology to help us enforce it in a way that it might not have been so easy 15, 20 years ago.

Let me give you an analogy from car insurance. I grew up in rural Arkansas, and my brother taught me the time-honored tradition of going to buy your car insurance, register your car, driving home, calling up and cancel your car insurance so you don't have to pay your premium anymore.

Well, it turns out that leads to about half the States not doing such a good job of enforcing car insurance mandates, as you know. It turns out some States have figured this out. Georgia, for exam-

ple, which is not known as a "big brother" place, figured out that the insurer could send an e-mail to the DMV and tell the DMV that Len Nichols just canceled his car insurance, at which point the DMV will mail a letter to the insured and say, "We understand you just canceled your car insurance. You just lost your driver's license. Have a nice day."

So it turns out if you share information in a very feasible way across settings, you can find out who is and who is not paying their fair share. We can enforce this, in my opinion, sir. Look at how Georgia went from 78 percent compliance to 98 percent compliance in 2 years with this kind of technique. You can do this and make it completely enforceable in our world.

Ms. BAICKER. Just a quick note that the lines between the carrots and the sticks that we are talking about are more blurred than one might think that they are. I don't think anyone is suggesting that people who don't comply with an individual insurance mandate should go to jail. The usual penalty is something like not being able to get a tax benefit that you would otherwise be entitled to.

On the other side, if you are trying to design a carrot, the way many of the carrots are designed are giving you a tax benefit if you are insured. So removing a tax benefit if you are not insured versus giving a tax benefit if you are insured might have very similar effects if the dollars at stake are similar, although there are clearly psychological issues.

Placing a mandate really changes the way people perceive the obligation, the responsibility on them. So they could have different effects, but it is not such a bright line, I think.

Ms. TRAUTWEIN. Can I just comment on that real quickly? Because I think all of us think that we have to get everybody into the system if we are going to be able to effectively make these reforms and that they will actually save money. Not to throw a wet blanket on the whole discussion, but I think we have to be realists about how easy it may or may not be to enforce a mandate.

I agree with Len that we have technology that we haven't had before, but this mandate and making it effective and enforceable is going to take a long time. We have 300 million people in this country. We are not the size of Massachusetts or one of the European countries that have been able to enforce it.

It is not that we don't want to do this. I think we just have to look and see what we need to do during this time in which the mandate is becoming more enforced because we will have to figure this out. There are going to be multiple checkpoints we will have to do.

One of the things that we have talked about in our recommendations is that we have to make sure that there is some system of risk adjustment or modified reinsurance arrangement to make sure that during this time when we don't really have everyone in the system yet that we have adequate means so that we haven't made coverage more expensive and done something that is exactly opposite than what we set out to do.

I just want to mention that it is not that we disagree, but we also need to say, yes, we need to do this, and we also need to do

this other thing, too, just in case it takes us a while to get the hang of it.

Senator BINGAMAN. Ms. Praeger, did you want to make——

Ms. PRAEGER. I just want to add, too, that eventually we have to have everyone insured. We will never get our arms around the rising cost of healthcare if we don't have everyone in the system.

I think Massachusetts has set a good example in terms of their program that phases in the individual mandate. There are some penalties, but the penalties are fairly minor initially. So, any kind of a mandate ought to be phased in, recognizing the impact that it is going to have on individuals and small groups.

I don't think we can mandate people have something they can't afford. So we have to—hand in hand goes both subsidies and cost reduction measures.

Senator HATCH. Mr. Chairman, as you said, I have to leave. But if each of you would take time and just write to us and be even more specific than you have been here. This is a very tough issue, as you know. It is not easy to resolve, although it may be easier than some of us think.

I would like to have each of you take time and give us the best that you can give us on this. I would personally appreciate it very much. I have a lot of other questions, but I will submit them for the record. OK? We hope you can answer all of the questions that we submit.

Thanks so much. I am sorry I have to leave.

Thanks, Mr. Chairman.

Senator BINGAMAN. Thank you very much.

Let me ask one question and then just open it up to anyone else who wants to ask questions here.

This letter, Ms. Ignagni, you referred to the letter that you and the president and CEO of Blue Cross Blue Shield Association sent, and you have this is dated today, sent to Senators Kennedy, Baucus, Grassley, and Enzi, saying that:

> "By enacting an effective and forceful requirement that all Americans assume responsibility to obtain and maintain health insurance, we believe we could guarantee issue coverage with no pre-existing condition exclusions and phase out the practice of varying premiums based on health status in the individual market."

That seems to me to be a significant part of what Dr. Nichols was advocating we need to do in the individual market. Let me just perhaps ask Dr. Nichols if he thinks that gets the job done?

Mr. NICHOLS. Well, sir, first I would have to say the statement that came from AHIP in that letter is such a long way from where we were as a Nation in 1993, we should all take a deep breath and have a round of applause. There is no question about that. This is real progress. I mean that.

I would say it is no question that what we want to do is end health status rating across the board. I would not limit it to the individual market. When you began your remarks, you mentioned the fact that two of our markets aren't working very well. One is small group and the other is individual.When a lot of us with gray in our beard and losing hair on top think about this a long time,

we think maybe there is no better way to get these things fixed than to put them together.

I wouldn't want to have one set of rating rules for the small group market and one set of rating rules for the individual market. In my view, you want to put them together.

The economies of scale are never going to be achievable that we want for everyone if the small group market continues to buy in groups of 10, 20, 7, 4, whatever. So you want to put them all together.

What I would say is it is a great way to start. What you want to do is have a goal of moving toward the end of health status rating across the board. I mean, I would ask Mr. Williams and Aetna, when they do the big employers, which is a large part of their business, as I understand it, they don't do health status rating. They do basically community rating across the board for those big groups.

Why not have the same kind of thing for everybody else? Therefore, we can move to a world where you make a new marketplace for small group and individual, and in that marketplace, you have the same rules for everybody, and the big guys can leave them alone because the big guys are doing fine relative to everybody else.

Mr. WILLIAMS. I would comment on that by saying I think there is a general misunderstanding that small groups are really not rated on their own health experience as a group. They really are part of a small group insurance pool that represents all of the small businesses in that geography that Aetna would aggregate together.

That an individual case has no credibility in an actuary—our underwriter would not attribute the experience of that group to its premium until a group is well over close to 400 employees or so.

When a small group gets an increase, that increase is not the result typically of the health experience of the individuals in that group. It is a reflection of the healthcare cost in that geography for all the small businesses pooled together.

Now I think there are opportunities to create one-stop shopping, and there are other things that we can do working with perhaps the brokers and others, other agencies to simplify the purchase process. But I think there is a misunderstanding about the pooling nature of the small group market.

Senator BINGAMAN. I believe Senator Roberts had a question.

Senator ROBERTS. Dr. Nichols, in your written testimony, you have discussed two options for assuring that all Americans have adequate health insurance benefits. First, a minimum benefits package requirement, which you have just talked about, and then an actuarial value target. Can you tell me who does that? Would that be done by States, or would that be done by something called a national actuarial exchange?

The pros and cons of this, I think, are obvious, but I don't want a national actuarial exchange morphing into a CMS in regards to the insurance industry. Would you care to comment?

Mr. NICHOLS. Sure. Fair question. I would say, Senator, the basic idea behind having a minimum benefit package that specifically specify—let us just take a concrete example of the Federal employees? Blue Cross Blue Shield Standard, which is kind of a bench-

mark that a lot of people know. The idea behind specifying that is to say that is the package we want all insurers to make their initial bid upon so we can compare apples to apples and see how their efficiencies rate.

Then the idea, at least in my head, is to allow insurers to offer supplements above that as long as they are priced separately. An alternative way to think about setting that minimum benefit package to permit apples-to-apples shopping is instead of saying Blue Cross Blue Shield Standard with its specific deductibles and its specific co-pays and all that stuff, allow insurers to offer another plan that would be actuarially equivalent.

You could say the actuarial equivalence of Blue Cross Blue Shield Standard, but that would, for example, allow people who wanted to offer higher deductibles with different kinds of health savings accounts arrangements. It would allow HMOs that might want lower deductibles and more access to care, but they expect to do more care management. It allows the marketplace in many ways to breathe.

What I believe and my actuarial colleagues have convinced me is that if we define that actuarial target appropriately enough, sir, it would allow the marketplace to actually be more competitive and allow more freedom of choice with some risk of adverse selection being created. However, if you define the target appropriately, most actuaries I know, the people I listen to, believe it is actually manageable. So that is the idea.

The idea is not to impose some standard from God. I would suggest that, in fact, what you want is——

Senator ROBERTS. I wouldn't refer to CMS as God.

Mr. NICHOLS. Well, neither would I. Sorry about that.

Senator ROBERTS. Well, you might have it sort of described in between there with some words in between God, but that is beside the point.

[Laughter.]

Mr. NICHOLS. I will let you go ahead. But what I would say is—what I believe you want, sir, is a set of Federal rules about the way all markets will work. But I could not agree with my colleague Sandy Praeger more. It has to be enforced at the State level, and you probably want to let States have some breathing room out there.

Senator ROBERTS. Well, that was my next question. I just don't—pardon me for the noise. A Federal one-size-fits-all approach to this issue, we have to preserve State flexibility, consumer choice. To be frank with you, the rural healthcare delivery system, Senator Coburn knows this—Dr. Coburn knows this firsthand. I am just trying to save what we have and improve upon it.

But every provider out there is getting reimbursed 70, 80 percent, and then choices are being made in regards to Medicare that are not good. We are rationing healthcare, and it scares me when we get into the individual mandate stuff.

So thank you, sir.

Senator BINGAMAN. Thank you.

Senator BROWN.

Senator BROWN. Thank you.

Mr. Williams, your comments about fee-for-service and the difficulty of the cost of fee-for-service took me back to something Senator Harkin said at the White House summit on healthcare, where he said that you pay for quantity, you get quantity. You pay for quality, you get quality.

Would you each talk about how we can manage costs better than we have? That it is pretty clear we—Doctor, I remember my first year in the Congress was 1993, and we brought in an orthopedic surgeon to speak to the Subcommittee on Health in the Commerce Committee, which I sat on. And he said,

> "If I have 10 people come to see me with lower back pain, what I should do is say take a couple of aspirin, go home, get some rest, come back in 2 weeks if you still have pain."

He said,

> "But what I do is I order tests. I order tests for three reasons. One is I make more money if I order tests. Two, if I don't order tests, I might get sued. And three, if I don't order tests, the patient will go to another doctor."

It is a bit simple, but not too far off perhaps.

Just your comments generally, Mr. Williams, since you have made me think of it. Start with you, but I would like to hear all of your thoughts on when you pay for quantity, you get quantity.

Mr. WILLIAMS. Well, I think that there is a huge opportunity to re-align the incentives in the system, both at the physician level as well as at the member level. What I mean is that the best investment we can make is in how we manage the chronic conditions—the asthma, the diabetes, the hypertension. Because the most effective thing we can do is avoid the health event so that we don't have to pay for the activity.

What we need is a healthcare system that emphasizes primary care, emphasizes prevention. If you look at the way the values are set for what physicians are paid, the system that has been put in place utilizes something called the RUC Committee. It is a committee of the AMA that operates under legislation of Congress, as I understand it.

That committee has 26 physicians on it. Twenty-three of them are specialists, and three are primary care. What happens is the reimbursement for primary care is at the low end of the spectrum, and the reimbursement for procedures is greater.

What that means is as a system we are not paying primary care, family practice, pediatricians to invest the time to help the patient understand their condition and stay healthy. So we need to change the system in terms of paying for activity to really paying for more managing of the population.

I think also we do have to address the tort reform issue in the sense that we need to recognize bad things do happen. People need to be compensated. But replacing a physician in the place, as your colleague described, they are going to be put on the witness stand and asked, "Was there any other test you could have conducted, no matter how remote the indications were for that patient?"

And that physician wants to say, "No, I did every conceivable test." And that drives cost.

So, we need to think about the evidence base, the guidelines, and give physicians some way to say that they are practicing consistent with evidence-based guidelines and applying their own clinical judgment. That if something bad happens, there is a way, through health courts or other mechanisms that States have come up with, to give us an opportunity to deal with that.

Senator BINGAMAN. Ms. Pollitz.

Ms. POLLITZ. Senator, I think that was very excellent, and I would add that we need to also look at some very basic design elements of our insurance policies with respect to chronic conditions. We have to remember that people who have chronic conditions use care all the time for a long period of time, sometimes for their whole lives.

Research shows that even little co-payments, things that we would think—you know, $6 co-payments for a prescription—will confound the ability of many patients with chronic conditions—diabetes, asthma, arthritis, depression—of taking the drugs that they need. They don't fill their prescriptions as often. They split pills. They get by. Because it is not just $6, it is $6 times 3 prescriptions that they have to fill every week.

We need to really focus, I would agree very much, on chronic conditions. That accounts for 75 percent of our medical spending. We need to take down barriers, including barriers that we build into our insurance policies, and not keep dinging people a little bit here, a little bit there. It really adds up.

