

**WHAT WOMEN WANT: EQUAL BENEFITS FOR
EQUAL PREMIUMS**

HEARING
OF THE
**COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS**
UNITED STATES SENATE
ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

ON

EXAMINING EQUAL HEALTH CARE FOR EQUAL PREMIUMS, FOCUSING
ON WOMEN

OCTOBER 15, 2009

Printed for the use of the Committee on Health, Education, Labor, and Pensions



Available via the World Wide Web: <http://www.gpo.gov/fdsys/>

U.S. GOVERNMENT PRINTING OFFICE

53-000 PDF

WASHINGTON : 2011

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

TOM HARKIN, Iowa, *Chairman*

CHRISTOPHER J. DODD, Connecticut
BARBARA A. MIKULSKI, Maryland
JEFF BINGAMAN, New Mexico
PATTY MURRAY, Washington
JACK REED, Rhode Island
BERNARD SANDERS (I), Vermont
SHERROD BROWN, Ohio
ROBERT P. CASEY, JR., Pennsylvania
KAY R. HAGAN, North Carolina
JEFF MERKLEY, Oregon
AL FRANKEN, Minnesota
MICHAEL F. BENNET, Colorado

MICHAEL B. ENZI, Wyoming
JUDD GREGG, New Hampshire
LAMAR ALEXANDER, Tennessee
RICHARD BURR, North Carolina
JOHNNY ISAKSON, Georgia
JOHN McCAIN, Arizona
ORRIN G. HATCH, Utah
LISA MURKOWSKI, Alaska
TOM COBURN, M.D., Oklahoma
PAT ROBERTS, Kansas

J. MICHAEL MYERS, *Staff Director and Chief Counsel*
FRANK MACCHIAROLA, *Republican Staff Director and Chief Counsel*

(II)

C O N T E N T S

STATEMENTS

THURSDAY, OCTOBER 15, 2009

	Page
Murray, Hon. Patty, a U.S. Senator from the State of Washington, opening statement	1
Prepared statement	2
Burr, Hon. Richard, a U.S. Senator from the State of North Carolina	3
Brown, Hon. Sherrod, a U.S. Senator from the State of Ohio	4
Casey, Hon. Robert P., Jr., a U.S. Senator from the State of Pennsylvania	6
Franken, Hon. Al, a U.S. Senator from the State of Minnesota	7
Prepared statement	8
Mikulski, Hon. Barbara A., a U.S. Senator from the State of Maryland	10
Hagan, Hon. Kay R., a U.S. Senator from the State of North Carolina	10
Prepared statement	11
Guest, James, President and CEO, Consumers Union, Yonkers, NY	15
Prepared statement	17
Furchtgott-Roth, Diana, Senior Fellow, Hudson Institute, and Director, Center for Employment Policy, Washington, DC	21
Prepared statement	23
Crouse, Janice Shaw, Ph.D., Director and Senior Fellow, Concerned Women for America, Washington, DC	28
Prepared statement	29
Greenberger, Marcia F., Founder and Co-President, National Women's Law Center (NWLCC), Washington, DC	33
Prepared statement	35
Buchanan, Amanda, Patient/Health Care Consumer, Weiser, ID	45
Prepared statement	47
Robertson, Peggy, Patient/Health Care Consumer, Centennial, CO	48
Prepared statement	49
Ignagni, Karen, President and CEO, America's Health Insurance Plans (AHIP), Washington, DC	50
Prepared statement	51
Merkley, Hon. Jeff, a U.S. Senator from the State of Oregon	57
Bennet, Hon. Michael F., a U.S. Senator from the State of Colorado	62

ADDITIONAL MATERIAL

Statements, articles, publications, letters, etc.:	
Senator Enzi	71
Washington Post article	71
Letters from:	
North Carolina Department of Insurance to Senator Burr	72
Consumers Union to Senator Mikulski	73
Response to Question of Senator Merkley by Jim Guest	74

(III)

WHAT WOMEN WANT: EQUAL BENEFITS FOR EQUAL PREMIUMS

THURSDAY, OCTOBER 15, 2009

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

The committee met, pursuant to notice, at 10:33 a.m. in Room SD-430, Dirksen Senate Office Building, Hon. Barbara A. Mikulski, presiding.

Present: Senators Mikulski, Murray, Brown, Casey, Hagan, Merkley, Bennet, Franken, and Burr.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. This hearing will come to order. Senator Mikulski will be chairing this committee, but she is running late and asked me to go ahead and get it started, so we could get opening statements going. I just want to express my appreciation to Senator Mikulski and for all of our colleagues who are here today for this hearing, where we are going to be talking about a topic that impacts not only women, but families and entire communities.

You know, when the rising cost of health insurance hits women, it hurts our Nation. For the millions of women across this country who open up the mail every month to see their premiums go up, or who cannot get the preventive care like mammograms because the co-pays are too high, or who work part-time or for a small business that doesn't provide insurance, or can't get covered for maternity health care, or, worst of all, forced to stay in an abusive relationship because if they leave they or their children lose coverage, we really have to be the voice of those women.

Today we are having this hearing to ask the questions that women and families and businesses across America are asking. Some of you in this room have heard me tell the story of a young boy I met by the name of Marcellas Owens from my home State—I met him back in the spring—who told me that he is watching me every day to see what we're going to do with this health care bill, because he has a very tragic story. His mom, whose name was Tiffany, got sick and, because she was sick, she lost days at work and her employer said: "If you can't come to work, we're going to fire you." She worked for a fast food restaurant. She had three kids and had health coverage through that fast food restaurant.

In September 2006, because she missed so much work, she lost her job, and with that she lost her health care coverage. When she

lost her health care coverage, she could not go to the doctor any more, and as a result of that Tiffany lost her life.

Marcellas, the little boy, told me last spring that he is going to be watching me to make sure that no other little boys lose their mom. That's what this health care debate is about, because our system really is broken. Women like Tiffany, across the country who are moms, shouldn't lose their health care because they are sick, and we need to make sure that this system works for them and for women who are denied coverage or charged more because of preexisting conditions, conditions like pregnancy or C-sections or domestic violence.

Our system is broken when insurance companies charge women of child-bearing age more than men, but they don't cover the maternity care anyway, or only offer it for hefty additional premiums. Women and their families and businesses need health insurance reform and that's why we're working so hard on this.

We know that health reform will help women by ending discrimination based on gender rating or gender-biased preexisting conditions, by covering maternity care, by covering preventive care and screenings, including mammograms and well-baby care, by expanding access to coverage even if an employer doesn't offer it, and making family health decisions, which are frequently made by women, by setting up a health insurance exchange.

There is a lot in the health care reform that is very important to women, and we're having this hearing today to talk about those issues in particular as we move forward on this.

Again, Senator Mikulski will be joining us in just a few minutes, but I will turn to our colleagues for their opening statements and then, if she's not here, we'll turn to our witnesses to begin.

[The prepared statement of Senator Murray follows:]

PREPARED STATEMENT OF SENATOR MURRAY

Thank you, Senator Mikulski, for holding this hearing.

And thanks to all of our colleagues for attending to discuss a topic that impacts not only women, but families and entire communities.

Because when the rising cost of health insurance hurts women, it hurts our Nation.

And for the millions of women across America—

- who open the mail each month to see premiums go up,
- who can't get needed preventative care like mammograms because the co-pays are too much,
- who work part time or for a small business that doesn't provide insurance,
- who can't get covered for critical maternity care, or
- who are forced to stay in abusive relationships because if they leave, they or their children will lose health care coverage—we are their voice.

And today we are asking the questions that women and families and businesses across America are asking.

Many of you in this room have heard me tell the story of a little boy named Marcellas Owens from my home State of Washington

whose mom, Tiffany, got sick and lost her life because of the high cost of health insurance.

Tiffany was a single mom who felt strongly about working to support her three children. She had health care coverage through her job at a fast food restaurant. But, in September 2006 she got sick and started to miss a lot of work.

Her employer gave her an ultimatum: make up the lost time or lose your jobs. Well, because of her illness, Tiffany physically couldn't make up the time and she lost her job and with it went her insurance.

As we have seen time and time again, women are charged nearly 50 percent more than men in the insurance market—and with a pre-existing condition it would be almost impossible to get coverage anyway.

Without the coverage and care she needed, in June 2007, Tiffany lost her life and Marcellas and his sisters lost their mom.

Our health care system is broken.

It's broken for women and moms like Tiffany who work to provide for their families but are charged nearly 50 percent more than men for health care in the individual market.

It's broken for women who are denied coverage or charged more for "Pre-Existing Conditions" like:

- "Pregnancy,"
- "C-Sections," or
- "Domestic violence."

It's broken when insurance companies charge women of child-bearing age more than men but still don't cover maternity care. Or only offer it for hefty additional premiums.

The status quo isn't working.

Women and their families and businesses need health insurance reform now.

Reform will help women by:

- Ending discrimination based on gender-rating or gender-biased "pre-existing conditions."
- Covering maternity care.
- Covering preventative care and screenings—including mammograms and well-baby care.
- Expanding access to coverage even if an employer doesn't offer it and making family health decisions—which are frequently made by women—easier by setting up a health insurance exchange.

For women across this country, and for their families, our businesses, and our Nation's future strength, we have to reform our health insurance system this year.

I want to thank Senator Mikulski again for her dedication to this issue and I look forward to hearing from all of today's witnesses.

With that, Senator Burr, if you would like to make an opening statement.

STATEMENT OF SENATOR BURR

Senator BURR. Thank you, Senator Murray. I want to thank you and Senator Mikulski for chairing this hearing this morning. I also want to thank our witnesses for their willingness to come in, to travel on a very messy day in Washington, DC, probably most of

the country. It's a sure sign that the season's changing as they call for snow just 60 miles away from here.

In many families women are the primary health care decision-maker for their loved ones. I appreciate having the opportunity today to discuss more specifically how health care reform would impact women across North Carolina and, more importantly, across our country. Today's hearing will help us inform our continued work on health care reform.

As I've told my constituents and colleagues many times in recent months and weeks, I agree that we need meaningful, meaningful health care reform. I was proud to join my Senate colleague Tom Coburn earlier this year when we introduced the first comprehensive legislation to fundamentally reform our health care system.

The Patients' Choice Act is based on the principle of promoting universal access to quality and affordable health care for all. Our bill avoids a one-size-fits-all government-run program, instead promoting choice for every American regardless of their income or employment, so that they can access a health plan that meets their income, their health needs, their conditions.

The Patients' Choice Act restores the idea of portability to health coverage. If you move or change jobs, you don't lose your health insurance. And we create State insurance exchanges to give Americans a one-stop marketplace to compare different health insurance policies and the ability to select the one that meets their unique health needs.

The Patients' Choice Act also moves our Nation away from our current health system that's been plagued by sick care for far too long, by promoting prevention, wellness, and chronic disease management. For example, we provide incentives for States to reduce rates of chronic disease like heart disease, the leading cause of death for both women and men in our Nation. And our legislation is sustainable for generations to come.

I think another important element that should be part of this discussion is medical malpractice reform. If we care about making sure women have access to OB-GYNs, we cannot ignore the fact that high malpractice insurance is driving doctors out of this specialty and, even worse, closing their practices or forcing them to migrate to urban areas only.

I hope this issue is part of the discussion today because it is the 800-pound gorilla in the room when it comes to access to affordable health care for women. Any serious piece of health care reform legislation must include these essential principles.

I look forward to continuing to work with my colleagues on health reform to ensure that constituents across North Carolina and, more importantly, this country have access to quality and affordable health care.

I thank the chair.

Senator MURRAY. Thank you.

Senator Brown.

STATEMENT OF SENATOR BROWN

Senator BROWN. Thank you, Senator Murray, and thanks to Senator Mikulski for calling this hearing. Thank you all, the seven of you, for joining us today.

There's been a lot of attention this year, as we know, to the need for health reform, but there's been too little attention focused on how health reform will work to improve the health and well-being of more than half our Nation's population, America's women. Our Nation's made significant progress toward equal treatment of men and women. We've passed legislation promoting equitable wages for the same work regardless of gender. We've passed legislation to prohibit gender discrimination in education and athletics. We've passed legislation to end housing discrimination on the basis of sex. We've passed legislation to provide compensation for victims of sexual harassment. We've passed legislation to end pregnancy discrimination in employment.

However, we've yet to pass legislation to end gender discrimination in health insurance coverage and to bridge the gender gap that exists so troublingly in our health care system. It's simply unacceptable that in a nation which has made such great strides with respect to women's rights, something we trumpet all over the world, that we allow more than 20 million American women and girls to go without health insurance each year.

In 2007, 14 percent of all women in my State of Ohio were uninsured. Part of the reason that so many women are uninsured stems from the fact that women are less likely to be employed full-time, especially full-time in jobs with health care benefits, making them less likely to be eligible for employer-based health benefits.

Another part of the reason is that important State and Federal laws that protect women with employer-sponsored coverage don't protect women purchasing health insurance in the individual market. For instance, in the private health market, insurance companies are allowed to deny care or charge higher premiums based on gender, history of domestic violence, or preexisting conditions such as pregnancy. As a result, women are often charged higher premiums than men.

In Columbus, the capital of my State, a 30-year-old woman pays 49 percent more than a man of the same age for Anthem's Blue Access Economy Plan. The woman's monthly payment is \$92.87; a man pays \$62.30. At age 40, women pay 38 percent more than men for that policy.

Compounding this premium hardship is the sad reality that women are generally poorer than men. In Ohio, women earn just 74 cents for every dollar a man earns. Insurers in Ohio and most parts of the country are also allowed to exclude coverage for preexisting conditions. For example, if a woman previously had a C-section, insurers are allowed to refuse to pay for future C-sections or reject her application altogether due to a supposed preexisting condition. In 2006, close to a third of all births in Ohio were by C-section, meaning that tens of thousands of women could face coverage exclusions or rejections because of these preexisting condition exclusions.

Health reform will finally put an end to these practices, which curtail access to, and undercut the value of, health insurance for women. No more gender discrimination in premiums; no more coverage denials because of preexisting conditions; no more exploitation of a woman's history, particularly a history of being victimized by domestic violence—all to inflate premiums going forward.

I would add that a public option is important to ensure these rules are indeed enforced. Health reform will then ensure coverage of basic health services, including maternity benefits. Health reform will place a cap on the costs insurance companies charge and, that insurance companies can shift to their enrollees.

One of the industry's smoothest tricks is to market a full loaf to get you to purchase coverage to protect against unanticipated health spending, but when you get sick what's unanticipated is how little your insurance actually covers. We all have stories. I go to the Senate floor night after night and read letters from people in Lima and Mansfield and Toledo and Cincinnati, people who thought they had really good insurance until they got really sick and found out their insurance wasn't what they thought it was.

That's why this health insurance legislation is so important. That's why the work of all of you on this panel is so important, to make sure that these problems that we've had in this country for decades are a thing of the past.

Thanks.

Senator MURRAY. Thank you.

Senator Casey.

STATEMENT OF SENATOR CASEY

Senator CASEY. First of all, I want to thank Senator Murray for chairing our hearing, and Senator Mikulski for her leadership.

I will echo, but not reiterate, a lot of what Senator Brown said about so much of the work that's been done this year in the Senate, in both the HELP Committee and the Finance Committee. I note two provisions among many, but two that we worked on in the HELP Committee. One was 2701, prohibiting insurance rating based upon gender, which of course leads to bad outcomes for women across the board.

Senator Brown mentioned just the issue of domestic violence. The idea that that would be a bar to coverage, that that would prevent a woman from getting the kind of health care coverage that she should have a right to expect, is really horrific. In the case of a victim of domestic violence, it's the ultimate betrayal, and then she gets betrayed again because the system doesn't give her the kind of coverage and/or treatment that she should have a right to expect.

The Office of Women's Health was also part of the HELP bill. Obviously, in the Finance Committee more work was done as well. I was on the HELP Committee, so I tend to favor that bill. I voted for it.

But I think between the two committees we can make tremendous progress on a whole host of issues that relate to women, but in particular those issues that center on the kind of coverage that all of us should have a right to expect. But the idea that we're still allowing gender discrimination to go on when we have the power to fix it at long last is particularly disturbing.

This is the year that we will not only vote on a health care bill, but it's the year at long last that we correct that continuing problem for women as it relates to the kind of coverage they get.

There's a lot more to talk about. I know that many of us have worked on—as I was a co-sponsor of the Women's Hospital—Wom-

en's Hospitals, plural, Education Equity Act, which among other things would create a \$12 million funding pool for graduate medical education for small women's hospitals, it also requires hospitals to report annually on the status of the residency training programs. Senator Whitehouse has led on this and others have helped as well.

We have to continually look for opportunities to make progress, but the most important thing we can do this year, I believe, is to make sure that no more gender discrimination occurs in our health insurance policies.

With that, Senator Murray, thank you for chairing the hearing. Senator MURRAY. Thank you. Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Thank you, Senator Murray. And I want to thank Chairwoman Mikulski for holding today's hearing on this crucial topic of how health reform will improve the lives of American women. I believe that women's health is fundamental to our country's health because women are the small business owners and entrepreneurs, they are the educators, doctors, and CEOs. As mothers and grandmothers, women are often also the health care decisionmakers for our families.

It is of utmost importance that the national health reform legislation makes a real difference in the lives of American women across their entire lifespan. As others on the committee have mentioned, women are among those most severely disadvantaged in our current health system. Right now, health insurance companies discriminate against women solely on the basis of their gender. Right now it is legal in many States for health insurance companies to charge women higher premiums or deny coverage altogether if they are, for example, survivors of domestic violence, as Senators Brown and Casey have spoken to.

Instead of providing the care and support that victims need in order to get out of abusive situations and stay healthy, health insurance companies actually punish these women. This is simply amoral and unacceptable.

It is also unbelievable to me that in this day and age we allow insurance companies to charge women more for health insurance simply because of the fact that they may become pregnant. I heard recently from a woman named Jessica in Minneapolis. Jessica is 35 years old and works as an independent contractor. When she started her business she knew that it was important to have health insurance, of course, and she wanted to do the responsible thing, so she looked into buying an individual health plan.

She found two main options, both of which had the same benefits except for one thing: maternity care. The plan that included maternity services cost about twice as much and was unaffordable for her. Right now she doesn't have any children, but she thinks she might like to become pregnant some time in the next few years. But as she was considering these individual health coverage options, Jessica found out that to get the pregnancy coverage she would also need to be enrolled in the maternity coverage for 18

months before becoming pregnant. Otherwise her pregnancy would be considered a preexisting condition and would not be covered.

Health insurance companies consider pregnancy a preexisting condition, and as far as I know it's only one that women can have. We permit this discrimination under current law.

Now, Jessica is a young entrepreneur, exactly the type of smart and innovative business person that we want to encourage in Minnesota. But this ridiculous practice of charging women more for health insurance sends a message that we don't want women to receive prenatal services and high quality maternity care, as if we don't all benefit from healthy mothers and healthy babies.

The reality is that if my wife or your sister doesn't have access to high quality affordable health care, that's bad for all of us, bad for our economy, our country, and our future.

Fortunately, when we pass national health reform we will begin a new era in women's health. For the first time, women will have access to comprehensive health benefits, including maternity care, without having to pay more than their male counterparts. This is a huge step forward for justice in our country and it's one of the main reasons why we must pass health reform this year.

It's also a top priority for me that health reform includes a crucial women's health service, access to affordable family planning services. These services enable women and families to make informed decisions about when and how they become parents. Access to contraception is a fundamental right of adult Americans, and when we fulfil this right we're able to accomplish a goal that we all share on both sides of the aisle, to reduce the number of unintended pregnancies.

I believe that affordable family planning services must be a part of the final implementation of health reform legislation. I look forward to working with all of my colleagues here to ensure that we make this a reality for all women in America.

Senator Murray and Senator Mikulski, I appreciate the opportunity to participate in today's discussion and look forward to hearing from all of our witnesses. Thank you all for being here today.

Madam Chairwoman.

[The prepared statement of Senator Franken follows:]

PREPARED STATEMENT OF SENATOR FRANKEN

Thank you, Madam Chairwoman. And thank you for holding today's hearing on this crucial topic of how health reform will improve the lives of American women. I believe that women's health is fundamental to our country's health because women are small business owners and entrepreneurs; they are educators and doctors and CEOs. And as mothers and grandmothers, women are often also the health care decisionmakers for our families. It is of utmost importance that national health reform legislation makes a real difference in the lives of American women, across their lifespan.

As others on the committee have mentioned, women are among those most severely disadvantaged in our current health system. Right now, health insurance companies discriminate against women solely on the basis of their gender. And right now, it's legal in many States for health insurance companies to charge women higher premiums—or deny coverage all together—if they have a

history of domestic violence. Instead of providing the care and support that victims need in order to get out of abusive situations and stay healthy, health insurance companies punish them. This is simply immoral and unacceptable.

It is also unbelievable to me that, in this day and age, we allow insurance companies to charge women more for health insurance simply because of the fact that they may become pregnant. I heard recently from a woman named Jessica in Minneapolis. Jessica's 35 years old and works as an independent contractor.

When she started up her business, she knew that it was important to have health insurance. She wanted to do the responsible thing so she looked into buying an individual health plan. She found two main options, both of which had all of the same benefits except for one thing: maternity care. And the plan that included maternity services cost about twice as much and was unaffordable.

Right now, she doesn't have any children but she thinks she might like to become pregnant sometime in the next few years. But as she was considering these individual health coverage options, Jessica also found out that to get the pregnancy coverage, she would also need to be enrolled in the maternity coverage for 18-months before becoming pregnant. Otherwise, her pregnancy would be considered a preexisting condition and would not be covered. Health insurance companies consider pregnancy a preexisting condition. And we permit this discrimination under current law.

Jessica is a young entrepreneur—exactly the type of smart and innovative businessperson that we want to encourage in Minnesota. But this ridiculous practice of charging women more for health insurance sends the message that we don't want women to receive prenatal services and high-quality maternity care. As if we don't all benefit from healthy mothers and babies. The reality is that if my wife or your sister doesn't have access to high-quality, affordable health care, that's bad for all of us—bad for our economy, our country and our future.

Fortunately, when we pass national health reform, we will begin a new era in women's health. For the first time ever, women will have access to comprehensive health benefits, including maternity care—without having to pay more than their male counterparts. This is a huge step forward for justice in our country, and it's one of the main reasons why we must pass health reform this year.

It is also a top priority for me that health reform includes a crucial women's health service—access to affordable family planning services. These services enable women and families to make informed decisions about when and how they become parents. Access to contraception is a fundamental right of adult Americans. And when we fulfill this right, we are able to accomplish a goal that we all share, on both sides of the aisle—to reduce the number of unintended pregnancies. And so I believe that affordable family planning services must be part of the final implementation of health reform legislation. I look forward to working with all of my colleagues here to ensure that we make this a reality for all women in America.

Madam Chairwoman, I appreciate the opportunity to participate in today's discussion and look forward to hearing from all of our witnesses.

STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. Well, good morning, everybody.

I'll kind of be the wrap-up speaker. The vagaries of the Baltimore-Washington Parkway delayed my arrival. But I will now turn to Senator Hagan and then I'll say a few words, and then we look forward to hearing from our excellent panel.

STATEMENT OF SENATOR HAGAN

Senator HAGAN. Thank you, Madam Chairwoman. Thanks so much for holding this hearing today. I think that it's critical that we highlight the disparities in affordable health insurance options between men and women.

Recently I received communications from several women in North Carolina. One woman in particular, when she was 27 years old she was diagnosed with breast cancer. She had a 16-month-old son and this woman was in an extremely abusive relationship. It was interesting, too: Her husband knew that she could not leave him because of her breast cancer and that she had to have his employer-provided health insurance.

She looked into individual insurance plans, but her breast cancer obviously was considered a preexisting condition. For 7 years this woman stayed in this abusive relationship.

Another woman called me about her sister, and the sister, who was uninsured, had waited years between mammograms because she couldn't afford to pay for the out-of-pocket screenings. She found a lump in her breast. What happened, the lump became a mass, she finally got a mammogram, and she paid for that with cash. The mammogram confirmed what she had suspected, that she did have breast cancer. Once she had that diagnosis, she still was unable to get the treatment she needed.

She ended up passing away last March. Her sister obviously feels that had she had preventive care, early detection, that perhaps she could still be with us today.

Unfortunately, we hear about these cases far too often. I think the inefficiencies and discriminatory practices in our health care system disproportionately affect women. In all but 12 States, insurance companies are allowed to charge women more than they charge men for coverage. I think some other people have already said it, that the great irony is that so many people who are being obviously cared for by women and mothers, these women are penalized under our current system.

I have two children in their early 20s, one male, one female. Guess what, the female is paying lots more for private health insurance than her brother. I had a 23-year-old staff member look up—she's from Fayetteville—look for health insurance on the open market. The best-selling plan with the \$2,700 deductible that she could find would cost her \$235 a month. For men of the same age, it was \$88 a month, more than 2½ times as expensive.

We looked up in Maryland, too, Senator Mikulski, you might be interested, one of the few States that prohibits gender rating. A basic health plan there costs as low as \$37 a month both for men and women.

After overcoming some of the cost and preexisting qualifying hurdles, many women who have health insurance are still stuck because some of the preventive screenings—mammograms, Pap smears—are not covered as preventive care, and often the co-pays for these extremely critical services are extremely high. In many cases, the difference between life and death is early detection. I think we all know that. I think everything we can do to give preventive screenings will pay off.

I also heard from a hospital in North Carolina that recently implemented a wellness program. A few years ago this CEO was meeting with about 20 to 30 of the nursing assistants, who were earning at the lower wage of the hospital. The CEO asked the group of those who were there who were old enough to require a mammogram how many had had one. Only 20 percent of these women said that they'd had one and the rest said, due to the out-of-pocket cost and the other financial items that they were juggling, food for their children, paying rent, et cetera.

After that meeting, the CEO said that the hospital decided to remove that cost-sharing barrier for those preventive services, which I think is a plus.

The bill that we put forward in this committee, the Affordable Health Choices Act, makes preventive care possible for women across America, and it eliminates the co-pays and the deductibles for these recommended preventive screenings.

I also think that we need to really look at the fact that so many places around our country, insurance companies are charging women more than men, whether it's just for basic coverage, and then obviously a separate item on maternity coverage; and that using these preexisting conditions as a reason to deny anyone health insurance is unacceptable.

Madam Chairman, thanks for holding this committee meeting and I look forward to hearing from our witnesses today.

[The prepared statement of Senator Hagan follows:]

PREPARED STATEMENT OF SENATOR HAGAN

Madame Chairwoman, thank you for holding this hearing today.

I think it is critical that we highlight the disparities in affordable health insurance options among men and women.

Recently, I received two e-mails highlighting the real world ramifications of health insurance inequities between men and women.

A few weeks ago, I received a heartbreaking e-mail from a young woman from North Carolina. When this woman was 27, she was diagnosed with breast cancer. She had a 16-month-old son, and was in an extremely abusive relationship.

Her husband knew she wouldn't leave him because she couldn't afford her medical treatment without his employer-provided health insurance.

This woman looked into individual insurance plans, but her breast cancer was considered by insurance companies to be a pre-existing condition. For 7 years, her husband kept her in this abusive relationship by threatening to take her off his insurance plan.

I also received an e-mail from a woman in Raleigh, NC about her sister, who was uninsured and waited years between mammograms

because she couldn't afford to pay for out-of-pocket screenings. She found a lump in her breast.

By the time the lump became a mass, Julie's sister finally got a mammogram—and had to pay for it with cash. The mammogram confirmed what she suspected—that she had breast cancer. But now that she had a diagnosis, she had no way to pay for the treatment.

Julie's sister lost her battle with breast cancer this March. Like thousands of women across America, Julie's sister probably could have beaten this cancer if she had access to affordable preventive care and, after her diagnosis, access to insurance to cover her cancer treatment.

In this heartbreaking situation, Julie's sister was sick and stuck.

Unfortunately, I hear about cases like these far too often. Inefficiencies and discriminatory practices in our health care system disproportionately affect women.

In all but 12 States, insurance companies are allowed to charge women more than they charge men for coverage. The great irony here is that mothers, the people who care for us when we are sick, are penalized under our current system.