I think we need to examine, back to Senator Roberts's question, when we look at the design of our health insurance policies and what should be covered and what is minimum credible coverage, in addition to any actuarial standard that we may decide upon that we feel sort of lives within our overall budget goals—I know this is going to be hard to afford. We need to line up those policies against what the very specific care needs will be for people who have chronic conditions and say how much are they going to be left to pay out-of-pocket?

If it gets very high, we need to recognize the fact that they won't be able to manage their conditions. However much we may pay doctors to try to do a better job, they just won't be able to afford the cost sharing.

Senator BINGAMAN. Senator Coburn.

Oh, did you have more? Oh, go ahead.

Senator BROWN. I wouldn't mind hearing from others, if that is OK?

Senator BINGAMAN. Yes, you could give a brief answer so we could get on to that other question, too.

Ms. IGNAGNI. Yes, sir. I think Senator Brown has asked a very important question. And quickly, there are three buckets I think you want to look at.

A number of the stakeholder groups have been working together on quality performance and how we can make recommendations to all of you. We have conferred with your staff about how you map all of this, and so I won't spend too much time, but to say there needs to be uniformity of performance measurement so physicians and hospitals aren't frustrated that many different payers, whether public or private, use different systems.

They need to be very oriented toward what are the goals, what are we measuring, No. 1? One bucket.

No. 2, there is a very significant need to—there has been underinvestment in research. The Institute of Medicine has repeatedly pointed to this. This is very important as we transition to a 21st century system. How do we get that research diffused into practice? That is a second issue in that bucket.

Third bucket——

Senator BROWN. Is that comparative effectiveness?

Ms. IGNAGNI. Well, it is not exclusively comparative effectiveness. Comparative effectiveness will talk about the effectiveness of drug-to-drug, drug-to-device, drug-to-bio, drug-to-therapy. What the investment in research, in addition to what I am talking about, is that the Institute of Medicine has pointed to gaps in research in specific areas.

So we need to have not just more evaluation of what works. That is very, very important. But in addition, research the gaps in evidence. How do we get the best practices, that the professional societies are coming up with, very importantly diffused into practice? Atul Gawande has talked about an "institute of best practice." There are many things in that area.

Third bucket—and I know, Senator, you want to move on, so I will be very quick about this—the whole idea of moving away from paying for a particular body part to be treated. Bundling services, episodes, global payments, capitation, a range of issues that were brought out in the 1990s, and from a health plan perspective, we understand what caused abrasion with physicians in the 1990s. And we have worked very, very hard.

Now in the area of imaging, for example, you have physician-to-physician conferring about what is being ordered and what would be better based on physician practice guidelines. There is much more sophistication about this. That is just one example.

But care coordination, as Karen said, is—Ken Thorpe has done terrific work here—how we can bundle things more effectively, do early intervention, keep people healthy. So I know, Senator, you want to move on, but those are just the highlights of the buckets, and we could provide more information.

Mr. NICHOLS. I will be very brief as well. I just wanted to point out there are two dimensions I would say, and I agree with everything that has been said so far, on how to reduce cost.

In the insurance case specifically, if you outlaw underwriting and aggressive risk selection and you make it not profitable, they will stop it. When they stop it, you will get money back.

The difference between a premium and the claims costs, that is to say medical gloss ratio, is made up of a lot of activities, all of which are designed to make money for the company or help it break even. If you take away that incentive to do that, that will save a bunch of money.

That is a fundamental difference between their load, by the way, in a large employer and a small employer. Ron is right. They don't risk rate individual employers when they are small, but they do put them into classes. There are a bunch of classes.

What is interesting is the load they pay in that small group market is much higher than in the large group market. What we want to have is a country where all of us get the large group load.

The second way is everything Karen just said about buying smart. The way I would put it, we want to re-align incentives so that hospitals and clinicians, and I mean across all sites of care, including drugs and devices, all of them should be aligned with the payers and the patients. We want high-quality care the first time, the best kind of care the first time. We want everybody to pay their fair share, but we want the docs and the hospitals to have the same interest in achieving that level of efficiency. To do that, you have to bundle.

There are a lot of experiments going on right now. A lot of us are thinking about this really hard. A lot of smart people are working on it. I would just tell you to stay tuned. But I do think you have to move toward paying for a bigger bundle of services than not.

Senator BINGAMAN. Senator Coburn.

Senator COBURN. Thank you.

First of all, let me thank you for being here. There are a lot of approaches for us getting to where we have a broad insurance market. I am convinced we don't have a market today. I don't think there is one that is really out there.

The idea of stopping cherry-picking. If, in fact, we had a real transparent market, a truly transparent market where everybody could see, and we had true risk adjustment based on a penalty, based on what that risk is, why would that not work in terms of averaging out the cost to everybody and averaging away from the cherry-picking? Having real interest where we spread the cost of this all over everybody, including the highly sick and the highly well, why would that not work?

Ms. BAICKER. Let me give a 30,000-foot view and then let the experts weigh in. One of the reasons the small and nongroup market, I think, works so badly is the different risk rating that goes on in large groups versus small groups. If there is an opportunity for low-risk people to move across markets and see their premiums drop, then you have a devolution of risk pooling that is always churning underneath.

How could you avoid that? Well, if each individual person were paying his or her expected costs, and sick people were paying a lot more and healthy people were paying a lot less, you wouldn't have any incentive for insurance companies to cherry-pick, and you wouldn't have any churning between markets. But we don't find that acceptable because we don't want sick people to have to pay a lot more for their healthcare than healthy people.

There are ways to get around that, such as the risk-adjusted vouchers I mentioned, where individuals are contributing the same amount to their healthcare regardless of whether they are high or low risk. But then insurers are getting paid more if they have a sicker pool and less if they have a less sick pool.

Senator COBURN. That is what risk adjustment does.

Ms. BAICKER. Exactly. That, I think, would both undo the incentive for cherry-picking and would also undo the pressure that destabilizes market pooling. That could be done through side pay-

ments between insurers, or it could be done more centrally through public funds being paid out to higher risk groups and taxes being levied on lower risk groups.

Senator COBURN. OK.

Senator BINGAMAN. Anyone else want to comment on that?

Mr. WILLIAMS. Yes, I would just comment briefly. I would first say that I think that there is an insurance market, particularly in the commercially insured sector where we have 177 million people in that sector and where the purchasers are incredibly innovative.

For example, one of the things that we are working on with our clients is a value-based insurance design that recognizes that for a person who has cancer, their medication has a very different implication for them than someone who is taking a convenience drug that you can do without based on their physician's judgment.

And for the patient who needs that medication, their co-pay may be zero. In some instances, we have clients we are thinking about paying them to take the medication. So, the level of innovation that goes on in the commercial sector is much greater than goes on in other sectors.

I think transparency is enormously important. But I think we focus a lot on transparency in the insurance component of the sector, but consumers need transparency at the physician's office.

Mr. NICHOLS. You bet.

Mr. WILLIAMS. They need it in the hospital. For example, at Aetna, any one of our members can go online and find out what the Aetna negotiated rate is for their physician and understand what they are going to pay for those top 30 procedures before they go see the physician.

Now we also would love to enrich the level of quality data that we have, but we do believe there should be national standards and should be easy for physicians and quality data that physicians believe is clinically meaningful.

I think what you miss is the level of innovation I mentioned. We have spent, one company, $1.8 billion, which is almost 10 percent of the entire amount that we are committing to health IT in the country. And so, the question of what do for-profit companies do?, we invest in innovation that really is about managing healthcare.

Two-thirds of our customers are self-insured Fortune 100 companies who very much have a population, long-term point of view. Their interest is, I have the employee now. I am going to have them mid-career, and they are going to work for me up until they retire. And so, there is just an enormous amount of innovation that goes on that would be missed.

Senator COBURN. Well, let me just say in follow-up we spend twice as much as any nation per individual on healthcare. The closest to us is Switzerland. They are 25 percent below us. I don't think we need to put another dollar into healthcare. What I think we need to do is let market forces truly work, and we can do that through universal access. We can have everybody covered, and we can still get great quality healthcare.

The idea of adding another $80 billion or $90 billion a year to enhance that, all that was going to do is make our problem worse. It is not going to make it better.

I appreciate so much the idea that we have incentivized subspecialization in this country to a lot of benefit. There is no question. But we have disincentivized primary care to a tremendous disbenefit to everybody in this country. We are never going to get the prevention dollar savings until we start incentivizing primary care.

Senator BINGAMAN. Senator Merkley.

Oh, yes, did you want to make a comment on that?

Ms. IGNAGNI. Could I just make one comment? I think Senator Coburn said something very important here, and one of the issues we have been working very closely with is the specialty societies are the primary care area, and it is very clear that there are shortages of slots in medical schools for primary care physicians. There aren't enough medical students going into primary care.

The one thing the committee might consider as it constructs its recommendations is giving very significant help, if not free tuition, for the best kids to go through in primary care, a sort of National Merit Scholar Program.

Senator COBURN. That doesn't solve the problem. Here is how you solve primary care: you pay them what they are worth. You pay for prevention. We have a pay differential where a pediatrician makes a third of what the average physician in this country makes.

Ms. IGNAGNI. I agree.

Senator COBURN. If you want people to go into pediatrics, you have to pay them.

Ms. IGNAGNI. I agree. We totally agree with that.

Senator COBURN. That means you may have to decrease some on the top side.

Ms. IGNAGNI. Right.

Senator COBURN. But to incentivize them to go there, when they are not going to be able to pay the med school loans afterwards, they are not going to stay there. That is what happens. We have internists all the time. Two percent of the medical school graduates this year went into primary care. That is 1 in 50. Forty-nine went into specialization or subspecialization, and it is going to accentuate our costs. It is going to drive the costs higher, much like the orthopedics.

Ms. IGNAGNI. Senator, you just hopped in right before I took the breath to say exactly what you did, which is that I think you could attack this on two ends very productively. But a small investment in the beginning of the pipeline could help considerably, in addition to exactly what you have just said.

Senator COBURN. We did it with the stimulus package. The fact is, it is not going to work until you make payment equitable.

Ms. IGNAGNI. We have to make payment equitable.

Senator BINGAMAN. Senator Merkley.

Senator MERKLEY. Thank you very much, Mr. Chair.

Some of you have touched on this, but I want you to try to address it straight on. That is incentives or adjustment in the structure of insurance related to health smart behaviors.

We had the CEO of Safeway here a few weeks ago, and he has really been driving the concept in their organization of addressing issues of smoking, of weight. I believe exercise was somehow incorporated into the model.

Individuals see financial rewards, if you will, for behavior that reduces the healthcare impacts, thereby making their quality of life higher and the costs for the organization much lower. I just wonder if you all would like to address the appropriateness of this in a broader healthcare strategy?

Ms. POLLITZ.

Ms. POLLITZ. I would absolutely agree that prevention and wellness is an overwhelming public health issue, goes way beyond the bounds of insurance coverage. Having worked in my younger days at the Department of Health and Human Services and having come to appreciate the unsung heroes in the Public Health Service and how difficult it is to promote public health, I think the more you can invest in that, the better.

I would add, though, that you will need to be very careful, and here is another area where accountability and transparency in your insurance products is going to come into play. You are going to need to be very careful about designing insurance products in ways that promote wellness or penalize non-wellness.

The Bush administration rewrote the rules. Congress passed a rule in 1996 that said group health plans may not discriminate against members based on their health status. Everyone in the group is the same. They get treated the same. They get the same benefits. They pay the same.

There was a small exception for modest premium surcharges or discounts that could be provided for wellness, but those were very much hemmed in. So that you could get a discount, for example, a wellness discount on your insurance premium if you took a smoking cessation class, but not only if you could quit smoking. Because they didn't want to kind of cross the line into treating people differently based on how healthy they were.

The Bush administration rewrote those rules and said that now group health plans can have penalties as big as 20 percent of the entire cost of the health insurance premium for people who not only don't enroll—who enroll in wellness programs, but who actually meet healthcare targets.

Days after this regulation took effect, new products came on the market that offered to small employers now who had been buying, say, a $500 deductible for their group, to give them a $2,500 deductible and then require all the employees to come in for a health screen. And every time you pass a test, you get a $500 reduction in your deductible.

So if you reduce your blood cholesterol, if your body mass index is the right amount, if you don't use tobacco products, if your blood pressure is not high, then you get a low deductible. But if you can't pass those things, now you are in a $2,500 deductible.

The effect of that is to split up the pool, and it puts the sick people in the high deductible plans, and it puts the healthy people in the low deductible plans. That may be a wellness incentive, but it also makes it hard for people who have high cholesterol all of a sudden to afford their cholesterol medication because it is subject to a $2,500 deductible.

When you look at the Web site of the company that is offering this, right on their Qs and As for employers, how can you save money with this? It says some of your sick people will go some-

where else. They won't like it. They will sign up for their spouse's plan that doesn't have this.