My daughter Carrie recently graduated from college and had to purchase her own insurance. For no other reason than her gender, insurance policies cost more for Carrie than they do for my son, Tilden.

For a 23-year-old, healthy female from Fayetteville, NC shopping for health insurance on the individual market, the most basic, best selling plan, would cost her \$235 a month. For a man of the same age, it would cost \$88 a month. That's more than 2½ times more expensive.

While some argue that females cost the health care system more in medical costs, these discrepancies are steep. Especially if you consider in Maryland, one of the few States that prohibit gender rating, a basic health plan costs as low as \$37 per month for both men and women.

After overcoming some of the cost and preexisting qualifying hurdles, many women who have health insurance are still stuck. Insurance companies often don't cover key preventive care services—ranging from mammograms to pap smears. And often the co-pays for these critical services are extremely high.

One in five women over the age of 50 has not received a mammogram in the past 2 years. More than half of all women, like Julie's sister, have reported delaying preventive screenings because of the exorbitant cost.

In many cases, the difference between life and death is early detection.

I heard from one of the hospitals in North Carolina which recently implemented a wellness program. A few years ago, the CEO of this hospital was meeting with about 20 to 30 nursing assistants who were earning relatively low wages. The CEO asked the group of those who were old enough to require a mammogram, how many had. Only 20 percent said they had and the rest said they could not afford the out-of-pocket costs with all the other financial items that they were juggling, like food for their children, paying rent,

etc. After that meeting, the hospital decided to remove the cost sharing barriers for preventive services.

The Affordable Health Choices Act, which came out of this committee, makes preventive care possible for women across America. It eliminates all co-pays and deductibles for recommended preventive services.

We also are stopping insurance companies from charging women more than men—or using preexisting conditions as a reason to deny anyone health insurance.

I look forward to hearing from our witnesses today.

Senator MIKULSKI. Well, good morning to everybody. I apologize for being late. It was not only the traffic, but, as you can see, I'm now looking at the health care system from the wheelchair up. A couple of months ago, coming out of mass, I took a fall on some steps and broke my ankle in three places, and have required extensive surgery and extensive rehabilitation. I have seen health care from a patient's perspective more up close and personal than I wanted; I also have spent a lot of time talking to very talented providers, from gifted surgeons to the physical therapists and GNAs; and I also have been in the rooms with others who've had to seek assistance, from knee replacements to amputations.

We know that health care is truly an American issue, where we need to be able to guarantee access. Health reform is how we achieve universal access in a way that meets quality standards and also cost standards.

Along our way, as we've looked at this, we see that there are other issues related to what appears to be discrimination or red-lining, and this is why we're holding our hearing today, called Equal Benefits for Equal Premiums. I want to thank my colleagues for their opening statements because they set the tone that I was going to call for if I kicked it off, which is: one, to welcome everyone, acknowledging that when coming to the table we will have diverse views, just as they are among ourselves here on the committee, and also at our witness table.

We welcome diverse views. That's how we arrive at what we hope will be the sensible center in which we can achieve health care reform that will provide the greatest range of access, but at the same time recognizing the mandate for prudence when it comes to cost to both our government, to insurance companies, but most of all to American families.

We have here a representation on a bipartisan panel. We've worked with Senator Burr, who is my ranking member on the subcommittee, and we thank you for being here. We really welcome your views and we want to hear them. What I will guarantee is that this hearing from our side of the table will be conducted with the utmost of civility. I believe that, in order to arrive at that sensible center, we really need to listen to each other and have a dialogue with each other.

In preparation for turning to our witness table, I just wanted to note that every single panelist will be treated with the utmost respect, dignity, and civility, because the issue is too big, it's too serious, to get into petty, prickly disputes.

For me, health care definitely is a woman's issue. My history goes back to my early days on this panel, when women were ex-

cluded from the protocols at NIH. The famous study, take an aspirin a day to keep a heart attack away, was done on 10,000 male residents, doctor residents, and not one woman was included.

Thanks to working on a bipartisan basis, Senator Kennedy, Senator Harkin, myself in the House, Senators then-Congresswomen Snowe and Connie Morella, and working with a very brilliant physician named Bernadine Healy, we were able to change the paradigm and I believe have improved quality care for women.

For us, health care as a woman's issue has been an important part of this panel. Health care reform, we believe, is a must-do woman's issue because so many women are affected by health care and they also often drive the decisions that families make about health care. And health insurance reform is a must-change issue.

We've heard many of the facts presented by colleagues in their opening statements, how we're concerned that women are discriminated against, No. 1, in paying higher premiums; also that often our life processes, like pregnancy, are treated as preexisting conditions; and also the issue of prevention and wellness often, because we want those much-needed screenings, are high-cost or have other barriers.

My colleagues have given an excellent set of facts and I am not going to repeat them. I think we can turn right to the witnesses. But I can tell you where I'm heading, which is I want to be able to listen to ideas and recommendations and experiences, but one of the largest consumers of health care are older women and, quite frankly, older Americans. At the end of the day, when we conclude our deliberations and votes on this, we want to save and strengthen Medicare.

No. 2, we want to eliminate those barriers to health insurance. Particularly the issue of gender rating is of great concern, where simply being a woman means you pay more.

No. 3, the very controversial issue of what is a preexisting condition that could be a barrier to getting health care. I was very concerned that simply being pregnant or having a C-section often can result in paying far more, far more for care.

Again, my colleagues have given the other facts and statistics, which I won't repeat. But the fact remains that women often pay more than their male counterparts: a 25-year-old male in roughly the same condition often pays less than a 25-year-old female; and the fact of the matter is that preexisting conditions like pregnancy or having had a C-section could be a barrier to health insurance.

And No. 4, often those vagaries of life, like being a battered woman, in eight States also means you can have a harder time affording or obtaining health insurance.

What we want to be able to do, because this committee and many at this table have fought for equal pay for equal or comparable work, we want to be able to have equal or comparable benefits for equal premiums.

I've said enough for now, and I want to turn to our panelists. I thought maybe, rather than saying should we go in alphabetical order or whatever, maybe we'll just start with Mr. Guest and go all the way down and, Ms. Ignagni, wrap up with you, and then we can go to our questions. What I'd like to do is welcome Mr. Guest, the President and CEO of Consumers Union, with a distin-

guished career in public service. We want to turn to Diane Furchtgott-Roth of the Hudson Institute, Senior Fellow on Employment Policy and also Lead Economist, who comes to us having actually served as a staff member in President Reagan's Council of Economic Advisers, and we look forward to her testimony.

Janice Shaw Crouse of the Concerned Women of America, who's also a Senior Fellow at the Beverly LaHaye Institute, and worked for Dr. Lou Sullivan, the wonderful Secretary of HHS. We miss seeing him as much as we used to. We welcome her and her expertise.

Marcia Greenberger, the Founder and Co-President of the National Women's Law Center, that has helped us, giving us many of the ideas that helped us with the Lilly Ledbetter Fair Pay Act and the Pregnancy Discrimination Act and so on.

Amanda Buchanan, who is a real live mother who has had to face the significant issues of family and responsibility both for herself and for her children.

Peggy Robertson, who also was someone who thought she had health insurance, then had a C-section, which I know she'll tell us about, and then what happened as she came up against the insurance bureaucracies.

Then Karen Ignagni, President and CEO of the American Health Insurance Plans. She herself was a professional staffer here to a beloved member, Claiborne Pell, and actually worked for the HELP Committee. Some might say, well, she's kind of a proxy staffer now, the way we see her so much. But she comes with a tremendous background in really the human service field and now is representing the insurance company and is viewed as one of the three trade associations.

Again, we welcome all views and we want everyone to really lay it out, because what we're here to do is not debate, but to discuss, to listen, to learn and to see how we can find that sensible center the American people want us to.

We look forward to hearing from you all.

Mr. Guest.

**STATEMENT OF JAMES GUEST, PRESIDENT AND CEO,
CONSUMERS UNION, YONKERS, NY**

Mr. GUEST. Well, Madam Chairwoman, thank you very much, and members of the committee. I'm Jim Guest, President of Consumers Union, publisher of Consumer Reports. Thank you for the chance to be heard on this crucial issue.

Clearly, one of the most important pocketbook issues for American families today is health care. For the last few years, Consumer Reports has both done extensive surveys about the health care crisis and we've also collected personal stories, thousands of personal stories, many from women, about the country's broken health care system.

Women are the chief purchasing officers in most households, as you know, making health care decisions, buying decisions, and managing the care of family members, as well as themselves. But there is another reason that we hear from women so often today and that's because the system makes accessing and affording high quality care uniquely difficult and burdensome for women. The reasons why—lower incomes, more part-time work, more small busi-

nesses, more periods of unemployment to care for children or aging parents, higher use of medical devices, and so forth.

In September, just last month, Consumer Reports conducted the latest of our nationally representative surveys and it shows significant differences between men and women in the impact of the health care crisis. Just to give a few numbers, 51 percent of all respondents said in the past year they had to put off a doctor's visit, not fill a prescription, skip a treatment, not pay a bill because of cost. But notably, women were much more likely than men—55 percent for women compared to 47 percent for men—to have faced those choices and given up needed medical care.

Sixty-seven percent of women, compared to 59 percent of men, fear they'll be denied coverage because of preexisting conditions and other circumstances; and 78 percent of women, versus 68 of men, fear they'll be unable to afford health care in the future.

Behind those numbers, of course, are real people. From the thousands of personal stories that we have gathered over the years, it's clear that women far too often are not adequately covered under current insurance practices. You members of the committee have given many examples of that.

We have also heard from numerous women who found themselves with coverage delayed or denied for some of the same causes that were described here earlier. You can see some of the stories, by the way, that we've collected in my written testimony and in a reprint from Consumer Reports I'm happy to make available.

The surveys and the personal stories highlight areas that urgently need attention in the health care crisis. I just want to flag three of them especially as they affect women. First is the question of affordability, which is a major concern, obviously, for everyone, for middle and lower income Americans, and disproportionately for women. We support proposals mentioned earlier that prohibit higher premiums due to gender and we support limiting age rating to two to one.

We support expansion of Medicaid to the 133 percent poverty level to provide a stable source of coverage for low-income working women. We support the employer mandate to cover lower wage workers, many of whom are women. And we support the highest feasible—this is really important—the highest feasible premium and cost-sharing assistance. On this, by the way, we believe that the HELP bill is better, significantly better, than the Finance version. And we support having a public insurance plan option, which will expand consumer choices, men and women, and hold down costs through greater competition.

Second, on transparency, more complete, easy to use information about medical providers and systems will enable women, as the primary health shoppers, to make informed choices. We like the HELP Committee scenarios, by the way, of what it would cost to be treated for certain common conditions. We support mandatory public disclosure of hospital-acquired infections and other adverse events.

When it comes to insurance plans, it's most useful to give not just what the premium's going to be, but the total cost of a plan, rather than just the premium. That allows more informed choices.

Then finally, I want to talk about the real importance of the investment in comparative effectiveness research, which will be a huge gain for women. It will help end the historic underrepresentation of women in medical research that the chairwoman referred to, and it holds the promise of medical care that's more effectively tailored to subpopulations, including subpopulations of women.

Finally, we vigorously support the HELP approach in terms of comparative effectiveness research in a public agency, not a private body. We think the advisory and oversight panels for CERs should include a substantial number of consumer and patient representatives, including women, as well as independent experts, and we urge that there be a requirement that all members of such panels be completely free of conflicts of interest whatsoever.

Bottom line, Madam Chairwoman and members of the committee, for women the health care crisis is very real, very personal, and very scary. The time for action is now.

Thank you very much.

[The prepared statement of Mr. Guest follows:]

PREPARED STATEMENT OF JAMES GUEST

Senator Mikulski and members of the committee, I'm Jim Guest, President and CEO of Consumers Union, publisher of *Consumer Reports*, and I thank you for the opportunity to testify on the subject of equal treatment for women in our health care system. Consumers Union is a non-profit, non-partisan, independent testing, research and public policy organization whose mission is to work for a fair, safe and just marketplace for all consumers. We have over 4 million subscribers to our print magazine and more than 3.2 million on-line subscribers. We have tested, reported and spoken out on health care matters since our very first issue in February 1936.

For more than 70 years, we have been dedicated to helping consumers make informed choices that affect their pocketbooks. And today, one of the most important pocketbook issues for American families is health care. For the past 2 years we have done extensive national surveys and research which we have used in *Consumer Reports* articles to educate consumers about what is happening in the health sector and the underlying causes of today's health care crisis. In addition, we have been collecting many thousands of personal stories from around the country that illustrate the realities Americans are facing in our broken health care system.

Several thousands of those who have shared their experiences with us are women. Women are the "chief purchasing officers" in most households—making most of the health-care buying decisions and managing the health care of family members as well as their own. But there is another reason we hear from so many women, and that is because the system today makes accessing and affording high-quality health care uniquely difficult and burdensome for women.

The reasons women are disproportionately impacted in the current health care system are well documented: lower incomes, more part-time work, more small businesses, more periods of unemployment to care for children or aging parents, more bankruptcies, higher use of medical services and so forth. The other experts on this panel can speak in depth about these factors.

In September, the Consumer Reports National Research Center conducted the latest of our nationally representative polls on health care. Two sets of questions, in particular, showed significant differences between men and women that are relevant to this panel's focus today.

First, regarding cost and its impact on access to care, we asked respondents if they were rationing their own care—that is, were they restricting their use of health care due to cost. The results were striking: 51 percent of all respondents said that in the past year they had put off a doctor's visit, or not filled a prescription, or skipped a treatment or procedure, or not been able to pay their medical bills due to cost. Women were much more likely than men to face such choices—55 percent to 47 percent.

Specifically, women are more likely to have:

- Skipped filling a prescription (23 percent versus 16 percent).
- Taken an expired medication (18 percent versus 11 percent).
- Shared a prescription with someone else (12 percent versus 6 percent).

Second, we asked respondents about their main concerns regarding health care. Women have greater concerns than men on most health care issues, including significantly greater concern that they would:

- Suffer a major financial loss or setback from medical cost due to an illness or accident (77 percent versus 70 percent).
- Face rising costs forcing a choice between healthcare and other necessities (69 percent versus 59 percent).
- Not be able to afford health care in the future (78 percent versus 68 percent).
- Be denied health coverage because of preexisting conditions or other circumstances (67 percent versus 59 percent).