I think we want to create opportunities for wellness. Many, many opportunities for wellness. Make it hard for people to not lead healthy lives. But we want to be very careful about penalizing them in their health insurance and in particular in their deductibles and co-pays and charging them more when they get sick because that has now crossed a line into discrimination, and it is going to be counter to good public health.

Senator BINGAMAN. Ms. Praeger, did you want to comment?

Ms. PRAEGER. I would like to comment on that because it does go back to the re-alignment of payment incentives. A primary care physician can be a great partner in helping a person achieve wellness, but they get no reimbursement. They get no reimbursement for spending the time that would be necessary to help counsel that person.

So re-aligning the payment mechanism I think is one of the real keys to achieving some overall—maybe not cost reduction, but certainly slowing down this escalating rising cost where the payment incentives are just——

Senator BINGAMAN. Ms. Ignagni.

Ms. IGNAGNI. Yes, Senator, the plans in your area that I know you know have been doing path-breaking work with primary care physicians. They are paying them significantly over the Medicare rates to actually take responsibility to help coordinate the care and support these healthy choices.

There is great data. So we would be happy to provide it to you. But you have some path-breaking things going on in your State that you should be very proud of, particularly in the area of Medicare Advantage.

Senator BINGAMAN. Mr. Williams and then Ms. Trautwein.

Mr. WILLIAMS. Just a couple of comments. I would agree wholeheartedly that this area is a slippery slope. But I think that we see a tremendous level of enthusiasm among the employer community to implement well thought out, appropriate programs. I can tell you from our own experience with 36,000 employees, our medical costs went up 3 percent last year.

The reason it went up only 3 percent was because our employees engage in wellness and fitness strictly on a voluntary basis, and each employee had an opportunity to earn an incentive based on their participation in exercise and wellness and fitness and really doing things that they were very comfortable with. Strictly voluntary basis.

We see this among a large number of employers, and I think given the obesity epidemic we have in the country and the tremendous problems with chronic conditions, it is very important.

Now one final comment is, again, another example with innovation. We are working with five large employers and with President Clinton's foundation and actually working with pediatricians so that children who are obese do not have to be diagnosed with a particular health condition in order for Aetna to pay for nutritional counseling, extra income for the pediatrician, and counseling sessions for the family with the dietician so that the family can have the dietician who is culturally appropriate to their background and

can help them figure out what they need to do. It is another example of innovation really tackling what we all, I think, would agree is a fundamentally important problem.

Senator BINGAMAN. Ms. Trautwein, and then Senator Burr had a question.

Ms. TRAUTWEIN. I just want to mention one more thing on the wellness and just to add on to what everyone else has said here.

You can set up these wellness programs, and most of them are set up based on a patient deciding what their own objectives are, and any rewards that they might receive are based on the plan that they have put together. So certainly someone that is in a wheelchair will have different objectives than someone who runs marathons, and that is critically important to know that the plan is not the same for everyone.

Now I really don't think that we do enough to encourage employers today to put these programs together. I think our incentives should be greater, not less. That they should be able to provide bigger incentives, and some of them have nothing to do with insurance. There are all kinds of things that employers can do, and I think engaging employers is the key to making this whole thing work because, in fact, that is where most of the people are every day.

Senator BINGAMAN. Senator Burr.

Senator COBURN. Mr. Chairman.

Senator BINGAMAN. Yes?

Senator COBURN. Will we be allowed to submit written questions?

Senator BINGAMAN. That is fine with me, if the witnesses are willing to answer them.

Senator COBURN. Thank you.

Senator BINGAMAN. I think it is a good idea.

Senator Burr.

Senator BURR. Thank you, Mr. Chairman. More importantly, thank you for taking some written questions because I certainly have more than the chairman seems scheduled to take.

Let me just make a comment on this last question, and that is that individuals who receive some benefit participate in wellness and prevention programs at a much higher rate. Self-insured employers have proven it, and they don't have to be punitive in the way they apply it.

But if you want prevention and wellness to be a centerpiece of healthcare in the future, then you have to make sure the individual feels the financial benefits of the decisions that they make. It is tough to run 2 miles in the afternoon. But when you see a financial benefit come to you for doing it, you are more inclined to do that and then to diet in conjunction with it because that might benefit the cost of your overall healthcare plan as well.

Now prior to the last two questioners, I was somewhat dumbfounded by the words that I hadn't heard. I read them in your testimony, but I didn't hear them in the verbal testimony—medical home, prevention and wellness. I was beginning to think maybe we were going to miss out on some things that I thought were absolutely staples of reform.

The words that I did hear the most often, subsidies and incentives. That is troubling because it sort of suggests right at the beginning that you can't change the model so it works without subsidies or incentives. I remember when Dr. Coburn and I offered an alternative to the SCHIP proposal a month or so ago that covered all children under 300 percent poverty, and it did it some $100 billion cheaper than the proposal. It didn't pass.

You can, with the right level of creativity, offer expanded coverage from the standpoint of the population and do it for less money. But you have to be willing to change what you are willing to try to achieve and how you are willing to structure that.

I want to move to Ms. Pollitz for just a minute because I think if I heard you correctly, you insinuated that co-payments, especially as it related to chronically ill patients, would alter whether they would get care. It may force them to get less care. It may force them not to get the preventive care that they need.

The Rand Health Insurance Experiment found that people that paid nothing for their healthcare consumed 30 percent more than those who had some skin in the game—co-payment, deductible. So how do we balance between what the Rand Corporation went out and found, and that is that when we have no skin in the game, there is a 30 percent higher rate of consumption by those individuals. When you require some degree of responsibility for payment, you begin to have at least less care delivered, and I think their conclusion was, more appropriately, the care that they needed versus the care that they just wanted?

Ms. POLLITZ. Well, I think the finding, Senator, of the Rand experiment was that cost sharing is a blunt instrument, that it deters people from seeking necessary care as well as from seeking care that they could do without.

Senator BURR. Well, as a matter of fact, what it found was a greater consultation with their doctors about the care that they did receive, that it was appropriate, that it was needed, but more importantly, that it would benefit their health outcome. I think that is the conclusion they came to.

Ms. POLLITZ. Well, and to go back to your opening about how much incentives versus how much medical homes, I think you are right. We need to find a balance.

But at the end of the day, once someone has been diagnosed with diabetes, they need to test their blood four times a day. They need to take their insulin and their diabetes medications. They need to have regular physician checkups, labs, eye visits, check their feet. They need these things. This is not optional care. This is what it takes to manage diabetes well.

And when they don't get that, they develop severe and expensive and life-threatening complications. They lose their eyesight. Their kidneys fail. Our ESRD program on Medicare, that is the most expensive healthcare program that is out there when people's kidneys fail, and half the people who are enrolled in that program have diabetes.

So when we try to save money, you know, just pay me a dollar every time for a co-pay for every one of your things, every one of your doctor visits, every one of your medications, all of your diabe-

tes supplies, we are erecting barriers to people getting that care because some just can't—they just can't do it.

I think we need to examine the role of co-payments and financial incentives and say for things that we know are tried and true, or as Mr. Williams said, once somebody gets cancer, I want them to take their antiemetic so that they can complete their chemotherapy course. I don't want them to pay for the cost of $1,000 drug.

Senator BURR. I think what Aetna's experience has been is that once they educate their beneficiaries on why they follow the path that Aetna and the healthcare professional lays out that, No. 1, the outcome is better and, No. 2, the amazing thing is the cost is less. So it actually suggests that if it takes co-payments to get people in a different conversation with their healthcare professional, that is probably a good thing.

Now you did say as well in your testimony that the public plan—I guess it is this public competition that we are talking about with the private sector—should be a tough negotiator. Is Medicare and Medicaid a tough negotiator?

Ms. POLLITZ. Well, Medicaid I think is an example of a strapped program that is underfunded.

Senator BURR. OK, let us just talk about Medicare.

Ms. POLLITZ. It absolutely underpays, and we should fix that. Is Medicare a tough negotiator? Medicare pays what it pays.

Senator BURR. Do we adequately address prevention and wellness in Medicare?

Ms. POLLITZ. Oh, I think we have improved over the years coverage of certain preventive services, but, no, I think we could do a better job.

Senator BURR. Certain preventive services, maybe six of them that we added——

Ms. POLLITZ. Exactly.

Senator BURR [continuing]. In the 1990s, and we fought tooth and nail to get that.

Ms. POLLITZ. Right.

Senator BURR. But when you look at those six services and you talk about prevention and wellness, they fall so far short from a standpoint of what is coverage, and that is a public plan. That is the U.S. Government. That is CMS. That is basically a plan that has been unlimited from a standpoint of what they could spend, but I think an example of a serious flaw in architecture compared to exactly what all of you have described today the architecture of the future.

Mr. NICHOLS. Sir, if I could jump in, I would just say that I agree with you——

Senator BINGAMAN. Why don't you give that answer, and then I will call on Senator Hagan?

Mr. NICHOLS. OK, sir. I agree with you. We have essentially tied Medicare's hands from becoming a very prudent purchaser, a value-based purchaser, and there is a lot of discussion about how to make Medicare a better buyer. But it ends up kind of making your fundamental point that is motivation and incentives are all part of this. But at the end of the day, we need to recognize it is in our interest if the chronically ill get appropriate services early,

and that is really what Karen is talking about. She is talking about ways to try to figure out how do we make that happen.

I remember Ron talking about how in Aetna now they have a product where they are actually going to have zero co-pay for certain things, maybe even pay people to do certain things because we are all better off if those diabetics manage their care with their condition absolutely appropriately and stay out of the hospital. That is really what we are all trying to work toward here, I think.

Senator BURR. Thank you, Mr. Chairman.

Senator BINGAMAN. Senator Hagan and then Senator Harkin.

Senator HAGAN. Thank you, Mr. Chairman.

I had the privilege to sit on the State employee health plan for the State of North Carolina, where we covered about 800,000 people. What we are talking about right now is the fact that so much of the cost is really for chronic disease—diabetes, cardiac failure. That is where so much attention needs to be given, wanting to be sure people take their medication on a timely basis.

What I really wanted to ask about right now has to do with cost, and Mr. Williams, this question is addressed to you. So many of the physicians that I talk to say that if health insurance plans have a standardized format, that is just the standardization of forms, they could save so much money in their individual offices from just handling the forms. Why can't we do that?

Mr. WILLIAMS. I would say that I think there are important and significant opportunities to administratively simplify so that physicians are spending less time on paperwork. We have a major initiative across the industry, that I am chairing, taking a look at what we can do to standardize processes and, most importantly, also automate processes.

For example, in our plan, we get over 80 percent of our claims electronically. Over 26 percent of the physician inquiries are handled over the Internet, where a physician gets the data they need electronically. We are trying to put in place a multipair portal so the physician can go one place and reach out to any health plan and get eligibility data.

I think it is a fair criticism, and I think it is an opportunity for the industry to really work hard to administratively simplify what we do.

Senator HAGAN. And to the whole panel, do you think this is something that Congress should weigh in on? Yes.

Ms. IGNAGNI. Senator, I think you should expect stakeholder responsibility. Mr. Williams said it very well. He is chairing a major effort that we are undertaking with the Blue Cross Blue Shield Association together to look at every area where we can simplify administrative processes and costs, and reduce costs.

I think you should expect us to come forward and identify that, talk about what the Government in a healthcare reform effort could facilitate as you move forward in developing legislation, what should be expected in the private sector. We hope by doing so, that might start a series of stakeholder responsibility conversations about the area, the broad area of cost containment and the opportunity to take a point or a point and a half off future growth.

We gave you a chart in our testimony if we were able to do that as a society, just over 10 years, if you took 1.7 percentage points

off future rate of growth, the projections, you are talking about savings in the neighborhood of $3.5 trillion. Those are quite significant.

But you should expect us to come forward and identify that.

Senator HAGAN. I do think with the initiative that we have from the health IT perspective that it is going to drive quite a bit of the standardization of these forms.

I had one other question having to do with the minimum benefit package, and I know a lot of regulation has to go on at the State and the Federal level. Many States have different individual requirements on benefits that they mandate that are covered at the State level.

This question has to do with how would a minimum benefit package be put together that would be available across all 50 States? Dr. Nichols, that was directly in one of your statements.

Mr. NICHOLS. I would say that the way you want to think about this, first of all, let us all get the same set of facts in our heads. A lot of discussion about the cost of benefit mandates out there, a lot of empirical work that would show, in fact, benefit mandates don't really add that much to cost. The serious econometric work that is in my profession suggest 3 percent to 5 percent. CBO has concluded that.

The State of Texas Department of Insurance, not a noted left wing organization, concluded 3 percent in the State of Texas. And by the way, they include in-patient adult rehab and alcohol counseling. So it is serious benefits there.

The point is this, how we pay for and manage care is far more important than the benefits that are covered. The reason those econometric studies find there is very little net impact of specific benefit mandates is because they compare the small group pockets where those things are relevant to the large group pockets. The large group pockets are uniformly more generous, and yet they have lower cost.

So let us ask ourselves how do they do that? A, they do what Ron said a moment ago. The big employers really have the time and potential in resources to work with the third-party administrators to try to be smarter about what they buy, and they also negotiate better contracts with the clinicians because they have buying power.

The point is we need to extend that bargaining power and that information utilization potential to all of us and not just some of us. So I would say the one thing Congress could do in the short run is to mandate transparency about how different activities are spent. That will encourage the industry and the clinicians to work together.

But on sort of selecting the benefit package itself, I would come back to at some level it has to be a Federal decision. You don't want 50 different benefit packages around the country.

What you do, however, want is to allow the market to breathe. You do not want this to be something that is absolutely written in stone and force, say, very efficient integrated health systems who are very good at managing care and patient satisfaction, you don't want to force them to a certain kind of deductible.

Similarly, you don't want to force folks who manage care differently to have a particular product. So, in my view, you want an actuarial value standard and let the market go.

Senator HAGAN. Ms. Pollitz.

Ms. POLLITZ. I would just add to that that while I agree you need to set a Federal standard—I mean, if people need coverage, they need coverage. It doesn't matter where they live.

To the extent that you are going to allow some flexibility through an actuarial equivalent standard, and I appreciate Len's stress on sort of the positive implications of certain kinds of different benefit designs, but I think you need to be very careful, and two actuarial equivalent plans might on average cover the same thing. But this plan covers 100 percent of what cancer patients need, but nothing of what diabetics need. This one, 100 percent of what diabetics needs and nothing——

We can't just sort of say actuarial equivalence is close enough. I think in the quest for transparency and monitoring this over time, you will also need to develop some better measures of uncompensated care and medical debt and check those frequently.

To the extent that we find that our actuarially equivalent plans that are meeting our standards are still leaving people in medical debt, and check them by conditions, then you need to go back and tweak it. But I think we buy health insurance in case we get sick. So the standard that you set needs to take care of people when they have cancer and diabetes and heart attacks and when they get pregnant, and it can't leave them with thousands of dollars of medical bills every year that they have to keep paying in addition to what we are asking them to pay for their premiums.

Senator BINGAMAN. Senator Harkin.

Senator HARKIN. Thank you, Mr. Chairman.

I have been trying to get my head around how insurance is utilized more effectively in the field that everyone has mentioned here earlier, and that is in prevention and wellness. How do we get insurance involved in that?

Just a couple of observations, 75 percent of all Medicare spending is on chronic illnesses, most of which are preventable. So the old saw, you cut where the fat is the thickest.

I saw a picture, a PowerPoint that Dr. Dean Ornish put up one time, and the first picture was of a sink that was overflowing with water, and you had people on the floor mopping it up. His point was that for most of our healthcare today, we are mopping up the floor, but no one is shutting off the sink.

It seems to me that is what insurance is. The insurance is paying for mopping up the floor, but not paying much to think about shutting off the sink. So, I have been trying to figure out how do we make it so?

Mr. Williams, your company, you have to pay your shareholders. Your obligation is to your shareholders. You have to make a profit. All insurance—well, except maybe mutuals. But that is a different situation.

We all know about prevention and wellness. Everyone has mentioned it. We have to focus more on that. What is the role of insurance in insuring people for engaging in healthful lifestyles, for businesses to be involved?

I can figure out the taxing system. I mean, I can figure tax incentives for businesses and individuals that can motivate, provide financial incentives and things like that. That is not a heavy lift.

Please explain for me how we get the insurance companies involved in this.

Mr. WILLIAMS. Sure. I would first start off by describing our business model today versus a number of years ago. A number of years ago, we were a financing mechanism. We paid the claims, and we provided customer service.

Over the past 10 years, we have transformed and added a whole set of prevention and wellness and clinical support in health informatics functions and capabilities, and I will be more specific. Twenty percent of the people who work at Aetna are nurses, doctors, pharmacists, behavioral health specialists, and 20 percent more are IT professionals.

Senator HARKIN. IT.

Mr. WILLIAMS. IT. What the IT professionals do is help us identify from the claims data, the pharmacy data, the lab values, the health risk assessments, patients or members who are on the path to becoming a diabetic or on the path to becoming a hypertensive.

Now our job is not to treat them. Our job is to identify them and offer them on a voluntary basis education, information, counseling support so that when they go see the doctor, they are in a position to really fully engage in understanding their health status. Because if you are a diabetic and you take better care of yourself, there are fewer claims.

Senator HARKIN. Pre-diabetic?

Mr. WILLIAMS. Pre-diabetic. Well, even if you are in an early stage of being a diabetic. What happens is most of these conditions are progressive. You start out "pre." You enter the early. You go through the mid-stage, and then you go through the late stage.

What we spend our time doing is first identifying people who have the condition, understanding the stage they are at, and trying to make certain they are educated and understand what they need to do to slow down the progression through that process.

Senator HARKIN. Let me ask one question. Medicare right now, Medicare will pay for nutrition counseling if you are diabetic.

Mr. WILLIAMS. Right.

Senator HARKIN. But they will not pay for nutrition counseling if you are pre-diabetic. Well, that doesn't make sense.

Mr. WILLIAMS. Well——

Senator HARKIN. Now let me ask you, does your insurance company, do you have policies that say to your policyholder that if you go in and get tested and you meet certain indices for being pre-diabetic, we will pay for you, we will cover you to go get nutrition counseling?

Mr. WILLIAMS. Yes, we do have. Yes, the short answer is yes.

Senator HARKIN. You have policies that do that? Covers everybody?

Mr. WILLIAMS. That is correct. Yes.

Senator HARKIN. Or is it a special thing that you have to get in a policy?

Mr. WILLIAMS. Well, what would happen is the policy choice is always the employer's choice. But I would say the vast majority—

and let me answer more broadly. There is a set of recommended prevention guidelines recommended by the U.S. Preventive Services Task Force.

Senator HARKIN. I am very familiar with it.

Mr. WILLIAMS. We cover it, period. If it is recommended as a preventive service, we cover it.

Then there are a set of things that relate to chronic conditions, and we have the flexibility to identify what we believe is a good investment to slow down the rate of increase. So we would pay for nutritional counseling. We pay for a whole host of things that would be appropriate services to slow down the rate of progression through a chronic condition. At our heart, our business is today managing that.

Senator HARKIN. That would be a minimum benefit in every one of your policies then?

Mr. WILLIAMS. Yes.

Senator HARKIN. And you have a smoking cessation, anything that is on the U.S. Preventive Health Task Force, the A or B?

Mr. WILLIAMS. Yes, we would typically cover. I mean, there would be rare exceptions. But I mean, just to be clear, I would easily—just sitting here today, I would say 85, 90 percent would easily cover everything.

Senator HARKIN. Right now, only 7 percent of employers offer wellness and prevention programs to their employees. Seven percent offer some form of wellness and prevention programs to their employees. So we have a long way to go to get in business.

Now again, we can figure that one out. With tax incentives and things like that, that is not a heavy lift. We can figure that one out. I still wonder about getting up front on the prevention side because a lot of what you are dealing with in insurance is the result of something that happens before insurance ever kicks in.

For example, Mr. Williams and Ms. Ignagni, I mean, representing the two insurance industries here, you should be in the forefront of the fight to get sugary sodas out of our schools and junk food out of our schools and getting kids exercise in schools, you know? You have to be in the forefront of that because kids learn their bad habits there.

What do we say to our kids when they go to school and they see soda machines and vending machines with all the junk food? What message are we sending to them? That is OK, fine. You go ahead and do that.

Again, this is not in your insurance realm, but it would seem to me as an insurance company, you ought to be in that battle, in that fight to have better—and also advertising to kids. Right now, a kid, a child—I am a little off here now—between 7 and 12, somewhere in that neighborhood, 5 to 12, sees an average of I think it is pretty close to 200, maybe in the thousands of ads on TV every year. OK, it is in the several thousands of ads they see every year for food. Just food ads.

How many of those ads are for fruits and vegetables and good eating and nutrition? None of them. They are all for sugar, starches, sodium, things that just lead to bad habits.

Well, you know, if we don't correct that, we are mopping the floor, and your insurance companies are paying for mopping the

floor. I, as a policyholder, am paying more for mopping the floor, and I don't want to pay anymore for that.

So, I just urge you to get engaged in that. Now I didn't mean to give a speech on that, but every one of you mentioned prevention and wellness as part of this battle. Well, it seems to me we have to do both. We have to figure out how the insurance companies handle that later on and then how we move up forward and start early programs.

I don't know how insurance is at all—you have just got to do it as a public policy thing? Well, maybe there is a bottom line. Looking ahead, there would be a bottom-line benefit for you if less people became obese or less people smoked and less people had chronic illnesses. It would be better for your bottom line, too, I guess, now that I think about it.

Let me ask one more question. My time is running out. I want to ask about a public plan. I think Senator Brown brought it up.

Can a public plan co-exist with private insurance plans? That seems to be a question I am getting all the time. Can we have a health reform that has all these private plans and then have a public plan? What do you think? I don't know.

Mr. WILLIAMS. My opinion is, no, it cannot.

Senator HARKIN. It cannot.

Mr. WILLIAMS. The public plan, Medicare does not negotiate. I have not yet met a physician who has negotiated with Medicare or a hospital that has negotiated with Medicare. It sets a market rate, and that is the rate.

It is extremely difficult for any one entity to be both the referee and a player in the game. I think that there are many opportunities to improve the market by having the Federal Government play a role in the context of regulator and referee, which we have talked about extensively today.

I think that the problem we are trying to solve, which is making certain that everyone has access to healthcare services, can be addressed through the guaranteed issue, no pre-existing exclusions, and some of the other reforms that we are describing. I also believe that when we look at why private insurance costs so much, we must confront the data I have seen that suggest private employers are paying $90 billion more than they would otherwise pay because of the cost shift from Medicare to the private sector.

To the extent that we create a public plan that exacerbates the cost shift, we are on the slippery slope, and I would say it probably would have been greased to accelerate our momentum toward a single payer system.

I believe that the innovation that the private sector represents is extremely important. I think we have 177 million people in that sector that is working well, and I think if we can address the limitations we have to make certain that everyone has access to healthcare without pre-existing conditions and that we are not looking at health status as a means of rating, that we can solve the problem in a way that would address the underlying issues.

Senator HARKIN. Ms. Trautwein, do you have—I am just going to go down the line. Do you have any views on that?

Ms. TRAUTWEIN. Yes, I would just add to that, and I also don't think that it is possible for a public and private sector to compete

on a level playing field. I don't see any way that is possible, given the nonrate negotiation that Ron was talking about.

I think when you don't have a level playing field, what happens is one entity or the other is selected against. So I suppose the public program could be set up so that it gets all the bad selection, but more likely what is going to happen is, as Ron said, the private programs will be selected against even more than they are today, and the cost shifting would be exacerbated even more than it already is. I just think that is a recipe for disaster.

Senator HARKIN. Ms. Pollitz.

Ms. POLLITZ. Private health insurance and public plans co-exist today. Almost half of our healthcare spending is covered by public programs today.

When you talk about the cost shift, we have had to develop public programs because private insurance won't take care of people who are vulnerable. That is why we created the Medicare program because private insurance wasn't taking care of people who are elderly or disabled or when their kidneys failed or when they got ALS. So we had to create a public program for that.

Two-thirds of the States have high-risk pools.

Senator HARKIN. Say that again.

Ms. POLLITZ. Two-thirds of the States have high-risk pools, public plans when private insurance won't take care of people, won't cover them because they are uninsurable. We have come up with this concept of uninsurable. So we had to create public plans to take care of that.

Our latest eligibility category for the Medicaid program was underinsured women who have breast and cervical cancer. That is now a reason that you can get into the Medicaid program to get treatments because the private sector isn't providing good coverage that takes care of what people need.

Of course, they can co-exist. They do co-exist. The cost shift overwhelmingly goes in the direction of the public plans. They do get—they get all of the expensive vulnerable cases that private insurance won't take care of. Now granted, as Len said, we need to change the business model and change the way markets compete so that we can try to get private insurers to begin, for the first time, to compete to take care of people when they are sick and not just to avoid them.

But I think, given that the track record on that is pretty sparse, it is very helpful to have a public plan that you create for that very purpose. It cues the market. It says this is the kind of behavior we want, and you can charter that plan so that it doesn't just compete. It certainly won't compete to maximize profits.

But you can charter that plan to be an innovator, not to crowd out other private sector innovations, but to be where public plans brought us DRGs and RBRVS and a lot of innovations that we have in payment that have been widely adopted by private carriers.

A public plan can do that and can be tasked in its charter with sharing what it learns and what it gains from that investment and not just trying to keep all those secrets for itself. I think it is absolutely essential.

Senator HARKIN. Very good.