And, by a difference of 75 to 70 percent, women are more concerned that needed care will be rationed or denied by their insurance company.

In the thousands of stories we gathered in recent years of people's experiences and concerns with the health care system, the reality is clear: Common health needs specific to women too often are not covered under current health insurance practices. We heard from numerous women who found themselves with coverage delayed or denied because of very common health needs such as benign fibroids, previous fertility treatments, pregnancies and the like.

Attached are some truly moving stories that illustrate the types of everyday problems women experience because of their unique health needs.

These survey results and personal stories highlight policy areas that need to be changed for all consumers of health care, but especially for women. I want to highlight four such areas.

1. AFFORDABILITY

We support proposals that prohibit higher premiums due to gender. These proposals will greatly help women, particularly in their young adulthood.

We support limiting age-rating differentials. Doing so will help women at an especially vulnerable time—the years leading up to Medicare eligibility—when they often find themselves without their husband's coverage due to divorce or death of their spouse. We recommend the lowest age rating of 2:1, as in the House bills and the Senate HELP Committee bill.

We support expansion of Medicaid to 133 percent of poverty (\$24,400 for a family of 3) in order to provide a stable source of coverage for low-income working women. We urge Congress to ensure that this expansion be coupled with improvements in Medicaid provider rates so that it increases real access to care, not just insurance.

Even with these important improvements, affordability remains a major concern for middle- and lower-income people who are, disproportionately, women. Because the costs of insurance are so high relative to their families' take-home pay, all of the current bills include sliding-scale subsidies to help them afford the insurance they will be required to get under all of the proposals. We strongly believe that more must be done to ensure affordability. We support the highest possible premium subsidies that waive mandatory premiums for those on Medicaid (those below 133 percent to 150 percent, or \$24,400 to \$27,500, for a family of three) and charge families at 400 percent of poverty (\$73,240 for a family of three) no more than 10 percent of their income. While this will increase costs, insurance reform will not work effectively if it requires Americans to buy policies that are unaffordable. Additional savings and progressive finances are needed to ensure affordability.

Another problem is that in recent years consumers have seen more and more of the costs of health care shifted to them in the form of higher out-of-pocket cost-sharing, often at levels they cannot afford. Therefore, we urge that you also limit out-of-pocket spending to no more than 5 percent of income for people with incomes below 200 percent of FPL and—using a graduated sliding scale—a limit between 5 percent to 10 percent of income for people between 201 percent and 400 percent of FPL. Finally, we support the approach taken by the HELP Committee to increase the actuarial value of plans that are offered in order to ensure that the coverage people will be required to carry will truly protect against health care costs.

Finally, we strongly support giving American families the choice of a Public Insurance Plan option, which will hold down costs by ensuring competition and holding private insurers accountable.

2. COVERAGE

All of the proposals under consideration make necessary and important improvements in coverage for conditions that only women experience—maternity and preventive services like mammograms and other screenings. In addition, ending exclusions due to preexisting conditions will help everyone, but as our stories show, this will especially help increase women's access to affordable care without penalty for

common female conditions like fibroid tumors, C-sections and other child-bearing-related experiences.

3. CONSUMER INFORMATION

Finally, I want to mention a third key reform that will help women as the primary decisionmakers about health care in most families, and that will greatly improve competition based on cost and quality, helping reduce the growth of health costs over time.

Health care experts like to talk about the “marketplace” and “competition.” But today’s health care marketplace lacks an essential element necessary for consumers to be able to choose the insurance or health care services that best meet their needs. People are forced to make high-cost decisions without being able to know the full costs or the relative quality and effectiveness of different insurance products, procedures or providers. This has to change.

First, we all know about the fine print, loopholes, and “got cha” aspects of health insurance policies. It is vital that the final law retains the HELP Committee provisions that define medical and insurance terms so consumers can compare apples-to-apples. We particularly like the HELP Committee’s “scenarios” of what it would cost to be treated for certain common conditions.

Second, in whatever “exchange” or “connector” marketplace that is established to help people shop, make sure that the consumer is told not just the premium cost, but also the estimated annual *total* cost, based on past medical history or on one’s own estimate of one’s health condition—for example, “good health, fair health, poor health.” Consumers Union has some data that shows that when consumers can see an estimate of their likely total cost, they make much better choices than if they only have premium information available. And if they make better insurance choices, they will need less subsidy help with premiums, deductibles, and co-pays. Total estimated cost data will help everyone win.

Third, make available to consumers comparable information about the quality and effectiveness of providers and different services. For example, we support the Senate Finance provision that requires the development of a rating system for plans based on relative quality and price compared to other plans offering products in the same benefit level. Consumers need this kind of help on the exchange Web sites to deal with what is likely to be a confusing, busy new market (similar to the 40–60 plans that faced seniors in Part C and D). As another example, we also support Senator Reed’s amendment in the HELP bill, requiring clearer fact-based labeling of pharmaceuticals.

4. COMPARATIVE EFFECTIVENESS RESEARCH (CER)

The CER provisions in the three bills will be a huge gain for women in the decades to come. Women, and minorities, historically have been badly under-represented in clinical trials and pharmaceutical and medical device research. The new CER Trust Funds will provide a robust level of funding that is mandated to give better, more balanced attention to research on what works for women. CER holds the promise of personalized medicine in the future, where, for example, the best treatment for breast and other cancers can be determined by an understanding of gene markers. We think it is crucial, however, that CER research is housed in a public agency, as proposed by the HELP Committee. Turning CER over to a private foundation means that the process is likely to be captured by the medical industries, and instead of delivering scientific research, it will become just another part of the drug and device sales juggernaut. Further, members of the CER body should be free of any personal or financial conflicts of interest, and membership should include a substantial number of consumer and patient representatives.

CONCLUSION

The disproportionate burdens of the current system are unfair to women. But in the end, the disparities have long-lasting effects on us all, men as well as women. For men, these are our wives, our mothers, our daughters, our sisters who are being denied the insurance coverage and access to care that they deserve. When a mother or wife or daughter or sister faces a serious health challenge, so does everyone in her family. It is in the interests of all consumers that our health insurance system must be improved. The time for action is now.

EXAMPLES OF WHY AMERICAN WOMEN NEED HEALTH CARE REFORM

DEE K. FROM FLORIDA

During her first pregnancy, Dee suffered a miscarriage, a devastating loss for her and her husband.

Sometime after that, Dee considered switching from her health plan (purchased through the American Veterinary Medicine Association) to her husband's non-group plan as the switch would save the family almost \$300 per month. Much to her surprise, and even the surprise of their insurance agent, carriers in Florida refused to cover Dee due to her miscarriage. In fact, they were told that Dee was considered uninsurable for 5 years.

Dee was incredulous and angry: "I am not a cancer patient. I am healthy, don't smoke, and exercise. I do have back issues and dry eyes, which I thought may cause more of a problem, but miscarriage is not a constant state. At least 20 percent of women suffer miscarriage, and probably many more go unreported."

Unfortunately, Dee regrets obtaining medical care for her miscarriage because now she must stay with her current policy which features a \$1,500 deductible and is not accepted by many physicians in her area.

NANCI L. FROM NORTH CAROLINA

During 1998, Nanci had a hysterectomy. Most of the surgery was paid for by her non-group insurance policy. However, a year later her insurers reversed their decision to cover Nanci's surgery. Why? Prior to her surgery, Nanci's ob/gyn had written on her chart that her uterus was fibrous, and the surgeon also found fibroids on her uterus during the hysterectomy.

Her insurance carriers asserted these fibroids were a "preexisting condition" and, hence, not covered under her policy. The carrier asked the hospital and surgeon to return their payment and Nanci was unexpectedly stuck with the bill for the hysterectomy—about \$12,000. The hospital that performed the surgery told Nanci, that if they didn't return the payment, they would have trouble getting other claims paid.

This reversal is an industry practice called "rescission." Exactly what is permitted will vary from State to State. In North Carolina, a fibrous uterus can be considered a basis for denying coverage, despite the fact that the condition is quite common among women. As happened in Nanci's case, this denial can be made retroactively leaving consumers vulnerable to large medical bills, despite paying for insurance coverage.

TINA G. FROM PENNSYLVANIA

Anticipating that she and her new husband would soon start a family, Tina called her health insurance company to make sure she was covered for maternity care. A customer service rep assured her that she had maternity coverage and that she would only be responsible to pay for 20 percent of all costs after the birth of the child. Four months into her pregnancy, Tina started getting huge bills from the insurance company.

Repeated phone calls finally revealed that she did not have maternity coverage and that Tina would be responsible to pay for everything. As Tina puts it "[b]eing pregnant was stressful enough, then to find out half way through the pregnancy that I didn't have the proper coverage was even worse." Tina believes that the added stress of huge, daunting medical bills contributed to high blood pressure during her pregnancy and gestational diabetes—increasing the risk to Tina's health and that of her unborn baby.

Tina contacted an attorney who suggested that she first try contacting her local news channel's consumer reporter. This reporter empathized with her plight and made some phone calls. As a result, the reporter got insurers to admit that they incorrectly represented the coverage during Tina's initial inquiries and convinced them to pay Tina's maternity bills.

Tina, a registered nurse, advised people who interact with their insurance company to document everything and to persist, using any method available, if your health insurer appears to have made a mistake.

STEPHANIE H. FROM TEXAS

Stephanie left the work force to care for her young child and left behind the family's group health insurance policy she had through her employer. Her husband is a self-employed professional without access to group coverage. At the time, Steph-

anie was unconcerned because her family (then ages 33, 35 and 2) was very healthy and not currently taking any prescriptions.

When she applied for non-group family coverage she was shocked to be turned down based on her usage of a drug called Clomiphene Citrate over a 5-day period approximately 1 year earlier. Clomiphene Citrate is a commonly used drug that stimulates ovulation. Stephanie notes it is "the mildest fertility drug available" and has a "risk" of less than 10 percent of having twins. Stephanie complained and, with her doctor, attempted to appeal the denial, but to no avail.

The stated reason for denial was that if she ever had another baby, the insurer would be forced to cover the newborn even if it wasn't healthy. Stephanie notes that rationale could be used to deny woman of childbearing years. She also notes that she was not applying for maternity health coverage and that her husband was also turned down for this reason. Further, she already had one healthy child with no medical complications. Stephanie contacted the Texas Department of Insurance as well as Texas representatives about her plight, but also to no avail. She was told that there was no remedy available within the current laws and regulations.

Senator MIKULSKI. Well, thank you, and you even had 9 seconds to spare. That was great.

**STATEMENT OF DIANA FURCHTGOTT-ROTH, SENIOR FELLOW,
HUDSON INSTITUTE, AND DIRECTOR, CENTER FOR EMPLOY-
MENT POLICY, WASHINGTON, DC**

Ms. FURCHTGOTT-ROTH. Madam Chairwoman, as a resident of the State of Maryland, it's a great honor to testify in front of you in this committee. Thank you very much for giving me the opportunity.

I would like to say that our health insurance system is in terrible shape. We never hear anybody say: "Oh my goodness, I'm losing my job, I'm losing my auto insurance." We never hear anyone say: "I'm losing my job, I'm losing my home insurance." But we do hear: "Oh my goodness, I'm losing my job, I'm losing my health insurance." This is because of the links between employment and health insurance.

We know how to do insurance. We don't have problems with life insurance, auto insurance, home insurance. What we need to do is give people a choice of health insurance plans, just as the way we have for auto, home, and life insurance, just like the Patients' Choice Act of Senator Burr and Senator Coburn, who is a physician, that would give everyone the opportunity to choose their own plans and have people, insurance companies, competing for people's business, just like we see ads from GEICO: Call us for a 15-minute quote and we'll give you a lower rate. That's what we need to do with the health insurance market.

Unfortunately, the bills in front of Congress right now, the House Democrats' bill, the two bills in the Senate, are anti-woman, anti-man, and anti-American. They would provide worse care to all Americans. They would hurt our economy by raising taxes, increasing our national debt, raising the deficit. This would lower job creation and stop women from progressing. Women progress when they are employed and right now their unemployment rates are 2 percentage points lower than men's. Women are doing well in this economy. But if they don't have any jobs, they're not going to be doing well any more.

This bill would only help one group, foreign workers. They would benefit from the outsourcing that American firms would do to plants and firms by shipping jobs overseas. Foreign workers are not the people we want to help. We want to help Americans.

There are four major things wrong with these bills. First of all, everyone would pay more for health insurance because the mandated plan that one would purchase under the health exchange is so large that it would be very, very expensive. A catastrophic bare-bones insurance plan, where you pay for routine care, is not permitted under the health exchanges. You would have to have no payments for routine care. A large array of things would be covered, such as mental health, substance abuse, that you might not need.

It's as though auto insurance paid for changing your windshield wiper blades and changing your oil. They're routine expenditures that you can pay on your own. You don't need insurance for that. Your auto insurance would be really expensive if it paid for all those little things. But people should be allowed to buy a plan that just has insurance against major things, maybe having a baby, breaking a leg, getting hit while you're on your bicycle, that kind of thing. But this plan doesn't do it.

The higher cost of the premiums for this expensive plan would lower cash wages, so lower income and minorities would be more likely to lose their job. Say you have a job at minimum wage, \$7.25 right now. Your employer is required to cover you, so in fact your wage couldn't go any lower. You would be covered, but what would happen is the employer would have an incentive not to hire you, just as when we raised the minimum wage this summer the teen unemployment rate hit 26 percent because these groups just were not hired any more.

Another problem with these bills is that those on Medicare would receive worse care. As Senator Mikulski pointed out, women are disproportionately large consumers of Medicare. But these bills—the Baucus bill, for example, would cut \$404 billion off Medicare with cuts in Medicare of 10 to 15 percent every year. We're going to be covering more people, lower cost, cuts in Medicare—no one can really believe that women are going to continue to get the care, and men, that they get now with these different cuts in Medicare, with such substantial cuts.

In fact, Congress has overridden its own laws and not allowed the 10 percent cuts in reimbursement rates for Medicare physicians that have been in the law right now. It's overridden those, but the bill mandates 25 percent cut in Medicare reimbursement rates for physicians. Women aren't going to be able to get to see their doctors.