Ms. IGNAGNI. We started our work from the proposition that the status quo was not acceptable. Everything we have proposed today and all the work we have done over the last 2 years is designed to change the market as it exists today. So we hope that you don't make judgments about what is the case today and what is to be the case tomorrow based on what are the rules today.

If we get everyone in, we can change the system dramatically to guarantee issue, to deal with the health status rating, to make the system more transparent and consistent across 50 States, and to create the kind of system that we believe the American people want. To have a system, we do have significant amount of cost shifting.

We have provided some data based on California, which is the best data system in the country, that shows you real cost shifting as Government continues to underpay both in Medicaid as well as Medicare. So this is a very significant issue in terms of ever establishing a level playing field.

Second, all of the work that is being done in disease management, care coordination, medical homes that are working right now, pay-for-performance, upside, downsides, and real measurement to actually do it in the way that all of you have suggested, all of that is being done and pioneered in the private sector.

We have data that is beginning to come in, and it is very impressive. It is going to be shared. It will be researched. It will be third party verified. So we have a lot to report about what is happening.

Clearly, the market today doesn't work because we don't have everyone in. Everything that is now in existence in terms of the regulatory structure works through that prism. When you change that and you create subsidies, there are a package of things you can do that will change everything.

What we have done is proposed an aggressive system of Government regulation that would supervise private sector competition and the competition that I think the people want.

Mr. NICHOLS. Senator, you asked a great question, and I would say in some ways, it is sort of the question of the week or month at least. I would say there really are two ways to start answering it.

The first is, to build on what Karen just said, the market is broken now. It is not working, and the consequence of that is that a lot of people have lost their trust. They have lost their trust in our ability to change the rules in such a way that all insurers will behave the way most of us think they would if you change the rules.

That lack of trust is real and that need for, if you will, reassurance of some other kind of plan being available is a real, profound, I would say, demand out there.

The second thing that we need to keep in mind is that if we just decide to put everybody into Medicare, except for the private plans that would survive for maybe 3 years—I will give Ron that—we are going to end up with a system that is basically going to be run from Washington and Baltimore. I don't think many of us are in favor of that either.

So what I would propose is you think about a public plan model more like what State employees do. Maybe we should ask Senator Hagan how it worked down there in North Carolina? But in gen-

eral, States, 34 of them today, decided to have a self-funded plan for which the State bears the insurance risk. That is to say the State has appointed the leaders of the plan. They don't profit in any way from the hint of denying care. They can't.

Senator HARKIN. Thirty-four?

Mr. NICHOLS. Thirty-four. Yes, sir. We can give you names and so forth. What they do with that plan, sir, is they let it compete with the private insurance industry, and in most cases where they have been doing this, they have been doing it more than 15 years. I am not making this up. This has been going on for a long time.

So what is the deal? The deal is they wanted a plan where they had basically—it is typically a PPO type arrangement—larger providers. They typically hire a private insurer to process claims and negotiate with contracts with the providers. So they got a big network. They compete head-to-head on a fairly level playing field.

Now it turns out we wrote a paper just last week, and we would be glad to send it to you and talk with you about it, that would outline kind of how you could do this. We would suggest even stronger firewalls between the people who run the new marketplace and the people who run the plan.

But the point is these States have been doing it without the kind of firewalls we would recommend you consider, and still it functions effectively and has led to, in many cases, better performance in that part of the insurance market than any other part of a lot of States. So I do think there is a model between Medicare and nothing that could get us where we need to be.

Senator HARKIN. I would like to see that paper.

Ms. BAICKER. Very briefly, I agree that in theory there could be great gains to having a public plan, and I worry that in practice one ends up doing more harm than good. So it very much depends on the implementation details.

With your indulgence, just one sentence or two on your last question about why we don't see more investment in prevention and wellness by insurers. I think there is an upstream problem and a downstream problem that as people age onto Medicare, the problems that they develop in middle age they bring with them to another insurer. So private insurers may not have the incentives to invest in wellness when the cost—or benefits accrue much further down the line.

Similarly, a lot of the problems that private insurers inherit happened at a time way before they had any control over what was going on, and that is a key case for public policy intervention that when we are talking about health reform, not just health insurance reform, but health reform to get all Americans access to better health through a lifetime, that has to be investment in wellness, in the availability of healthy foods.

If you go to poor neighborhoods, there aren't supermarkets in a lot of places, and that is a matter of public policy. There aren't green spaces to exercise in. That is a matter of public policy. So I think we have to look at health reform as a much broader endeavor, and that may be much more cost effective than anything we can do within the healthcare or health insurance system.

Thanks.

Ms. PRAEGER. Thank you, and I just have to comment on the supermarket. If you go to a supermarket in an affluent neighborhood, the fresh produce is like you are in an art museum. It looks gorgeous. It is beautiful. It is perfect. If you go into low-income neighborhoods, if they have fresh produce at all, it doesn't look very good, and it is kind of expensive. So it is no wonder the diet issue is a problem.

The public plan, and I have read Dr. Nichols's report. It is a good read and a fast read, and I think he makes some very good points.

Senator HARKIN. You mean we could probably understand it?

[Laughter.]

Ms. PRAEGER. Well, I could, so, yes.

The public plan, if it is competing on a level playing field with the private marketplace, I think there can be some benefits to it. But I think, first, you need to make sure that that public plan is charging a premium that is sufficient to pay the claims, and that is critically important for the long-term viability and for the competitiveness of it.

The public plan should comply with all of the State regulations that are in force in that State where that public plan is offered, and Kansas is a State that has a State-run, State public plan for its State employees, and it does work side by side with the private market plans.

Then the payment system should be based on a negotiation and not just dictated that this is what providers will be paid. So if you have equal rules and are treating the public plan the same as the private plan, it can help drive market changes because of the ability to perhaps bring some standards across the States, and I think eventually there are areas where standards set at the Federal level are pretty important.

Some of the things that we have done through State regulation that we are advocating should happen in all States are things that would address some of the administrative costs that Senator Hagan referred to a few minutes ago. Utilization review ought to be standardized, and we have worked with our health insurance plans to get model legislation drafted so that utilization review is handled in the same way so that companies don't have to comply with different rules in different States.

External review, the same. Rate and form filing. We have a system for electronic rate and form filing through our national association, and that needs to be extended to health insurance as well. So uniform standard. So there are a lot of things that the States are working on that could benefit and inform and perhaps lead to greater uniformity by those things being adopted at the Federal level.

Senator BINGAMAN. Senator Casey is the only one who hasn't had a chance to ask some questions. Go ahead.

Senator CASEY. Thank you, Senator Bingaman.

I appreciate and it was interesting to listen to that line of questioning that Senator Harkin was propounding to the witnesses. I appreciate that. Whenever Senator Harkin is speaking, we listen and we learn. He has a lot of wisdom.

And I have you for the next 2—no, I am only kidding. I was going to say 2 hours.

[Laughter.]

We have some time here. I wanted to pick up on—I am serious about one of the lines of questioning that Senator Harkin focused on. I will deal with two things. One is the question of what we are going to do going forward on the individual market and small group markets. But before I get to that, I wanted to get back to prevention because he asked some important questions.

Dr. Baicker, I wanted to start with you. So many Americans today understand what we are talking about here when we talk about prevention and wellness. They get it. We may not practice it enough. The statistic about 7 percent of employers having it in place, even if that were tripled, it wouldn't be enough.

I think people understand it, but they also understand that we are not there yet. Tell me two things, if you can—and I will ask anyone else to chime in—what are the strategies on prevention and wellness that we know work, that it is irrefutable that the strategy works?

And second, tell me the mechanics of getting there. It is great to have something that works. We can point to programs that work. We can point to strategies that work and a whole series of whether it is healthcare or other parts of our economy, but we have to put in place a strategy that we know will work. We also have to have the mechanics to make sure it gets implemented so that it actually will work and not just theoretically work.

But tell us about that. Tell us what we know that—and not that it is a Democratic idea or a Republican idea, tell me what we know about the consensus of what works strategically for prevention and wellness.

Ms. BAICKER. That is a great question, and I wish I could give you a complete answer. But I am not sure we have a complete answer. I will give you my best answer.

Senator CASEY. In other words, let me just interrupt for one second. If you had a magic wand and you had total control over what the U.S. Senate does on healthcare, what are the three things you would do on prevention and wellness? What would you put in the statute?

Ms. BAICKER. You are going to want to take the wand back.

[Laughter.]

Senator CASEY. Give it a try. This is not a real formal hearing. Give it a try.

Ms. BAICKER. I know there is no wand. I would like to unbundle the idea of prevention or wellness as a monolithic thing because I think there are many different things with different implications for cost and effectiveness that frequently get bundled up together, and I think that damages the debate.

Senator CASEY. OK.

Ms. BAICKER. We talk a lot about should preventive care be coverage and preventive care have no co-payment. Shouldn't we invest more in preventive care? By and large, preventive care does not save money. There are lots of chunks of preventive care that are cost effective, meaning you spend some money and you get a lot of health for it.

The best, most cost-effective items in what we generally call preventive care do save a little bit of money. Flu shots for toddlers.

There are some interventions that when you spend money on them, you actually reduce healthcare spending over the short run, but there are very few.

Senator CASEY. Let me stop you there for a second. Tell me about the ones that—preventive strategies that are helpful to the individual but don't save money.

Ms. BAICKER. There is a great article on this in the New England Journal of Medicine——

Senator CASEY. It is still the idea of the——

Ms. BAICKER [continuing]. That I would love to send your way, not authored by me. That there are a chunk of tests that yield life savings at a reasonable cost. So the metric that I am using is how much does it cost to save a life year? For the most cost-effective things, flu shots, you actually save money and save a life year.

Then there is a chunk of things that cost money, but buy you life years at a very reasonable rate, at a rate that we think, boy, that is worth the money spent on it instead of spending it on other things besides healthcare. So things like screening people who are at risk of hypertension or who are at risk of diabetes or other complications.

Now that same screening procedure that is done on a person who has risk factors, if, instead, you do that on a much older person or a person without those risk factors, it becomes cost ineffective. So the very same procedure is cost effective for some people and not cost effective for others based on the underlying risk, based on the individual circumstances.

Some of the innovation that Mr. Williams was talking about at Aetna is how do you tailor your insurance design to promote the kind of consumption that is high value while not promoting the kind of consumption that is low value? That is tricky when the same procedure sometimes falls into one category, or sometimes falls into the other.

Now there are some procedures that are almost never cost saving, or never cost effective, that are still preventive, but they are tests that really yield very low returns in terms of health. Those you probably don't even want to think of as preventive care.

How do you get there for preventive care? Then I will do a quick recap on wellness. On preventive care, value-based insurance design is one promising angle, where you pay people to get the care that is of high value and you charge much higher co-payments for the care that is of lower value. Lots of things are going to fall differentially along that spectrum based on the individual patient's risk characteristics.

That makes for a very tricky contract, and the logistics of how you write that down in a way that promotes stretching our healthcare dollars as far as possible while not being discriminatory or unenforceable or tricking people into thinking that they are getting protections when they aren't, that is an important regulatory question.

On the wellness side of things, I think the reason we are seeing a rising roll of employers in that market where you would naturally think why aren't the insurers doing this is that employers often have a longer-run relationship with their employees than insurers have with their covered lives.

If you are going to be at an employer for a decade, your health and productivity matters more to that employer than it does to the insurer when you might only be in their plan for a few years. Employers also accrue some of the benefits of having you be more productive in terms of being a more productive worker.

So we would like to think that individuals should just do this on their own for their own health, but there are all sorts of barriers to individuals being able to successfully implement a lifelong wellness program, where an employer might be able to step in with an environment that promotes it 8 hours a day instead of the few interactions that you have with your insurer or even with your physician.

So what works on the wellness front, evidence is still coming in on that. But I think there is strong evidence that it matters a lot that there be day-in, day-out enforcement of health behaviors, reinforcement of good health behaviors, and the workplace is one place for that. Communities are another place. You want integration of community efforts and employer efforts. Again, that is a matter of public policy, not one that I think insurers can implement on their own.

Senator CASEY. Let me stop you there for a second and put you on the spot with regard to employers. Give us a large employer example of the strategy just on wellness that is working.

Ms. BAICKER. I am hesitant to name a particular employer, but Len said Safeway.

[Laughter.]

But there are——

Senator CASEY. What do you say?

Mr. NICHOLS. Pitney-Bowes.

Ms. BAICKER. That is another good example.

Senator CASEY. Tell me what they did. In other words, around here, there aren't always a lot of original ideas in Washington. We borrow all the time, and there is nothing wrong with being a copycat if it is a good idea.

Tell me—if you don't want to specify a company—what the elements are that are in place for those big companies that we should put in the bill.

Ms. BAICKER. Those are two different questions, and I think it is a key distinction. The things that seem to work are highly integrated efforts where it is not just a class once a week or once a month. It is not a bonus at the end of the quarter if you have reached a goal.

It is every day at lunch there is a class. Every morning there is stretching exercises. You have time off from work to participate in those activities. The employer provides——

Senator CASEY. There are lots of opportunities.

Ms. BAICKER. So it is an environment. It is not just a limited program. Now those are the things that work.

Senator CASEY. A culture, right?

Ms. BAICKER. I hesitate to say that you can legislate a culture that way. I don't know how you would write down a bill that promoted that kind of culture without——

Senator CASEY. Right. OK.

Ms. BAICKER [continuing]. Being so prescriptive that you shut down the innovation that you are trying to foster.

Senator CASEY. Good point. OK.

Ms. POLLITZ. Senator.

Senator CASEY. Yes? And we have others.

Ms. POLLITZ. I would just add I think an investment in public health is so important. That tens of billions of dollars that you just invested in IT, you should at least match that for new investment in public health.

Prevention may not score savings, but public health does save, and we underinvest in public health more than just about any other developed nation. The root cause of so much of our healthcare spending is in junk food, as Senator Harkin said, gun violence, speed limits, people who don't wear helmets, lack of family planning, food safety problems. I mean, I am not buying peanut butter still.

So we need to invest in public health in a big way. And with Senator Harkin here—I think you are still on Appropriations, right? So you can authorize the spending here and send him next door to make the money available in the budget. But we do underinvest.

I know you are a champion, Senator, of our Public Health Service agencies, and I know they always eat last at the trough after everybody else comes in. But we need to stop that, and that is such a cost-effective investment, and it will just embrace all of these other things that we are talking about. I just think that has to be a priority in this legislation.

Senator CASEY. I want to go to the other question, but anyone else have anything on——

Mr. WILLIAMS. Yes, just quickly on——

Senator CASEY. Mr. Williams, you have been dealing with this at the insurance company level.

Mr. WILLIAMS. We deal with it quite extensively, and I think that the large employers we work with, which I described earlier is two-thirds of our almost 19 million medical members, are very focused on this fundamentally as a productivity issue in the context of their employees. Smoking cessation is absolutely critical.

I think the other area that we haven't talked about, which I think was addressed through the mental health parity bill, is the undertreatment of depression and being certain that the whole issue of depression is thought about holistically and that we don't send the person over here for their medical care and over there for their behavioral health but is thought about holistically.

The person who has a heart attack is screened for depression because they may very well be depressed. They might not take their medications. They might not engage in their rehabilitation. And therefore, their recovery is prolonged. So I think that is a huge area.

Ms. IGNAGNI. Senator, just a footnote on that. Fifteen years ago, there was a lot of discussion about managing care that went out of favor, but the concept—we threw the baby out with the bathwater. Clearly, over the last 15 years, our plans have been reinventing the tools, and now care management is about doctor-to-doctor, using specialty society guidelines, best practice, etcetera.

We are about to issue a study on disease management and care coordination for Medicare Advantage participants, many in your area, and we can show a reduction, significant reductions because of disease management in ER usage in days per thousands.

So, as Mr. Williams said, there are phases of intervention—early, middle, and late. But if you get the chronically ill organized into care systems that are supported by physicians, organized by physicians, you can see some major implications here that are quite productive.

If you marry that with the kind of public health investment that Ms. Pollitz is talking about, I think particularly in the area of obesity, we attack smoking in a very significant area. A number of decades ago, the surgeon general stood up before the American people and said we have to attack this. Similarly for obesity because it runs through every chronic illness.

The area of disparities. There are a number of things that we put in our testimony that Congress can do now in addition to what is being done in the private sector. Our health plans are monitoring disparities. In some cases, we can't collect data or there are barriers at the State level from doing that. That should be addressed.

We now can target early individuals who are at risk of certain things. So we can go on and on, but there is quite a body of evidence and experience now to really begin to answer your question of where do we intervene, how do we do it, and how do we do it in the way that is most effective, cost efficient, and provides the highest value?

Senator CASEY. Thank you.

I know we are running out of time. Senator Harkin may say we are out of time. He is in charge now. We have to be cognizant of that.

But just a few more moments. I wanted to—and at the risk of being redundant here because I know I missed the first 45 minutes or so—with regard to one topic and one example. The topic is the individual and small group market for insurance, and the example is Massachusetts. What, if anything, have we learned from their experience with the exchange concept?

Well, A, what have we learned? And B, no matter what we have learned, can we apply that lesson to what we do in a Federal or a national sense? Anybody want to try a take on it?

Doctor?

Mr. NICHOLS. Senator, I would certainly start by saying what we learned is you can achieve bipartisan agreement on how to reform a health system. Let us go back to Governor Romney, who was at the time a Republican presidential aspirant, willing to use the word "all." And you had a Democratic legislature maybe among the bluest on the planet willing to accept the word "limit."

That was an appropriation bill. Not an entitlement. So what you had there, I think, is a very good lesson for how you all can move forward.

Senator CASEY. Good point.

Mr. NICHOLS. Second, I would say what they have done technically is they were, believe it or not, even though it was Massachusetts, they were humble. They didn't try to do it all in 60 days. They tried to do it all over a couple of years. They phased it in,

and they were very intentional about signaling where they were going.

We are going to essentially eventually meld the individual and small group markets. We are going to build on what we have now. We are not going to blow up the employer system. We are not going to do away with Medicaid. In fact, we are going to strengthen both.

But we are going to move into a world where we absolutely outlaw discrimination based on health, and we encourage people to buy and we are going to give them incentives to buy. We are going to give them subsidies to buy. But we are going to require them to fulfill their part of the bargain, which is to make sure they achieve the level of coverage so that they can get the care they need so there are no more free riders.

They exempted people they thought couldn't afford it. So they were mindful of the affordability. That is a very small number in Massachusetts, but it is nevertheless a very important principle.

Then I would say the final thing they did was they made it clear that we are going to have a penalty on not buying coverage, but we are going to phase it in. So we are going to take Janet's point, you can't move there in a very fast way. You have to be cognizant of human nature. At the same time, made it very clear where they are going, and I think it is a very interesting model.

Senator CASEY. So you think it is readily applicable to what we are trying to do here?

Mr. NICHOLS. I think all of those things are readily applicable. The details will certainly have to be different. Massachusetts is not Utah, or Pennsylvania, or Iowa, so you are going to have a little bit of different things on the ground in those places.

But at a minimum, that structure is a very good structure to go with, yes.

Senator CASEY. Thank you.

Anybody else?

Ms. PRAEGER. Senator, I think the healthcare costs will need to be addressed because I do think it is becoming increasingly more expensive. So I think any reform again has to address the underlying increasing costs of just the healthcare delivery system.

I want to re-emphasize also the point about public health. I think public health is a critical component. We all have the opportunity in our States to advocate for clean water, clean air, healthy schools, and healthy environments for our schools. We need to partner with the schools to get junk food out of school cafeterias and out of the vending machines.

There are just a lot of things that we can do from a public health standpoint that I think will serve us well for the next several generations.

Senator CASEY. I know we have to wrap up. Anyone else who didn't have a chance here? Yes?

Ms. IGNAGNI. Senator, I think that I agree with my colleagues, the observations they have made. This point about proceeding to line up cost containment and universal access together.

I don't think they did enough in Massachusetts early on, and I think that most people there would agree with that now, and they are trying to catch up and figure out what to do. So that is point

No. 1. This is the hardest thing to do, to actually achieve consensus on cost containment.

The second thing is to the extent that you have the kinds of rules, aggressive rules and robust rules that everyone on the panel is talking about, to what extent do you need purchasing through a connector, or is that connector there to supervise, provide information about plan selection, track subsidies, et cetera, et cetera?

I think there will be a lot of important discussion around that principle.

Senator CASEY. Well, unless anyone else—Ms. Pollitz.

Ms. POLLITZ. I would just add I am not sure if I am disagreeing with Karen or I misheard her, but I agree that you need to address getting everybody coverage and addressing rising costs. But I wouldn't, I absolutely wouldn't urge that you wait to cover everybody until you have figured out how to cover the costs.

I think we have been doing that for decades, and we need to cover everybody now because people are in need, and we do need to figure out how to control costs. I think, as Sandy Praeger said earlier, that will be easier to do once we have everybody invested in the system.

Senator CASEY. Well, thanks, everyone.

I don't have the gavel near me, but I am going to bang the gavel. Hearing adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF SENATOR ENZI

Mr. Chairman, I want to take a few minutes to express my very sincere gratitude to Senator Bingaman and his staff. They have worked very closely with my office to plan today's roundtable as well as set an agenda for two additional roundtables in the near future. Senators Kennedy and Baucus have laid out very aggressive schedules for moving forward on health care reform legislation and Senator Bingaman's job of working on the coverage piece is so vital to the larger health reform debate.

I also appreciate how much Senator Bingaman's staff worked with my staff to come up with the list of witnesses before us today. I think we have a stellar panel and I am really looking forward to hearing from our experts and getting into the details of insurance market reforms. I have said many times how helpful it is to hear from people that have actually enacted policies in the real world who can tell us what they did right, what they did wrong, and how they would improve things moving forward. I hope the members of this committee can learn from our witnesses and use that knowledge to better inform their decisions on health care reform legislation.

I travel back to Wyoming almost every weekend and lately I have been really worried by what I am hearing. Most people think that once Congress moves forward on health care reform, their health care will be free. This worries me; nothing is free. The humorist and writer P.J. O'Rourke once noted, "If you think health care is expensive now, wait until you see what it costs when it's free."

Even more disturbing than misunderstandings outside of Washington about free health care are the reports of the hospitals, physicians, drug manufacturers, health plans, and others who don't think that Congress should pay for health care reform. They see a price tag of over a trillion dollars and say, charge it. This thoughtless disregard for the long-term economic health of our Nation, and for the future of our children and grandchildren, is reckless and irresponsible.

These health care stakeholders all seem determined to ignore the fundamental problem that plagues the U.S. health care system. The truly difficult challenge that Congress must address is how to get control of America's exploding health care costs. Simply throwing more money at the problem is not a solution.

The fact is health care isn't free and there will be tradeoffs with any policy we devise. Insurance reforms all result in tradeoffs. Rating rules are a perfect example. We must be cautious when considering reforms that may result in unaffordable prices for our young and healthy—we need those folks to participate because they help keep costs down. However, ensuring access to quality insurance for those struggling with health conditions is, I hope, a priority for all of us. Our job here is to find the sweet spot that accomplishes our goals but doesn't create a disruption in our insurance marketplace.

I have a few ideas about ways we can reduce costs—some of them pertain to getting better value out of every dollar we spend on health care by reforming the health care delivery system. Other

ideas include making the health insurance market function more efficiently by encouraging insurance companies to compete and offer the best plans at the most affordable prices. I look forward to hearing suggestions from our witnesses about ways to reform the health insurance market.

While it is critical that we get the policy of insurance market reform right, I would be remiss if I didn't at least mention the perils of process. Without the right process, we can't move forward on the best health care reforms for the American people. The first real test of whether the new Administration and Senate leaders are serious about developing bipartisan solutions will be how the upcoming budget addresses healthcare. Reconciliation cuts off most avenues for real debate in the Senate and is intended primarily as a tool to reduce the deficit. If those in the Majority attempt to use the budget reconciliation process to jam health care reform through the Senate, they will be sending a clear signal that they are not interested in a truly bipartisan effort. I urge President Obama to stand by his promise to work on health care in a bipartisan way by pledging that he will not support passing reform through reconciliation.

With that, I will look to our witnesses to make recommendations for how we should shape the policies of health care reform. Mr. Chairman, thank you again for holding this roundtable today.

AMERICA'S HEALTH INSURANCE PLANS (AHIP),
WASHINGTON, DC 20004,
March 27, 2009.

Hon. JEFF BINGAMAN,
Hon. ORRIN HATCH,
Senate Committee on the Budget,
U.S. Senate,
Washington, DC 20510.

Re: Response to Senator Hatch's question submitted for the record regarding the implementation of an enforceable individual mandate.

DEAR SENATORS BINGAMAN AND HATCH: On behalf of America's Health Insurance Plans (AHIP), I appreciated the opportunity to testify and participate in the roundtable discussion hosted by the Senate Committee on Health, Education, Labor and Pensions on March 24, 2009. AHIP is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We are responding to a question Senator Hatch submitted for the record regarding how the panelists would construct an individual mandate to purchase health insurance coverage. AHIP's Board of Directors is continuing to examine this issue as a part of our effort to bring tangible strategies to the discussion that will address specific problems in the health insurance market. In response to Senator Hatch's question, we offer one potential method to construct an enforceable mandate for individuals to obtain and maintain coverage.

We believe that an enforceable individual mandate is an essential reform to bring everyone into the system. An individual mandate combined with other market reforms, including guarantee-issue of coverage and removing health status as an allowable rating factor in the individual market, are important building blocks in constructing a 21st century health care system. Achieving universal participation with an individual mandate will require specific attention to the mechanisms for making the mandate enforceable and will require coordinated action at multiple levels of government.