Finally, health reform would discourage job creation and incentive to work by raising taxes. House Democrats' bill, the top rate would go to 45 percent, penalizing the most productive small businesses, the most productive workers. They wouldn't have an incentive to expand and create jobs.

It's also true at the low end. The Joint Tax Committee has estimated that the effective tax rate for people at 150 percent of the poverty line is 59 percent. They would face a tax of 59 percent because of the phaseout of the benefits. Those at 250 percent of the poverty line would face a tax rate of 49 percent. This is not something that we want to have. This bill, we need health reform, but this is not the reform we have. We need to take a serious look at Senator Burr's bill that would give everyone tax credits to go out

and buy their own plan, just like we use our own money to go out and buy auto insurance, life insurance, and home insurance.

Thank you very much.

[The prepared statement of Ms. Furchtgott-Roth follows:]

PREPARED STATEMENT OF DIANA FURCHTGOTT-ROTH

Senator Mikulski, Mr. Chairman, members of the committee, I am honored to be invited to testify before your committee today on the subject of the effects of the health reform bills on men and women. I have followed and written about this and related issues for many years. I am the coauthor of two books on women in the labor force, *Women's Figures: An Illustrated Guide to the Economic Progress of Women in America*, and *The Feminist Dilemma: When Success Is Not Enough*. I am currently working on a sequel to *Women's Figures*, entitled *Better Women's Figures*.

Currently I am a senior fellow at the Hudson Institute. From February 2003 until April 2005 I was chief economist at the U.S. Department of Labor. From 2001 until 2003 I served at the Council of Economic Advisers as chief of staff and special adviser. Previously, I was a resident fellow at the American Enterprise Institute.

Women are doing better than men in many measurable areas. Women live on average 5.1 years longer than men.¹ In September 2009, men's unemployment rate was 11 percent and women's was 8.4 percent.² Last year women received 58 percent of all BA degrees awarded, and 61 percent of all MA degrees.³ Women have made tremendous progress in labor force participation over the past 50 years: last year their labor force participation was 14 percentage points lower than men's, compared with 46 percentage points lower than men's in 1960.⁴ When demographics, education, work experience, workplace and occupational characteristics, and child-related factors are taken into account, women earn practically the same as men. In order to continue this progress, it is vital that American employers be given the maximum opportunities to create jobs.

Although the leading Democratic healthcare reform bills in Congress—the Senate HELP Committee's Affordable Health Choices Act,⁵ the Senate Finance Committee's America's Healthy Future Act of 2009,⁶ and the House Education and Labor Committee's America's Affordable Health Choices Act of 2009⁷—intend to help women, they would leave all Americans, including women, worse off than they are at present. First, everyone, including women, would pay more for health insurance. Second, the higher cost of health insurance premiums would lower cash wages for Americans. Third, those on government plans, such as Medicare and Medicaid, predominantly women, would receive worse care. Fourth, the economy-wide effects of health care reform mandates would discourage job creation and incentives to work by raising taxes.

Everyone, including women would pay more for health insurance. Young women would have to pay substantially more for health insurance than they do at present because premium differentials for health insurance would be capped. All women would have to pay more due to the government's definition of a qualified plan.

One feature of the health reform bills is that variation in premiums would be limited. Under the House Democrats' bill, for example, the most expensive premium could not be more than twice as much as the cheapest for the same plan, and variation would only be allowed on the basis of age. This means that younger women would have to pay far more in premiums than they would otherwise.

¹Jiaquan Xu, Kenneth D. Kochanek, and Betzaida Tejada-Vera, "Deaths: Preliminary Data for 2007." Division of Vital Statistics, National Vital Statistics Reports, Vol. 58, No. 1, August 19, 2009. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_01.pdf.

²Bureau of Labor Statistics, "The Employment Situation—September 2009," October 2009. Available at: <http://www.bls.gov/news.release/pdf/empst.pdf>.

³U.S. Department of Education, National Center for Education Statistics, "Digest of Education Statistics: 2008," March 2009.

⁴Bureau of Labor Statistics and Haver Analytics.

⁵U.S. Senate "Affordable Health Choices Act." 111th Congress, 1st session. S.1679. Washington: GPO, September 2009. Available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:s1679pcs.txt.pdf.

⁶U.S. Senate Committee on Finance, "America's Healthy Future Act of 2009." Available at: http://www.finance.senate.gov/sitepages/leg/LEGpercent202009/100209_Americas_Healthy_Future_Act_AMENDED.pdf.

⁷U.S. House "America's Affordable Health Choices Act of 2009." 111th Congress, 1st session. H.R. 3200. Washington: GPO, July 2009. Available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3200ih.txt.pdf.

The Baucus bill would require everyone to purchase health insurance or face penalties. Americans with incomes up to 400 percent of the poverty line (currently \$90,100 for a family of four) who are not covered by an employer plan would receive tax credits to purchase health insurance plans in an “exchange.”

Plans purchased in the exchange would be Cadillac plans, with generous coverage and no lifetime or annual limits on any benefits. Only Americans under 25 and those who spend more than 8 percent of their income on health insurance premiums would be allowed to purchase “young invincible” plans, catastrophic insurance against major accidents. American men and women would have to pay a far higher cost for health insurance, since plans would have to accept everyone, regardless of health or pre-existing conditions.

It’s easy to see from the Baucus bill why the cost of health insurance is going to skyrocket. According to the Senate Finance Committee, “All plans would be required to provide primary care and first-dollar coverage for preventive services, emergency services, medical and surgical care, physician services, hospitalization, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings, including x-rays, maternity and newborn care, pediatric services (including dental and vision care), prescription drugs, radiation and chemotherapy, and mental health and substance abuse services. Plans would not be allowed to set lifetime limits on coverage or annual limits on any benefits.”⁸

Half of the Baucus plan would be funded through an excise tax on expensive plans of 40 percent on premiums above \$8,000 for singles and \$21,000 for families, bringing in \$201 billion from 2013 through 2019. Today health insurance premiums cost on average \$4,824 for singles and \$13,375 for families.⁹ CBO’s calculates that in 2019, in addition to the \$46 billion in excise taxes, Americans would be paying over \$100 billion in higher premiums.¹⁰ Since CBO forecasts increases in excise tax revenues of 10 percent to 15 percent annually after 2019, health insurance premiums must also rise by the same percent annually. This government mandate will amount to a steady drain on American men and women. A memo dated October 13, 2009, from Thomas Barthold, chief of staff of the Joint Committee on Taxation, said “Generally, we expect the insurer to pass along the cost of the excise tax to consumers by increasing the price of health coverage.”¹¹

The higher cost of health insurance premiums would lower cash wages for everyone, in particular women. A government mandate for employers to provide health insurance would cause wages to decline, because the costs of the insurance would be passed on to workers, who would see a decline in wages. Alternatively, discussed in the following section, employers would reduce employment, especially for low-wage workers.

Harvard University economics professor Katherine Baicker and University of Michigan economics professor Helen Levy concluded that low-income, minority workers would be the most affected by a government mandate:¹² “We find that 33 percent of uninsured workers earn within \$3 of the minimum wage, putting them at risk of unemployment if their employers were required to offer insurance. . . . Workers who would lose their jobs are disproportionately likely to be high school dropouts, minority, and female. Thus, among the uninsured, those with the least education face the highest risk of losing their jobs under employer mandates.”

Employers are likely to respond to the higher costs resulting from mandated provision of health insurance by employing fewer workers, or outsourcing jobs overseas. This would be especially harmful for small businesses which employ low-income wage workers at or near the minimum wage since employers cannot reduce these wages to absorb the increased cost. It is no coincidence that this summer’s increase in the minimum wage to \$7.25 hourly¹³ was followed by record teen unemployment

⁸U.S. Senate Committee on Finance, “Baucus Introduces Landmark Plan to Lower Health Care Costs, Provide Quality, Affordable Coverage” (News Release) September 16, 2009. Available at: <http://finance.senate.gov/press/Bpress/2009press/prb091609h.pdf>.

⁹The Kaiser Family Foundation and Health Research and Educational Trust, “Employer Health Benefits 2009 Annual Survey” September 15, 2009. Available at: <http://egbs.kff.org/pdf/2009/7936.pdf>.

¹⁰Congressional Budget Office. “Letter to the Honorable Max Baucus on the Preliminary Analysis of the Chairman’s Mark for the America’s Healthy Future Act, as Amended,” October 7, 2009. Available at: http://www.cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus_letter.pdf.

¹¹Joint Committee on Taxation. “Memo from Thomas A. Barthold to Cathy Koch and Mark Prater,” October 13, 2009.

¹²Katherine Baicker and Helen Levy, “Employer Health Insurance Mandates and the Risk of Unemployment,” NBER Working Paper No. 13528, October 2007. Available at: <http://www.nber.org/papers/W13528.pdf>.

¹³U.S. Department of Labor Wage and Hour Division, “Employee Rights under the Fair Labor Standards Act,” July 2009. Available at: <http://www.dol.gov/esa/whd/regs/compliance/posters/minwagep.pdf>.

rates, the latest almost 26 percent in September.¹⁴ Employers laid off the less-skilled workers rather than paying them more than they were worth.

CBO concluded that a requirement for employers to provide health insurance would encourage employers to hire more part-time workers and fewer full-time workers. According to CBO, the creation of different penalties for full- and part-time workers “would increase incentives for firms to replace full-time employees with more part-time or temporary workers.”¹⁵

According to Ezekiel Emanuel and Victor Fuchs in the *Journal of the American Medical Association*,

“It is essential for Americans to understand that while it looks like they can have a free lunch—having someone else pay for health insurance—they cannot. The money comes from their own pockets. Understanding this is essential for any sustainable health care reform.”¹⁶

Peter Orszag reiterated this as CBO director, saying that,

“The economic evidence is overwhelming, the theory is overwhelming, that when your firm pays for your health insurance you actually pay through reduced take-home pay. The firm is not giving that to you for free. Your other wages or what have you are reduced as a result. I don’t think most workers realize that.”¹⁷

Those on government plans, such as Medicare and Medicaid, predominantly women, would receive worse care. Medicare recipients, who are primarily women,¹⁸ would receive a lower standard of care than they do at present due to cuts in the program. Putting more low-income women into the Medicaid program would give them a lower standard of care.

Nearly 90 percent of the \$404 billion Medicare and Medicaid savings would be from Medicare in the period 2013 to 2019 in the Baucus bill. Thereafter, savings would be expected to continue at the rate of 10 percent to 15 percent. Of all demographic groups in America, elderly women would be the biggest losers under the Baucus plan. CBO estimates that Medicare Advantage plans, popular bundled health maintenance organizations serving 20 percent of Medicare patients, primarily women, would be cut by \$117 billion.¹⁹ Under the heading “Ensuring Medicare Sustainability,” more than \$200 billion would be cut from payments to hospitals, elder care, doctors, and hospices. Payments to Medicare doctors would be cut by 25 percent in 2011. A Medicare Commission would propose further cuts.

The government would persuade doctors to cut Medicare costs by associating more tests with lower reimbursements. Ranked in order of spending per patient, every year the top 10 percent of physicians would have their reimbursements cut. Since by definition there would always be 10 percent of physicians in the top 10 percent, they would have an incentive to avoid the sickest patients or the specialties with the most tests. Since women are disproportionate users of Medicare, they would be the most affected.

According to the Kaiser Family Foundation, women comprise 69 percent of Medicaid recipients.²⁰ The House Democrats bill plans to expand the Medicaid program to 133 percent of the poverty line in order to cover low-income uninsured workers. Not only would this cause a financial drain on already-strained budgets, but Medicaid does not provide as high a level of care as with many other private plans. Women would be disadvantaged by being put on Medicaid rather than being given

¹⁴ Bureau of Labor Statistics, “The Employment Situation—September 2009.”

¹⁵ Congressional Budget Office, “Effects of Changes to the Health Insurance System on Labor Markets,” July 13, 2009. Available at: <http://www.cbo.gov/ftpdocs/104xx/doc10435/07-13-HealthCareAndLaborMarkets.pdf>.

¹⁶ Ezekiel J. Emanuel and Victor R. Fuchs, “Who Really Pays for Health Care Costs,” *Journal of the American Medical Association*, March 5, 2008. Similarly, Harvard economist Katherine Baicker wrote, “Employees ultimately pay for the health insurance 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 for primarily out of workers’ wages.” Katherine Baicker and Amitabh Chandra, “Myths and Misconceptions about U.S. Health Insurance,” *Health Affairs*, 2008.

¹⁷ CBO Director Peter Orszag Testimony before the Senate Finance Committee, June 17, 2008.

¹⁸ The Kaiser Family Foundation, “Medicare’s Role for Women,” June 2009. Available at: <http://www.kff.org/womenshealth/upload/7913.pdf>.

¹⁹ Congressional Budget Office, “Letter to the Honorable Max Baucus on the Preliminary Analysis of the Chairman’s Mark for the America’s Healthy Future Act, as Amended.”

²⁰ The Kaiser Family Foundation, “Medicaid’s Role for Women,” October 2007. Available at: http://www.kff.org/womenshealth/upload/7213_03.pdf.

a refundable tax credit to purchase a private plan, as has been suggested by Congressman Tom Price.

Many Medicaid patients cannot find doctors who will see them. In California, 49 percent of family physicians do not participate in Medicaid²¹ while in Michigan the number of doctors who do not see Medicaid patients has risen from 12 percent in 1999 to 36 percent in 2005.²² Physicians don't want to take Medicaid patients because of low reimbursement and substantial paperwork. A 2009 Health Affairs report indicated that Medicaid physician fees increased 15.1 percent, on average, between 2003 and 2008.²³ This was below the general rate of inflation of 20.3 percent, resulting in a reduction in real fees.

The economy-wide effects of health care reform mandates would discourage job creation and incentives to work by raising taxes. The tax increases in the House bill would disproportionately fall on women, discourage job creation, and reduce the incentives for married women to work.

According to Dr. Jonathan Javitt, adjunct professor of public health at Johns Hopkins University,

“Many more women are single parent heads of households than are men. If families are taxed for not having health insurance, this tax is certain to disproportionately penalize single-parent families who are barely making ends meet.”