First, an effective individual mandate must be supported with premium assistance for lower-income individuals and working families. Refundable, advanceable

tax credits should be available on a sliding scale basis for those earning less than 400 percent of the Federal Poverty Level (FPL).

Second, individuals need access to affordable, quality health insurance. To this end, AHIP supports the ability for health insurance plans to establish "essential benefits plans" that are available nationwide, provide coverage for prevention and wellness as well as acute and chronic care, and are not subject to varying and conflicting State benefit mandates. The coverage under an essential benefit plan must be at least actuarially equivalent to the minimum Federal standards for a high-deductible health plan sold in connection with a health savings account, along with the opportunity to include enhancements such as wellness programs, preventive care, and disease management.

Third, the verification and enforcement of an individual mandate may be achieved through the Federal tax code. The Federal tax return could ask for any applicable information, including affordability or financial hardship standards, the availability of employer coverage, and eligibility for government subsidies. Individuals would then indicate their insurance status over the course of the year. A financial penalty should be imposed for all breaks in coverage or an allowance could be made for short breaks in coverage. Such penalty could equal 100 percent of the premium for the essential benefits plan offered in the individual's geographic area. The financial disincentive must be close enough to the actual cost of coverage in order to deter individuals from foregoing health insurance coverage until a significant medical need arises.

Last, individuals should have the opportunity to enroll in health insurance coverage during an initial open enrollment period (after enactment of health care reform) without the imposition of a preexisting condition exclusion. Individuals should face disincentives if they elect health insurance coverage after this initial open enrollment or after a significant break in coverage.

We appreciate the opportunity to offer suggestions regarding the implementation of an enforceable individual mandate. AHIP believes that health care reform will only occur when individuals and stakeholders bring concrete solutions to the table, and we are doing our part to advance new strategies.

Sincerely,

KAREN IGNAGNI,
President and CEO.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC),
WASHINGTON, DC 20001–1509,
April 20, 2009.

Hon. ORRIN HATCH,
U.S. Senate,
Washington, DC 20510.

DEAR SENATOR HATCH: During the HELP Committee Roundtable Hearing on health insurance reform on Tuesday, March 24th, you asked each witness to describe an "enforceable" individual mandate. Since time was not sufficient for a verbal response, I am happy to provide my answer via this letter.

To begin, let me say that as a State regulator I can see great benefit to an effective individual mandate. If our goal, as a nation, is to make quality health care accessible and affordable to all Americans, then making comprehensive insurance coverage available to every American is critical. However, if only those in need of medical care purchase insurance, then the insurance market could become unsustainable. An individual mandate that ensures the young and healthy participate in the marketplace will allow the risk to be spread over a broader population and stabilize the insurance pool.

This, of course, brings us to your question, "What is an enforceable mandate?" State regulators look at this question from two different perspectives.

First, an enforceable mandate must have sufficient penalties and oversight to ensure compliance. As has been seen with some automobile insurance laws, low penalties and/or lax oversight can lead to low compliance. The penalties must be high enough to make purchasing insurance the better option and there must be constant oversight to identify those who are noncompliant and ensure that people remain compliant. We can look to States' experience with auto insurance, and to Massachusetts with health insurance, to craft an effective enforcement plan.

Second, an enforceable mandate must provide affordable options so people can comply with the mandate. If consumers are required to purchase a "Cadillac" plan that they cannot afford, and subsidies are insufficient, then people will be forced

into noncompliance. This is probably the trickiest, and certainly the most expensive, part of developing an enforceable mandate. Some flexibility at the State level may be the best approach.

As I stated in my testimony, years have been spent talking about broad health care reforms that will ensure that all Americans have access to affordable health insurance coverage and the peace of mind that goes with it. Action is long overdue and State regulators stand ready to assist Federal lawmakers in whatever way we can.

The NAIC encourages Congress to work with States and learn from past reforms. Together, we can implement successful initiatives that will truly protect and assist all consumers.

Sincerely,

SANDY PRAEGER, *Chair,*
NAIC Health Insurance & Managed Care Committee,
Commissioner of Insurance, State of Kansas.

RESPONSE TO QUESTION OF SENATOR HATCH BY KATHERINE BAICKER, PH.D.

According to a study published in 2007 by the National Bureau of Economic Research, an employer mandate of $9,000 for family coverage would reduce wages by $3 per hour and cause 224,000 workers to lose their jobs.

Your colleague, Dr. Chandra, himself in the past on employer mandates has stated that "The populist view is this will only come out of profits. But, ultimately, the money will come out of wages. And, worse, for some people, it can't come out of wages."

Question. What are your thoughts on imposing an employer mandate during current conditions on your labor sector and economy in general?

Answer. The effectiveness of a mandate depends both on the ability to enforce it and on the size of penalty imposed. The ability to enforce requires the existence of and access to administrative data on compliance (such as centralized data from insurers). The size of the penalty depends on the dollar value of the fine (assuming the penalty is a fine and not a jail sentence) and, just as importantly, the frequency with which it is imposed. A mandate that is "enforceable" but rarely enforced would not likely meet with universal compliance.

RESPONSE TO QUESTIONS OF SENATOR HATCH BY RONALD A. WILLIAMS

Question 1. Our goal in health reform is to provide affordable and meaningful health insurance for all Americans. Assuming this is our goal, many health policy experts have identified significant problems in the American health insurance markets, particularly in the small group and individual market. As a result, they have proposed significant health insurance reforms. What are the most critical challenges we face in American health insurance markets (if any) and what are the most critical reforms needed to address these challenges (if any)? Are there any reforms that have been discussed that concern you?

CRITICAL CHALLENGES FACING HEALTH INSURANCE MARKETS

Answer 1. There are a number of critical challenges we face in American health insurance markets:

• *Lack of universal coverage creates an expensive, inefficient system.* Individuals often have trouble accessing insurance coverage in the individual market. Insurers who offer products in the individual market face adverse selection—wherein only those who are sick or anticipate needing expensive medical treatment choose to buy insurance. For these people the costs of the medical care they need can greatly exceed the costs of insurance premiums they would pay. In other words, those who join the system late are not purchasing "health insurance," but rather "pre-paid health care," which is something health insurers cannot provide in an economically sustainable way. Therefore, insurers need to employ preexisting condition exclusions and medical underwriting to encourage people to become and stay insured even when they are not sick, keep the population of insureds balanced between sick and healthy people, and keep premium costs stable. As a result, high-risk individuals who are not covered through the employer-based system face challenges accessing individual insurance in many States. In those States where they do not have trouble accessing insurance—States with guaranteed issue and community rating—healthier individuals often go uninsured as they are reluctant to purchase coverage before they need it because of its high cost. The differences in premiums for nearly identical products in the neighboring States of New Jersey (community rating and

guaranteed issue) and Pennsylvania (medical underwriting) is illustrative, with premiums for a 35 year-old male purchasing a standard HMO product being 158 percent to 368 percent higher in New Jersey than in Pennsylvania.[1]

With people unwilling or unable to participate in the individual market, we have a universally acknowledged access problem that affects both the uninsured and the insured. The uninsured face decreased access to health care and expensive medical bills for the care they do receive, while the average insured family pays an additional $922 in premiums (or 8 percent of total premiums paid) each year as a result of cost-shifting from care being provided to the uninsured.[2] This does not even consider the cost-shifting from government programs.

• *Chronic illness can be exacerbated, and its expense multiplied, by delays in care.* Uninsured and under-insured individuals with chronic illnesses often wait until an acute episode to seek medical care or insurance coverage, as discussed above. This increases costs for everyone in the system and results in poor quality and possibly worse outcomes for those who are forced to wait. Greater attention must be placed on prevention, wellness and chronic disease management, and on getting these people early and continuous access to the health care insurance system.

• *Cost inflation results in part from misaligned incentives in our payment system.* The current system is filled with incentives to offer more services, typically failing to discriminate between services with high and low value. Health insurance premiums directly reflect the underlying costs of health care, with premiums rising because of increasing doctor, hospital, drug and other medical costs. In fact, in 2007, health care costs grew at an annual rate of 6.4 percent while the cost of health insurance premiums increased at an annual rate of 6.1 percent.[3] If we want to ensure the affordability of coverage, we have to address health care costs, and without effective payment reform the cost of health care will continue to grow.

• *Divergent State laws and regulations add complexity that increases costs.* The complex and duplicative web of 50 State insurance laws and regulations is administratively burdensome and unnecessarily increases healthcare costs and premiums for health insurance.

TYPES OF REFORMS NEEDED TO ADDRESS CHALLENGES

• *Individual Mandate.* We at Aetna, believe that an enforceable individual coverage requirement is the key to addressing our country's access challenge because it allows us to bring everybody—both healthy and unhealthy—into the insurance pool. By using an individual coverage requirement to address the challenge of adverse selection, we can transform our system into one where private insurance is provided on a guaranteed issue basis with no preexisting condition exclusions and a rating system that does not include health status.

• *Subsidies.* We believe that an individual coverage requirement must be coupled with sliding scale subsidies to ensure that income is not a barrier for any individual's fulfillment of this requirement. In addition, we must offer tax credits for small businesses to encourage them to offer (and subsidize) employee coverage.

• *Health Insurance Exchange and Federal Charter.* We believe that we must create a rational regulatory structure that is conducive to creating affordable coverage options. Our system would be best served by a Federal regulatory structure for health insurance, with regulation enforced by State insurance departments. A national entity would need to determine a standard benefit package and determine what types of actuarially equivalent plans could be offered. Under a national framework, plans could be offered through a national exchange, or through State or regional insurance exchanges that create new pooling mechanisms. At the very least, we would encourage greater uniformity of State laws and regulations and the development of a new optional Federal charter. Today, insurers with a multi-state presence face costly administrative burdens to comply with divergent State laws and regulations, and these higher administrative costs are passed onto the market at large through higher insurance premiums.

• *Payment Reform.* Payment reform will also be a critical tool to improve quality and bend the cost curve. The traditional fee-for-service payment structure often rewards physicians and hospitals for the volume of services they deliver rather than

[1] Based on comparison of quotes derived on www.ehealthinsurance.com on July 11, 2008 for an August 1, 2008 start date. The percentage range is based on the premium in Pennsylvania reflecting 100 percent to 150 percent of the standard (quoted) rate, depending on medical underwriting.

[2] Families USA, "Paying a Premium: The Added Cost of Care for the Uninsured." Publication No. 05–101, June 2005. Available at www.familiesusa.org.

[3] PriceWaterhouseCoopers, "The Factors Fueling Rising Healthcare Costs 2008." Prepared for America's Health Insurance Plans, December 2008.

the value or quality of care they provide. Aetna supports transforming the payment system into one that aligns provider reimbursement incentives with the pursuit of high-quality outcomes for patients. We need a payment system that works for patients, bringing them value-high quality at the right cost. Reform also needs to focus on promoting patient-centered care that integrates the multiple aspects of the health care delivery system and shifts the model from episodic, acute care to comprehensive, evidence-based care.

• *Health Information Technology.* The use of health information technology (HIT) will not only be a powerful tool to bend the cost curve, but will also help address pervasive quality issues. The United States continues to lag behind its peers globally in embracing HIT solutions necessary to yield cost reductions and quality gains. Aetna continues to strongly support the President's initiatives to accelerate HIT adoption and commends the Congress' recent work to invest up to $22 billion to promote the use of electronic health records that have clinical decision support capacity as recommended by the Institute of Medicine. If 90 percent of all providers in the United States were using EMRs, we could see savings of about $77 billion within 15 years.[4] With the advent of sophisticated clinical decision support capabilities, those savings, coupled with lives saved, could exceed current expectations. At Aetna, we have made significant investments in health information technology, and we are not finished. Our investments are designed to help patients and doctors take action on their health conditions and help patients get the standard of care they expect and require.

TYPES OF REFORMS THAT RAISE CONCERNS

• *Public Plan.* First and foremost, insurers bring innovation, value and choices, allowing individuals to choose a tailored approach for their own needs that a one-size-fits-all public plan could just not achieve. Health care is one area in which we must leverage the agility of the private sector to provide continued innovation and customization of health care plans. We believe that this incentive to innovate will be stifled if a public plan is put into place.

A new public plan could also have negative repercussions for those who are already privately insured. A public plan would most likely employ the payment rates used in Medicare, which are far lower than the rates paid by private payers. In fact, the average family of four with private insurance spends an additional $1,788 on health care each year because of Medicare and Medicaid underpayments to providers that result in cost-shifting to the privately insured. On an aggregate level, commercial payers incur approximately $89 billion more in costs than they would if public and private payers all paid equivalent rates.[5] In other words, while the government saves money with underpayments, the 200 million Americans with private insurance are paying for it. Expanding the use of low public payment rates would mean expanded cost-shifting for our health care system, with providers charging higher rates to privately insured individuals, ultimately raising their insurance premiums and decreasing the affordability of their insurance. Moreover, a public plan is not the most direct or precise policy intervention to reduce significantly the number of uninsured. The Massachusetts health reform plan, for example, does not include a public plan and has achieved near-universal coverage.