Health reform is expensive, and some of the bills pay for it through increased taxes. For instance, the House bill relies on income tax surcharges on the most productive workers, bringing the top tax rate to 45 percent, as well as an 8 percent payroll tax on employers who do not offer the right kind of health insurance to their employees. Moreover, anyone who does not sign up for health insurance would face an additional 2.5 percent income tax. Taxes discourage work and investment, thereby reducing employment.

Such tax increases would adversely affect married women because their incomes are frequently secondary. It would not only discourage marriage, but also discourage married women from working.

By raising taxes on upper-income Americans to 45 percent, Congress would worsen our tax system's marriage penalty on two-earner married couples, and women would pay even more tax married than single. Unless, of course, women left the workforce, lowering a couple's Federal tax rate. Federal taxes are not the whole story. State taxes would take another 9 percent of incomes in States such as Oregon, Vermont and Iowa; Medicare would take another 1.45 percent; and Social Security taxes would add another 6.2 percent up to \$107,000.

The tax penalty for working is even more substantial at the low end of the income spectrum. The staff of the Joint Tax Committee estimated that combined effective income and premium marginal tax rates, including payroll taxes, for poor families of four under the Baucus bill would be substantial, dwarfing rates for upper-income individuals. They would reach 59 percent at 150 percent of the poverty line; 49 percent at 250 percent of the poverty line; 39 percent at 350 percent of the poverty line; and 40 percent at 450 percent of the poverty line.²⁴

When mothers take jobs, earnings are reduced by taxes, in addition to costs for childcare and transportation. This discourages women not just from working, but also from striving for promotions, from pursuing upwardly-mobile careers. Mothers are more affected by the marriage penalty than other women because they are more likely to move out of the labor force to look after newborn children and toddlers, and then to return to work when their children are in school.

Our tax system should not make it harder for women to work. The penalty falls both on women struggling to escape from poverty, and on married women who have invested in education, hoping to shatter glass ceilings and compete with men for managerial jobs. Throughout the income spectrum, higher taxes would exacerbate the penalty for working.

Our health insurance system needs to change, but not in the way envisaged by Congress. Rather than mandating one expensive plan, Congress would do better to

²¹ Lisa Backus et al., “Specialists’ and Primary Care Physicians’ Participation in Medicaid Managed Care,” *Journal of General Internal Medicine*, Volt. 16, No. 12, December 2001.

²² Jay Greene, “Committee looks at taxing Michigan doctors to help avert 12 percent Medicaid cuts,” *Michigan State Medical Society*, September 22, 2009. Available at: <http://www.msms.org/AM/Template.cfm?Section=Advocacy&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=12302>.

²³ Stephen Zuckerman, Aimee F. Williams, and Karen E. Stockley, “Trends in Medicaid Physician Fees, 2003–2008,” *Health Affairs*, Volt. 28, No. 3, 2009.

²⁴ Joint Committee on Taxation. “Memo from Thomas A. Barthold to Mark Prater, Tony Coughlan, Nick Wyatt, and Chris Conlin” October 13, 2009.

change the current health insurance tax credit from employers to individuals and allow people to pick their own portable plans, as they do with other forms of insurance. That would help women, and men too. It is vital that women's progress in the labor force continue, and the main route to this progress is an abundant supply of job opportunities. As configured, the three plans under consideration today would impede such job creation.

Thank you for allowing me to appear before you today. I would be glad to answer any questions.

REFERENCE

- Bureau of Labor Statistics, "The Employment Situation—September 2009," October 2009. Available at: <http://www.bls.gov/news.release/pdf/empsit.pdf>.
- Congressional Budget Office, "Effects of Changes to the Health Insurance System on Labor Markets," July 13, 2009. Available at: <http://www.cbo.gov/ftpdocs/104xx/doc10435/07-13-HealthCareAndLaborMarkets.pdf>.
- Congressional Budget Office. "Letter to the Honorable Max Baucus on the Preliminary Analysis of the Chairman's Mark for the America's Healthy Future Act, as Amended," October 7, 2009. Available at: http://www.cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus_letter.pdf.
- CBO Director Peter Orszag, Testimony before the Senate Finance Committee, June 17, 2008.
- Ezekiel J. Emanuel, MD, PhD and Victor R. Fuchs, PhD, "Who Really Pays for Health Care Costs," *Journal of the American Medical Association*, March 5, 2008.
- Jay Greene, "Committee looks at taxing Michigan doctors to help avert 12 percent Medicaid cuts," *Michigan State Medical Society*, September 22, 2009. Available at: <http://www.msms.org/AM/Template.cfm?Section=Advocacy&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=12302>.
- Jiaquan Xu, Kenneth D. Kochanek, and Betzaida Tejada-Vera, "Deaths: Preliminary Data for 2007." Division of Vital Statistics, National Vital Statistics Reports, Volt. 58, No. 1, August 19, 2009. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_01.pdf.
- Katherine Baicker and Amitabh Chandra, "Myths and Misconceptions about U.S. Health Insurance," *Health Affairs*, 2008).
- Katherine Baicker and Helen Levy, "Employer Health Insurance Mandates and the Risk of Unemployment," NBER Working Paper No. 13528, October 2007. Available at: <http://www.nber.org/papers/w13528.pdf>.
- Lisa Backus, et al., "Specialists' and Primary Care Physicians' Participation in Medicaid Managed Care," *Journal of General Internal Medicine*, Volt. 16, No. 12. December 2001.
- Stephen Zuckerman, Aimee F. Williams, and Karen E. Stockley, "Trends in Medicaid Physician Fees, 2003–2008," *Health Affairs*, Volt. 28, No. 3, 2009.
- The Kaiser Family Foundation, "Medicaid's Role for Women," October 2007. Available at: http://www.kff.org/womenshealth/upload/7213_03.pdf.
- The Kaiser Family Foundation, "Medicare's Role for Women," June 2009. Available at: <http://www.kff.org/womenshealth/upload/7913.pdf>.
- The Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits 2009 Annual Survey" September 15, 2009. Available at: <http://ehbs.kff.org/pdf/2009/7936.pdf>.
- U.S. Department of Education, National Center for Education Statistics, "Digest of Education Statistics: 2008," March 2009.
- U.S. Department of Labor Wage and Hour Division, "Employee Rights under the Fair Labor Standards Act," July 2009. Available at: <http://www.dol.gov/esa/whd/regs/compliance/posters/minwagep.pdf>.
- U.S. Senate "Affordable Health Choices Act." 111th Congress, 1st session. S.1679. Washington: GPO, September 2009. Available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:s1679pcs.txt.pdf.
- U.S. Senate Committee on Finance, "America's Healthy Future Act of 2009." Available at: http://www.finance.senate.gov/sitepages/leg/LEGpercent202009/100209_Americas_Healthy_Future_ActAMENDED.pdf.
- U.S. Senate Committee on Finance, "Baucus Introduces Landmark Plan to Lower Health Care Costs, Provide Quality, Affordable Coverage" (News Release) September 16, 2009. Available at: <http://finance.senate.gov/press/Bpress/2009press/prb091609h.pdf>.
- U.S. House "America's Affordable Health Choices Act of 2009." 111th Congress, 1st session. H.R. 3200. Washington: GPO, July 2009. Available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3200ih.txt.pdf.

Senator MIKULSKI. Ms. Crouse.

STATEMENT OF JANICE SHAW CROUSE, Ph.D. DIRECTOR AND SENIOR FELLOW, CONCERNED WOMEN FOR AMERICA, WASHINGTON, DC

Ms. CROUSE. Thank you. I'm from Maryland, too, Senator Mikulski. It's a privilege to present testimony before this august group on such an important topic and to participate in a debate on an issue that is so important to the future of this Nation.

Let me assure you that I agree with the wonderful arguments that have been put forth about the importance of the equality of care—health care—for women. I represent Concerned Women for America, the Nation's largest public policy women's organization. We are a membership group with over 600,000 members from all across the United States. Our grassroots members are women on the Main Streets of small town America and big city America. We are the women who will be most affected by health care reform provisions, those things that are being discussed.

You can read my formal testimony. Copies are on the table and all of the members have received copies. But in my verbal remarks this morning I want to focus on two issues that are vitally concerning to the women that I represent. Those two issues are the elephant in the room this morning when it comes to women's concerns, and that is abortion and end of life women's issues.

In the Old Testament, the Fifth Commandment is given with a promise. We are told that we should honor our father and mother, and if we do we will live long lives. No Nation can hope to prosper if it does not act in accordance with this mandate. To claim that cutting Medicare by half a trillion dollars will have no impact on senior citizen benefits mocks voters and insults our intelligence. No amount of smoke and mirrors can conceal this fact from our Nation's senior citizens, and most of our senior citizens are women. Many of them, if not most of them, have been mothers.

These mothers are the backbone of our Nation. They are the very DNA. The DNA of a mother is a mandate to answer the call to sit in vigil with a sick child or any loved one who is sick. Mothers generally do not begrudge that labor and service to those that they love.

It's an outrage when we hear politicians say to these mothers that as old women their years of service are ended and it's time for them to quit consuming resources. In a democratic representative democracy, elected officials are honor-bound to represent those whom they serve.

A November 2008 Zogby poll revealed 71 percent of Americans oppose government-funded abortion. Those of us who give testimony and represent the public are free citizens, very grateful for the opportunity to give feedback and opinion on the issues before this great body of legislators. But in a representative democracy we are not summoned by masters and we are not intimidated by power. Instead, we are here representing the views of thousands, if not millions, just like us, who do not intend for our voices to be unheard or our choices limited or for our hard-fought liberties to be taken away by those who would obfuscate, distort, or hide the truth.

No one today here should forget that the citizenry of this Nation has a history of overthrowing tyranny, and nothing is a clearer act of tyranny than for Congress to legislate change that abrogates our God-given right to choose life.

It is clear that the current health care reform legislation would classify abortion as an essential benefit and make it illegal for health care workers to deny abortion to anyone who seeks it, regardless of their personal convictions or their beliefs. Further, it is clear that the legislation would overrule State laws that require limitations, such as mandatory parental notification or even waiting periods.

It is also clear that the current bills would force American citizens, whether they want to or not, to subsidize abortion on demand with their tax dollars. Even those with incomes up to 400 percent of poverty would receive subsidies to pay for abortions.

Many things are negotiable and amendable to finding some middle ground, but human life is sacred. Its defense is not open to negotiation or to compromise. Defending life is our sacred duty.

The 6,000 women of CWA and the millions of like-minded women in this country count it a privilege to stand for those who are too vulnerable to stand for themselves.

Thank you for this opportunity.

[The prepared statement of Ms. Crouse follows:]

PREPARED STATEMENT OF JANICE SHAW CROUSE, PH.D.

SUMMARY

While the cost is a major concern, health care reform must respect all life, at the beginning and end of life.

ISSUES RELATED TO ABORTION

We have two primary concerns about health care reform relating to abortion—whether it funds and covers abortion and whether it allows health care workers freedom of conscience.

Funding and Covering Abortion: Without explicit wording prohibiting abortion funding and coverage, health care reform will involve all American taxpayers in explicit financial support for abortion-on-demand. In addition, Planned Parenthood is a “community provider” under health care reform bills.

Freedom of Conscience for Health Care Workers: Any health care reform provisions must provide protection for the rights of conscience for health care workers and medical providers. Those whose faith or conscience prevent them from performing abortions must have the ability to object and refrain from participating in actions that are contrary to their beliefs.

ISSUES RELATED TO END-OF-LIFE

Life Sustaining Treatment: Pro-lifers are, rightly, concerned about the possibility of limitations on life-sustaining treatment of the elderly, permanently disabled, terminally ill, or those with long-term chronic illnesses. No one should suggest the least expensive treatment or no treatment for those who are at or near the end of life or those whose conditions are irreversible.

Care at the End-of-Life: One of the most troubling aspects of health care reform legislation concerns end-of-life issues. Any health care reform must provide effective treatment for the Nation’s older people—without curtailment, withdrawal or denial of life-sustaining care for the terminally ill, the chronically ill, or the permanently disabled. Further, those provisions that address end-of-life issues must clearly leave no room for an interpretation that would pressure healthcare providers to make decisions based on cost rather than the best medical care.

CONCLUSION

Concerned Women for America believes that for any health care legislation to pass Congress it must protect life from conception to death. Therefore, we recommend:

1. First and foremost, abortion must be explicitly prohibited both in funding and coverage, with the Hyde Amendment permanently codified in law.
2. Second, the right to free exercise of their conscience must be granted to all health care workers without penalty or intimidation.
3. Third, life-sustaining treatment must be available to all citizens, including the elderly, terminally or chronically ill or those who are permanently disabled.
4. Fourth, we categorically reject end-of-life counseling based on cost considerations and government formulas generated by Comparative Effectiveness Research. And, we reject all assisted suicide measures.

It is a pleasure to address this distinguished committee and to be a part of this distinguished panel. We are part of one of the most important debates to face this Nation—especially for women and children. Ironically, as this debate rages, my book, *Children at Risk*, is being printed by the publisher. That book details all the ways that we are failing our children—primarily because of fatherless families leaving both women and children to face the vicissitudes of life without the support, protection and comfort that they need to thrive. With the additional costs and the problems associated with the health care reform bills currently in Congress, the burdens on women and children will escalate.

There is ample evidence (including a just-released report from PricewaterhouseCoopers) that health care reform measures will be prohibitively expensive—more than twice the expected growth in the Consumer Price Index with the increased cost of health insurance premiums being borne by individuals and families.¹

While the cost is a major concern, I would like to focus this morning on health care concerns at the beginning and end of life. Health care reform must respect all life, but human beings are especially vulnerable at the beginning and end of their lives. Provisions of a satisfactory plan must protect the baby in the womb and provide effective care for citizens at the end of life. At both these stages of life, females are more vulnerable than males.

ISSUES RELATED TO ABORTION

We have two primary concerns about health care reform relating to abortion—whether it funds and covers abortion and whether it allows health care workers freedom of conscience.

Funding and Covering Abortion: In spite of all the rhetoric to the contrary, all the health care reform bills currently before Congress *mandate* abortion funding and coverage. As pointed out so effectively by Americans United for Life (AUL), all of the pro-life amendments that came before the various committees were rejected. It is very clear that any health care reform bill *must* contain express language prohibiting abortion funding and coverage. Otherwise, “courts and administrative agencies will interpret health care reform to include it, based on prior interpretations of Medicaid’s ‘Mandatory Categories of Care.’ In addition, the Hyde Amendment, as added yearly to HHS Appropriations, is insufficient to prevent abortion funding and coverage under the health care bills.”² In short, without explicit wording prohibiting abortion funding and coverage, health care reform will involve all American taxpayers in explicit financial support for abortion-on-demand.

For instance, the Senate HELP bill provides for a “Medical Advisory Committee” (Sec. 3103) to determine the specific benefits that are offered by the private and public health care plans. The members of this committee (to be appointed by President Obama’s administration rather than be elected or result from a Senate-appointed bipartisan effort) will make decisions regarding whether abortion will be mandatory in the health care plans that are offered. President Obama has made it clear that he supports such coverage. Indeed, in July 2007 speech he promised Planned Parenthood that his Administration would provide mandatory abortion coverage.

¹“Potential Impact of Health Reform on the Cost of Private Health Insurance Coverage,” PricewaterhouseCoopers, October, 2009.

²Mary Harned, “A Pro-Life Look at the Health Care Reform Bills Currently in Congress,” Americans United for Life, October 12, 2009, p. 1. <http://blog.aul.org/2009/10/10/a-pro-life-look-at-the-health-care-reform-bills-currently-in-congress/>.

In addition, Planned Parenthood is a “community provider” that would be included in the health insurance networks under health care reform bills. Under Sen. Mikulski’s (D–MD) amendment, accepted by the Senate HELP committee, community providers “that serve predominantly low-income, medically under-served individuals” would be covered to provide “any service deemed medically necessary or medically appropriate.” At the time that her amendment passed, Sen. Mikulski pointedly refused Senator Hatch’s request to specifically *exclude* “abortion services.”

In the Senate HELP Committee, four separate pro-life amendments were defeated along party lines, with the notable exception of Sen. Bob Casey (D–PA) who consistently votes pro-life. The amendments would have prevented taxpayer funding for abortion, excluded abortion clinics from Federal grants and would have kept health care plans from including provisions to invalidate State laws regulating abortion. Obviously, the defeat of these amendments indicates the intent to implement by stealth what cannot be openly passed by vote. Lest anyone think such statements are an exaggeration, the lawyers at Americans United for Life have itemized cases where the courts have interpreted “Mandatory Categories” of care to include abortion.³ AUL notes that though abortion is not explicitly named as a service, the courts have concluded that abortion is included in “family planning,” “outpatient services,” “inpatient services” and “physician services.”

In seeking to reassure pro-life citizens, supporters of health care reform measures always refer to the Hyde Amendment as protecting the pro-life cause. Sadly, the Hyde Amendment, which prohibits taxpayer money for abortion through the Medicaid program, is not permanent law, instead, it is a pro-life rider that *must be re-introduced and passed* annually. Further, the proposed health care reform measures include funding mechanisms that enable Congress to circumvent the Hyde Amendment. This “back door spending authority” completely bypasses the Appropriations Committee. In addition, the tax credit provisions of the Baucus bill are not dependent upon the annual appropriations process so Hyde doesn’t apply there, either.

Freedom of Conscience for Health Care Workers: Any health care reform provisions must provide protection for the rights of conscience for health care workers and medical providers. Those whose faith or conscience prevent them from performing abortions must have the ability to object and refrain from participating in actions that are contrary to their beliefs. The Kennedy amendment [the late Sen. Ted Kennedy (D–MA)—(amdt. 205) is often invoked to reassure pro-lifers that health care workers will continue to be free to object to participate in performing abortions. The Kennedy amendment, however, has limited scope: it does not cover those *who refuse to pay for or to refer* patients for abortion services. Further, the Kennedy amendment has a provision for an exception in “cases of emergency”—an undefined phrase allowing for broad interpretation.⁴ Again, an amendment—(amdt. 246) to specifically allow health care providers to refuse to participate in an abortion or to be discriminated against when they do so—failed, clear evidence of the intent of those who are pushing for health care reform measures with vague references and back door mechanisms. The American people deserve—and demand—clarity on any measures that are brought to vote and passed into law.

ISSUES RELATED TO END-OF-LIFE

Life Sustaining Treatment: Pro-lifers are, rightly, concerned about the possibility of limitations on life-sustaining treatment of the elderly, permanently disabled, terminally ill, or those with long-term chronic illnesses. All the health care reform measures currently under consideration utilize the CER, Comparative Effective Research, a technique that compares and measures the benefits and harms of treatments, including prevention, diagnosis, treatment, and monitoring of health care delivery services. There are legitimate concerns that the CER will be used to determine whether to come to the aid of those who are elderly, terminally or chronically ill or those who are permanently disabled. Certainly, high profile politicians have made comments that would indicate they believe the least expensive treatment or no treatment at all is appropriate for those who are at or near the end of life or those whose conditions are irreversible.

³<http://www.aul.org/>.

⁴The Congressional Budget Office sent a devastating analysis of the provisions to Senator Kennedy in a letter dated July 2, 2009 with two attachments. Their analysis indicated “a net increase in Federal budget deficits of \$597 billion over the 2010–2019 period—reflecting net costs of \$645 billion for the coverage provisions which would be partially offset by net savings of \$48 billion from other provisions in title I. (CBO has also estimated the budgetary impact of provisions in titles III and VI of an earlier draft of the legislation, which would add another \$14 billion to the net cost of the proposal.” They estimated very little change in the number of people covered by insurance.

Currently, the Senate HELP bill contains a comparative effectiveness provision—the Center for Health Outcomes Research and Evaluation (CHORE)—but the CHORE is charged to “report and recommend” rather than to “mandate.” Nothing in the bill, however, keeps it from being used to *deny* treatment. Further, the bill provides *incentives* for health care providers to use cost-effective measures. (See Sec. 2707 (1)(C)). Most troubling, the bill establishes a Medical Advisory Council, reporting to the Secretary of Health and Human Services, to establish a minimum set of *required* “health care benefits.”

It must be noted that, as is true with the other pro-life amendments, all amendments (amdts. 278 and 280) to prohibit cost-driven “curtailment, withdrawal or denial” of care and those that would prevent rationing or forcing taxpayers to fund assisted suicide (amdts. 232, 233, 228) were rejected along party line votes. Amazingly, amendments ensuring that everyone have access to essential health benefits regardless of their age, expected length of life or disability (amdts. 209, 210, and 211)—even amendments preventing private health insurers from being prevented from covering treatments—were defeated along party lines.

Care at the End-of-Life: One of the most troubling aspects of health care reform legislation concerns end-of-life issues. In the House bill (H.R. 3200, section 1233) it is unclear whether patients could choose physician-assisted suicide in cases of terminal illness. Amendments prevent “promotion” of assisted suicide, but not the practice of it. And, there are potential conflicts in various sections of the bill which preclude advance directives with a suicide or assisted suicide option and those that have State exceptions (see section 1233 and section 138). The Senate Finance Committee added a modification prohibiting Federal funding for assisted suicide and a conscience protection clause for those refusing to participate in assisted suicide. (#C12, Page 17).

It is no secret that senior citizens require far more health care than younger people. Any health care reform must provide effective treatment for the Nation’s older people—without curtailment, withdrawal or denial of life-sustaining care for the terminally ill, the chronically ill, or the permanently disabled. Further, those provisions that address end-of-life issues must clearly leave no room for an interpretation that would pressure healthcare providers to make decisions based on cost rather than the best medical care.

CONCLUSION

In conclusion, Concerned Women for America is concerned about some key issues regarding abortion in the health care reform provisions. The current bill contains required benefits that the courts can interpret as covering abortion. The current bill precludes the Hyde Amendment from applying to new funds. Current language requires health plans to contract with abortion providers, like Planned Parenthood, and allows abortion providers to receive identical non-discrimination protections. Further, the bill could pre-empt some State anti-abortion laws.

CWA believes that for any health care legislation to pass Congress it must protect life from conception to death. Therefore, we recommend:

1. First and foremost, abortion must be explicitly prohibited both in funding and coverage, with the Hyde Amendment permanently codified in law. The Enzi Amendment #276 ensures that taxpayer’s dollars will not be used to fund procedures that are ethically and morally objectionable to a vast majority of Americans.

2. Second, the right to free exercise of their conscience must be granted to all health care workers without penalty or intimidation. We recommend the language of the Pitts/Stupak amendment to H.R. 3200 rather than the Kennedy Amendment to the Senate HELP bill.

3. Third, life-sustaining treatment must be available to all citizens, including the elderly, terminally or chronically ill or those who are permanently disabled.

4. Fourth, we categorically reject end-of-life counseling based on cost considerations and government formulas generated by Comparative Effectiveness Research. And, we reject all assisted suicide measures.

In the Old Testament, the very first commandment [the 5th commandment—Exodus 20:12] given with a promise [that those who follow the commandment will live long lives] is to honor your father and mother. No nation can hope to prosper if it does not act in accordance with this mandate. To claim that cutting Medicare by half a trillion dollars will have no impact on senior citizen’s benefits, mocks voters and insults our intelligence. No amount of smoke and mirrors will conceal the facts from the Nation’s senior citizens.

Most of our senior citizens are women—most of whom have been mothers. Those mothers are the backbone of the Nation; there is in the very DNA of a mother the mandate to answer the call to sit in vigil when a child or loved one is sick. Mothers

generally do not begrudge that labor in service to those that they love. It is an outrage to hear politicians say to those mothers, in effect, that as old women whose years of service are ended, it is time for you to quit consuming resources . . . now roll over and die.

In a representative democracy, elected officials are honor bound to represent those whom they serve. A November 2008 Zogby poll revealed 71 percent of Americans oppose government-funded abortion. Those of us who come to give testimony and represent the public are free citizens, grateful for the opportunity to give feedback and opinion on the issues before this great body of legislators. We are not here summoned by masters. We are not here intimidated by power. Instead, we are here representing the views of thousands just like us who do not intend for our choices to be limited or for our hard-fought liberties to be taken away by those who would obfuscate, distort and hide the truth. No one here today should forget that the citizenry of this great Nation has a history of overthrowing tyranny. And nothing is a clearer act of tyranny than for Congress to legislate change that abrogates our God-given right to choose life.

It is clear that the current health care reform legislation would classify abortion as an "essential benefit" and make it illegal for health care workers to deny abortion to anyone who seeks it (regardless of their personal convictions or beliefs). Further, it is clear that the legislation will overrule State laws that require limitations such as mandatory parental notification or waiting periods. It is also clear that the current bills would force American citizens, whether they want to or not, to subsidize abortion-on-demand with their tax dollars. Even those with incomes up to 400 percent of poverty would receive subsidies to pay for abortion.

Many things are negotiable and amenable to finding some middle ground. But human life is sacred; thus, its defense is not open to negotiation or compromise. Defending life is our sacred duty. It is also a privilege to stand for those who are too vulnerable to stand for themselves.

Senator MIKULSKI. Ms. Greenberger.

STATEMENT OF MARCIA D. GREENBERGER, FOUNDER AND CO-PRESIDENT, NATIONAL WOMEN'S LAW CENTER, WASHINGTON, DC

Ms. GREENBERGER. Madam Chairwoman and members of the HELP Committee, thank you very much for this opportunity to testify on behalf of the National Women's Law Center. The center has long advocated for national health care reform that meets women's needs and we are, unfortunately, all too familiar with the challenges that characterize women's everyday experiences in the current health care system and, as has been described in very graphic and moving terms by a number of the Senators on this committee, subcommittee, among the most damaging are the unfair and discriminatory practices of the health insurance industry, including gender rating, the exclusion of health care services that only women need, and preexisting condition denials.

I would appreciate my full statement being made a part of the record, and appended to it is a report that the National Women's Law Center issued, "Nowhere To Turn: How the Individual Health Insurance"——

Senator MIKULSKI. I'm going to ask unanimous consent your full statement be in the record, that Ms. Crouse's full statement be in the record. All of you I know have a more amplified one, and so let's just ask one unanimous consent. And I appreciate everybody staying in the time line. Yours will be, Ms. Crouse, and all others, who have a rather extensive one.

Ms. GREENBERGER. The report that the National Women's Law Center prepared, which focused on the individual market in particular, would be the subject of my brief remarks just now. But I would hope in the questions to be able to address some of the other

issues that have been brought up with the members of the panel this morning.

In 2008 the center study documented women's experiences that have been described and showed what a difficult and unfair place the individual market can be for women in particular. Since then, we've also begun to speak out about the problems of gender rating in insurance that affect the group market. The very fact that employers also have to pay different rates for their women employees versus their male employees serves as a major disincentive for those employers who have a large number of women employees in their workforce to be able to provide adequate health care. Gender rating is not only a problem in the individual market; it affects the entire health care system, and we have found it in group association plans as well.

With respect to gender rating, just a few additional statistics to elucidate the unfairness. As much as 45 percent more is what is charged for women at age 25 than men at age 25; at age 40, as much as 48 percent more; and, as has been described, those are figures excluding maternity care coverage.

Sixty-percent of plans that we surveyed did not offer even a rider to cover maternity coverage. As has been described, if you are reduced to having to buy that rider, it is extraordinarily expensive and there are many limitations that make the coverage inadequate.

A second issue. Some have said that, well, women just cost more than men to insure. Well, that is not an answer that's acceptable as a matter of common fairness and justice. But let's look at some of the numbers as well. In looking at some of the best-selling plans, we saw ranges where, for example, in Arizona a 40-year-old woman was charged anywhere from 2 percent to 51 percent more than a man; in Lincoln, NE, between 11 percent and 60 percent more than a man. Well, the idea that 11 percent is actuarially based and yet 60 percent could be actuarially based strains credulity, to say the least, and we have many other wild variations in the charges that are imposed, because there isn't the protection in the law that health care reform would provide to eliminate gender rating.

With respect to the group market, what we have been told repeatedly is of employers with large percentages of women in their workplace who have been told by their insurance companies that what we see in rates can also reflect the gender composition of that workplace. We have heard the statistics of the difficulty women have in getting insurance, including that they are often working for employers that don't provide health care at all. Well, when those employers are charged more it's hardly any wonder why that would be the case.

I want to skip now, with just a few seconds actually that I have remaining, to make some specific recommendations with respect to the differences in the plans. The HELP Committee eliminates gender rating in all plans, in groups of all sizes. That's a very important protection to be sure exists when these bills are merged. That across the board protection is not in the Finance Committee version right now.