Finally, there are some who argue that a public plan is the only way to ensure access to coverage for all Americans, regardless of health status. However, it is important to remember that in the absence of an individual coverage requirement, a public plan would face the exact same selection problems that private plans face today. As such, a public plan is not the silver bullet for the guaranteed issue of high-quality coverage. With the right regulations in place, however, private plans can provide guaranteed access to coverage for all Americans, while fostering innovation in the realms of wellness and chronic disease management and providing a suite of coverage options designed to respond to the unique needs of different people. A new public plan is not only an unnecessary use of public dollars, but also not the most effective policy response to the problem at hand.

• *Elimination of Employer-Sponsored Health Insurance.* We should avoid systemic disruption to the 177 million Americans who have employer-sponsored coverage, and we should build upon the strengths and innovations of private health coverage for other populations. Many Americans are satisfied with their current employer-sponsored coverage. According to a survey performed by the National Business Group on Health, 67 percent of employees believe their health plan is excellent or very

[4] Modem Healthcare, "By the Numbers." 2006–2007 Edition. December 17, 2006, p66.

[5] Milliman, *Hospital & Physician Cost Shift*, December 2008: figures reflect 2006 and 2007 data.

good, and 75 percent consider a health plan to be the most important employee benefit. Eighty-three percent of employees surveyed would rather see their salary or retirement benefits reduced than their health benefits if an employer needed to reduce their total compensation.[6] Among workers who are offered health insurance coverage, 82 percent elect to participate in their employers' health plans.[7] Instead of disrupting a system that works for many individuals, it would be more effective to explore ways to extend coverage to those currently not in the system.

Question 2. Individual health insurance markets are regulated both at the State level and Federal level. Should regulations be reformed at the national level, State level, or some hybrid? Additionally, if you think that regulation should occur to some degree at the national level, is it necessary for Congress to consider a phased-in approach or some other mechanism to address the diversity of initial regulatory conditions in each State?

Answer 2. We must create a rational regulatory structure that is conducive to creating affordable coverage options. Today's system of 50 divergent sets of State regulation imposes unnecessary and costly administrative burdens on our existing system. As such, I believe our system would be best served by a Federal regulatory structure for health insurance, with regulation enforced by State insurance departments. Given the current diversity in State regulation, a phased approach will be necessary to provide Americans with a seamless transition over to a new system.

As we make the system more accessible to all Americans, it is important to consider the 18 million people currently enrolled in the individual market whose initial premiums are based on health status. The transformation to the new system would result in a larger pool that would include previously uninsured, high risk people who, in a community rated system, would likely increase premiums for the already insured persons.

Question 3. Thus far, Massachusetts is the only State to successfully achieve a near universal expansion of health insurance. Before implementing the following reforms, Massachusetts had already made significant reforms to its insurance market and stood to lose Federal Medicaid dollars if they did not enact additional reforms. The 2006 Massachusetts insurance reforms focused on: (1) developing a statewide exchange that pools the small group and individual markets, (2) developing a minimum coverage standard, (3) mandating that all individuals secure health insurance, and (4) including subsidies for low-income individuals. Do you believe the Massachusetts' reform could serve as a model for national reform? What aspects of the reform are most promising (if any) and what aspects raise the most significant concerns (if any)?

GENERAL COMMENTS ABOUT MASSACHUSETTS HEALTH REFORM

Answer 3. One of the key issues in insurance reform is determining how to disperse risk across a group of people. The Massachusetts health reform plan has demonstrated that creating an insurance exchange is an effective mechanism to spread risk while ensuring that everyone has access to coverage. The Massachusetts Connector creates a level playing field for offering and purchasing health insurance for those unable to access coverage through an employer. The exchange also offers many of the same efficiencies as a large group market.

While the basic components of the Massachusetts model could serve as a national model for health reform, there are several key issues that should be addressed before implementing this type of plan at a Federal level. In particular, we need to fix our current volume-based payment system and address the growth of health care costs. Not doing so will greatly impact affordability of health insurance and sustainability of efforts to achieve universal coverage. In addition, increasing the role and supply of primary care providers will be essential.

KEY COMPONENTS OF MASSACHUSETTS' HEALTH REFORM PLAN

The Connector Exchange

What works well: The Connector creates a centralized location for individuals and employees of small businesses to purchase health insurance. This type of insurance pooling also helps to expand the risk across these different market segments. Additionally, the Connector does not have a public plan.

[6] National Business Group on Health, "Employer-Based Health Benefits Survey." April 2007. http://vww.businessgrouphealth.org/pressrelease.cfm?ID-87

[7] Pickreign, Jeremy et al. "Employer Health Benefits 2008 Annual Survey." Kaiser Family Foundation and Health Research and Education Trust. September 2008.

Opportunities for change: The Connector limits participation to six insurers who must bid for a spot on the exchange. In any future adaptation of the Massachusetts plan, we believe we must provide for open competition, allowing consumers to be the true judges of "winners" and "losers" among companies providing insurance coverage.

Individual Mandate

What works well: Requiring individuals to purchase health insurance is critical to reforming the healthcare system. An individual mandate is an effective method of ensuring all people—healthy and sick—are included in the system, thus avoiding adverse selection where people only seek insurance when they need it and when their health care costs are higher. Massachusetts redirected money previously spent on providing care to subsidize new insurance options for the uninsured.

Opportunities for change: In Massachusetts, the individual mandate was not enforceable until 2008, 2 years into the program. For an individual coverage requirement to be effective, it has to be enforced as early as possible. Also, if Congress phases in an individual mandate nationally, effective risk adjustment mechanisms must be explored to help offset the risk of adverse selection and keep individuals' premiums affordable.

Insurance Regulation

What works well: Even before Massachusetts' health reform plan was enacted, the State required guaranteed issue and renewal, prohibited medical underwriting, limited preexisting condition exclusions and had modified community rating rules. By adding an individual mandate and subsidies to help lower-income people afford coverage, the Massachusetts reform plan stabilized the market and the exchange more effectively pooled risk than the market did prior to reform.

Opportunities for change: Particularly if there is a phase-in of the individual mandate, there needs to be risk adjustment provisions to help offset the costs of adverse selection and keep the system and individual premiums stable. Importantly, a well-enforced individual coverage requirement with risk adjustment or reimbursement provisions will enable insurers to provide access to insurance on a guaranteed issue basis without exclusions for preexisting condition or rating on the basis of health status, similar to the regulation in place in Massachusetts.

Premium Assistance

What works well: The sliding scale subsidies available for those under 300 percent FPL is an effective method of ensuring low-income individuals and families can purchase insurance.

Opportunities for change: Many of the insurance products available are still unaffordable for those under 400 percent FPL. Insurance providers should be given the flexibility to create a variety of benefit packages that meet consumer's expectations. Available subsidies should be generous enough to allow low-income individuals and families to purchase insurance.

Financing and Cost-Containment

What works well: Creating viable opportunities for the uninsured to access health insurance is a start to reducing the cost of providing care to individuals currently accessing the healthcare system at expensive points of entry (e.g. emergency rooms) and with potentially untreated and complicated medical problems.

Opportunities for change: Massachusetts' health reform has done little to address the issue of cost containment. A Massachusetts-like program implemented at a Federal level must include payment reform and further investments in HIT and comparative effectiveness to bend the cost curve. Without changes to improve the value of healthcare, reform efforts will quickly become unaffordable.

Benefit Package

What works well: Massachusetts established actuarial equivalence for the plans offered through the Connector, allowing insurers the flexibility to design their benefits within a set of requirements.

Opportunities for change: The minimum benefit package levels under the Massachusetts plan are very comprehensive, requiring people to purchase plans that may be richer than what they truly need. It would be more cost-effective for minimum benefits levels to be set at a more modest level (e.g., only cover catastrophic and preventive services), allowing individuals to purchase other coverage as they see fit.

Expanding Public Programs

What works well: Massachusetts expanded Medicaid eligibility to all those under 100 percent FPL. This not only expands coverage to a vulnerable population, but ensures that cost-sharing is not a deterrent for care for low-income citizens. Aetna supports this expansion of Medicaid, as those living beneath the Federal poverty level would be very unlikely to be able to pay for or access another source of insurance coverage.

Question 4. How should an individual coverage requirement be enforced?

Answer 4. Aetna believes an individual coverage requirement should be enforced through the tax system, with verification conducted through annual income tax forms. Under a prospective enforcement system, individuals would be expected to provide proof of government or private coverage—or demonstration of financial hardship, the standards for which would need to be determined in advance. Those individuals not complying with the individual coverage requirement would need to pay a penalty equivalent to the cost of an essential benefits plan in their geographic area. With a penalty set at this level, there would be a lower incentive for noncompliance, with most individuals likely calculating that their dollars are better spent on a health insurance policy than on an equivalent penalty. The penalty could be delivered either through reduction of the individual's tax refund or as an additional tax liability.

Enrollment in insurance coverage should also be facilitated at the point of health care service, with uninsured individuals enrolled in either a government program, if eligible, or in a basic essential benefits package.

RESPONSE TO QUESTION OF SENATOR HATCH BY LEN M. NICHOLS, PH.D.

Question. What is an enforceable individual mandate?

Answer. Considerable evidence suggests that an individual mandate is enforceable. This is fortunate because an individual purchase requirement is absolutely necessary to make private insurance markets work for all Americans. Insurers must be required to sell to all comers regardless of health status. However, insurers must also be assured they will get to insure the entire population, not just the sick, to make the market work efficiently and fairly. Relevant research and our moral compass also tell us that the first step toward making a mandate enforceable is making the cost of compliance affordable. Therefore, in order to enforce a mandate we must first ensure that health insurance is accessible and affordable for all.

The key to an enforceable individual mandate is combining and integrating a number of approaches. Enforcement methods in a U.S. context should include:

• **Information sharing:** Electronic information sharing between citizens and the institutions they come in contact with, including: insurance marketplace managers, (i.e., those who administer enrollment for the "exchange"), employers, health providers, health insurers, schools, department of motor vehicles, and government agencies. This does not mean turning schools, hospitals, etc., into enforcers. These institutions need never be asked to deny care or service. But they would be asked to inform the authority responsible for enrollment records that a particular individual does not appear to be insured as of a particular date. The uninsured person would then be contacted by the exchange administrator's office and either enrolled in a plan of the enrollee's choice or possibly levied with a penalty and/or a requirement to pay back premiums.

We would need to allow insurance administrators to systematically review and monitor enrollment. Increased information sharing of this sort would also help identify people who are eligible for public or subsidized coverage but who are not enrolled. Information sharing has proved particularly effective in raising the rate of compliance with car insurance mandates.

POLICY SPOTLIGHT: GEORGIA CAR INSURANCE

In 2001, Georgia's uninsured motorist rate was 20 percent. Legislators recognized that individuals were purchasing car insurance in order to register their vehicle, but were cancelling their insurance when the registration process was completed.

To address this problem, Georgia requires all insurers to report policy enrollments and cancellations to a central database. This information is then cross-referenced with the car registration information. If after 30 days the system finds a motorist with a cancellation entry but without a new policy enrollment, a set of penalties (including fines and registration suspension) is put in motion. This process reduced Georgia's uninsured motorist rate from 20 percent to 2 percent in less than 2 years.

• **Proof of insurance on tax returns:** Many uninsured Americans could be identified through the tax system. While not all low-income individuals file tax returns, this could be a useful mechanism to identify middle- and high-income uninsured Americans. Almost 20 percent of uncompensated care in the U.S. is delivered to people who make more than four times the Federal poverty level.

• **Auto-enrollment/insurance checks at point of service:** Individuals who do not sign up for their own insurance (or if eligible, do enroll in a government program) would be automatically enrolled in a health plan by an insurance administrator. When they seek medical care from a doctor, hospital or clinic, their insurance status would be checked. Unpaid premiums would be reported to the insurance exchange administrator. A payment schedule would be identified, based on the uninsured person's income and ability to pay, to pay the overdue bills.

The idea is to create a seamless system and normative expectation that all citizens would have and maintain coverage. The net result of these information conduits is to make sure each person/family pays their fair share and no more. We do not need nor recommend criminal penalties. Monetary penalties should suffice. Remember, most people buy insurance today without a mandate, and the vast majority of the uninsured are in that situation because they cannot afford health insurance. Most uninsured are likely to buy as soon as we make it accessible and affordable.

No one suggests an individual mandate because they want to "make" people buy insurance. When combined with insurance markets and subsidies, an individual requirement to purchase coverage will actually help the market function more efficiently and fairly. In addition, a more sustainable health system will be a shared responsibility between individuals, employers, providers, and governments. A requirement to purchase or enroll in coverage represents one part of an individual's responsibility to the larger community.

[Whereupon, at 12:24 p.m., the hearing was adjourned.]

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