Also, it's very important to be sure that the cost and the affordability considerations are closer to the HELP plan for all the reasons that have been described, of the difficulties of women, who

earn less than men, who have these greater out-of-pocket costs, and who also end up often right now not only going into bankruptcy, which we know is a major cause—caused by health care costs, unfortunately, with loss of homes and foreclosures and all of those things this country does not need, but women in particular are vulnerable for that.

Also with respect to coverage, it's very important that that coverage be comprehensive in nature. I want to say just a few quick words about the idea that older women would end up losing coverage.

Senator MIKULSKI. We don't want to muzzle or gag rule anybody, but you've gone 2 minutes over.

Ms. GREENBERGER. Oh, OK. Well then, I'll wait for questions and answers. But we don't agree with that.

Senator MIKULSKI. We certainly want to hear about those older women.

Ms. GREENBERGER. And I could describe why we—

Senator MIKULSKI. Perhaps you could elaborate on that in the Q and A's.

Ms. GREENBERGER. OK, yes, and with respect to reproductive health care coverage I also disagree with some of those comments that were made as well.

[The prepared statement of Ms. Greenberger follows:]

PREPARED STATEMENT OF MARCIA D. GREENBERGER

Madame Chairwoman and members of the committee on Health, Education, Labor and Pensions, thank you for this opportunity to testify on behalf of the National Women's Law Center. The Center is a non-profit organization that has worked to expand the possibilities for women and girls in this country since 1972. Since its founding, the Center has confronted the health care coverage problems that women face, which have extracted a high toll on women and their families. The health care reform legislation now under debate can provide the major improvements in health care quality and affordability that women and their families so desperately need.

INTRODUCTION

In particular, I want to focus on the results of the Center's research for a report we published in 2008 called *Nowhere to Turn: How the Individual Health Insurance Market Fails Women*, supplemented by the stories of many individual women who have told us about the challenges they encounter in the health system every day. A copy of the report* is attached as an appendix to my testimony. Among the most deplorable of these obstacles are the harmful and discriminatory practices of insurance companies, including gender rating and coverage exclusions of health care services that only women need. Regardless of whether they receive their coverage from an employer via the group health insurance market or are left to purchase health insurance directly from insurers through the individual market, health insurance practices can hinder a woman's ability to obtain affordable and comprehensive health care coverage.

The majority of American women have health insurance either through an employer or through a public program such as Medicaid. In 2008, nearly two-thirds of all women aged 18 to 64 had insurance through an employer, and another 16 percent had insurance through a public program.¹ In addition, about 7 percent of non-elderly women purchase health coverage directly from insurance companies in what is known as the "individual market."² For the 18 percent of women who are currently uninsured³—largely those who lack access to employer coverage and who do not qualify for public programs—the individual insurance market is often the last resort for coverage.

While women who get health insurance from their employer are partially protected by both Federal and State employment discrimination laws, States are left

*The Report referred to may be found at: [http://action.nwlc.org/site/DocServer/Nowhere toTurn.pdf](http://action.nwlc.org/site/DocServer/Nowhere_toTurn.pdf).

to regulate the sale of health insurance in the individual market with no minimum Federal standards. In the vast majority of States, few if any such protections exist for women who purchase individual health coverage. Furthermore, those seeking health coverage in the individual market are often less able to afford insurance without the benefit of an employer to share the cost of the premium.

The individual health insurance market presents numerous problems for women, but even those who obtain group health insurance from their employer are adversely affected by some of the same harmful practices that impede access to affordable coverage in the individual market.

WOMEN FACE MANY CHALLENGES IN THE INDIVIDUAL INSURANCE MARKET

To learn more about the experiences of women seeking coverage in the individual insurance market, between July and September 2008, the National Women's Law Center ("NWLC" or "the Center") gathered and analyzed information on over 3,500 individual health insurance plans available through the leading online source of health insurance for individuals, families and small businesses.⁴ The Center investigated two phenomena: the "gender gap"—the difference in premiums charged to female and male applicants of the same age and health status—in plans sampled from each State and the District of Columbia (DC), and the availability and affordability of coverage for maternity care across the country.⁵ NWLC examined State statutes and regulations relating to the individual insurance market to determine whether the States and Washington, DC have protections against premium rating based on gender, age, or health status in the individual market, and to determine whether States have any maternity coverage mandates requiring insurers in the individual market to cover comprehensive maternity care (defined as coverage for prenatal and postnatal care as well as labor and delivery for both routine and complicated pregnancies).

Based on this research, NWLC found that the individual insurance market is a very difficult place for women to buy health coverage. Insurance companies can refuse to sell women coverage altogether due to a history of any health problems whatsoever, or charge women higher premiums based on factors that include gender, age and health status. This coverage is often very costly and limited in scope, and it fails to meet women's needs. In short, women face too many obstacles obtaining comprehensive, affordable health coverage in the individual market—simply because they are women.

- **Women often face higher premiums than men.** Under a practice known as gender rating, insurance companies are permitted in most States to charge men and women different premiums. This costly practice often results in wide variations in rates charged to women and men for the same coverage. The Center's 2008 research on gender rating in the individual market found that among insurers who gender rate, the majority charge women significantly more than men until they reach around age 55, and then some (though not all) charge men only somewhat more.⁶ The Center also found huge and arbitrary variations in each State and across the country in the difference in premiums charged to women and men. For example, insurers who practice gender rating charged 40-year-old women from 4 percent to 48 percent more than 40-year-old men.⁷ The huge variations in premiums charged to women and men for identical health plans highlight the arbitrariness of gender rating, and the financial impact of gender rating is compounded when insurers also omit coverage for services that women need (like maternity care) or charge a higher premium because a woman has a preexisting condition.

- **Insurance companies can deny applicants health coverage for a variety of reasons that are particularly harmful to women.** In the vast majority of States, individual market insurers can use evidence of a "preexisting" condition to deny coverage or exclude important health benefits. Simply being pregnant or having had a Cesarean section is grounds enough for insurance companies to reject a woman's application.⁸ And in eight States and the District of Columbia, insurers are allowed to use a woman's status as a survivor of domestic violence to deny her health insurance coverage.⁹

- **It is difficult and costly for women to find health insurance that covers maternity care.** After reviewing over 3,500 policies available to women across the Nation in 2008, NWLC found that the vast majority of individual market health insurance policies do not cover maternity care at all. Just 12 percent included comprehensive maternity coverage (i.e. coverage for pre- and post-natal visits as well as labor and delivery, for both routine pregnancies and in case of complications) within the insurance policy.

While women in some States may be able to purchase optional maternity coverage (called a "rider") for an additional premium, the extra cost can be prohibitively ex-

pensive; NWLC identified maternity riders that cost over \$1,000 per month, in addition to a woman's regular insurance premium. Riders may also involve a waiting period (1 or 2 years, for example) and benefits are often limited in scope.¹⁰ Moreover, insurers that sell maternity riders typically offer just a single rider option. Typically, a woman cannot select a more or less comprehensive rider policy—her only option is to purchase the limited rider or go without maternity coverage altogether.¹¹

Other research confirms the dearth of maternity coverage in the individual health insurance market. In California, for example, the California Health Benefits Review Program found that only 22 percent of the estimated 1,038,000 people in the individual market in California in 2009 had maternity benefits—a dramatic decrease from the 82 percent of people with individual policies that covered maternity in 2004.¹²

• **Both women and men face problems in the individual insurance market that gender rating compounds.** Insurance companies also engage in premium rating practices that, while not unique to women, compound the affordability issues caused by gender rating. These include setting premiums based on age and health status.¹³

WOMEN FACE SIMILAR CHALLENGES IN THE GROUP INSURANCE MARKET

The practice of gender rating also occurs in the group health insurance market, most notably when employers obtain coverage for their employees.¹⁴ Insurance companies in most States are allowed to use the gender make-up of an insured group as a rating factor when determining how much to charge the group for health coverage. From the employee's perspective, this disparity may not be apparent, since employment discrimination laws prohibit an employer from charging male and female employees different rates for coverage, and employers themselves often do not know the factors that determine the rates they are charged. Yet gender rating in the group insurance market can present a serious obstacle to affordable health coverage for an employer and all of its employees. If the overall premium is not affordable, a business may forgo offering coverage to workers altogether, or shift a greater share of health insurance costs to employees.

• **Gender rating may affect health premium costs for employers of varying sizes.** As a result of State and Federal employment discrimination protections that apply to employer-provided fringe benefit plans including health insurance, gender rating—while still present in the group market—manifests itself differently than in the individual market. Under Federal and most State laws, employers unlawfully discriminate if they charge female employees more than male employees for the same health coverage.

Nonetheless, when a business applies for health insurance, the majority of States allow insurance companies to determine the premium that will be charged using a process known as “medical underwriting.” As part of this process, an insurer considers various criteria—such as gender, age, health status, claims experience, or occupation—and decides how much to charge an applicant for health coverage. In the large group market, insurers underwrite the group as a whole rather than considering the health-related factors of each employee—but this limitation provides little relief for employers with a high proportion of female workers.¹⁵ Under the premise that women have, on average, higher hospital and physicians' costs than men, insurance companies that gender rate may charge employers more for health insurance if they have a predominantly female workforce. This can raise premiums for all employees and potentially move the employer to forgo providing health coverage all together.

In the wide range of industries in which women dominate the workforce, gender rating makes group health plan premiums harder to afford. The fields of home health care and child care, for instance, are majority-female (90 percent and 95 percent, respectively).¹⁶ More than three-quarters of people employed by hospitals and physician's offices are women, as are an estimated 82 percent of the employees in dentists' offices.¹⁷ Women dominate the workforces of pharmacies and drug stores (63 percent), retail florists (70 percent), and community service organizations (69 percent).¹⁸ Over two-thirds of employees in the nonprofit industry are women.¹⁹

DISCRIMINATORY INSURANCE INDUSTRY PRACTICES CONTRIBUTE SIGNIFICANTLY TO WOMEN'S AFFORDABILITY CHALLENGES

Unfair insurance industry practices—including gender rating, denials based on preexisting conditions and exclusion of coverage for essential needs like maternity care—exacerbate the affordability problems that women are especially likely to face. Greater health care needs,²⁰ combined with a disadvantaged economic status and

discriminatory industry practices, make it difficult for many women to afford necessary care.

Regardless of whether they have health insurance, women face more cost-related challenges to securing access to health care than men.²¹ They generally have less income, earning only 77 cents, on average, for every dollar that men earn.²² Roughly 57 percent of the adults living in poverty (i.e. with incomes below 100 percent of the Federal poverty level) are women.²³ In 2008, the median earnings of female workers working full time, year round, were \$35,745, compared to \$46,367 for men.²⁴

Women spend a greater share of their income on out-of-pocket medical costs than men, and are more likely to avoid needed health care because of cost. In 2007, for example, 52 percent of all nonelderly women reported a cost-related access barrier—including not filling a prescription, skipping a recommended test or treatment, or not getting needed basic or specialist care because of cost—compared to 39 percent of all nonelderly men.²⁵

Women are also more likely than men to experience significant financial hardship as a result of medical bills. In 2007, one-third of women, compared to one-quarter of men, were either unable to pay for food, heat or rent; had used up all of their savings; had taken out a mortgage or loan against their home; or had taken on credit card debt because of medical bills.²⁶ Overall, 7 in 10 women are either uninsured or underinsured, struggling to pay a medical bill, or experiencing another cost-related problem in accessing needed care.²⁷

SOME STATES HAVE TAKEN ACTION TO PROTECT CONSUMERS IN THE INDIVIDUAL AND SMALL GROUP MARKETS

Some States have taken action to address the challenges that women, and employers with female employees, face in the individual and group markets.

• **Protections against gender rating:** Because the regulation of insurance has been largely left to the States,²⁸ no Federal law provides protections against gender rating in the individual and group markets. Overall, 39 States and Washington, DC allow gender rating in the individual market, with two of these States limiting the amount premiums can vary based on gender through “rate bands.”²⁹ However, even States that ban gender rating allow some plans to use this practice, such as the bare-bones basic and essential plans offered in New Jersey.³⁰ There are three basic approaches to prohibit or limit gender rating in the individual market:

- *Explicit Protections against Gender Rating:* Five States in the individual market have passed laws prohibiting insurers from considering gender when setting health insurance rates: California,³¹ Minnesota,³² Montana,³³ New Hampshire,³⁴ and North Dakota.³⁵ California became the most recent State to ban gender rating, through a bill that Governor Schwarzenegger signed into law on October 11, 2009.
- *Community Rating:* Currently, six States prohibit the use of gender as a rating factor under community rating statutes: New York imposes pure community rating³⁶; while Maine,³⁷ Massachusetts,³⁸ New Jersey,³⁹ Oregon,⁴⁰ and Washington⁴¹ impose modified community rating that, in addition to prohibiting rating based on health status, also bans rating based on gender.
- *Gender Rate Bands:* Some States have passed laws limiting insurers’ ability to base premiums on gender by establishing a “rate band,” which sets limits between the lowest and highest premium that a health insurer may charge for the same coverage based on gender. In the individual market, two States—New Mexico⁴² and Vermont⁴³—use rate bands to limit insurers’ ability to vary rates based on gender.

In the group market, 12 States have banned gender rating altogether. Three States have applied gender “rate bands,” and one State prohibits gender rating unless the carrier receives prior approval from the State insurance commissioner.

- *Explicit Protections against Gender Rating:* Only one State—Montana—prohibits insurers from using gender as a rating factor in *any* type of insurance policy issued within the State. Montana’s distinctive “unisex insurance law” considers gender rating to be discrimination against women, and bans the practice among insurers issuing all types of insurance, including health coverage, to individuals and groups of all sizes.⁴⁴ In addition, California,⁴⁵ Colorado,⁴⁶ Michigan,⁴⁷ and Minnesota,⁴⁸ specifically prohibit insurers from considering gender when setting health insurance rates in the small group market.
- *Community Rating:* New York⁴⁹ imposes pure community rating in its small group market, while Maine,⁵⁰ Maryland,⁵¹ Massachusetts,⁵² New Hamp-

shire,⁵³ Oregon,⁵⁴ and Washington,⁵⁵ ban gender-based rating under modified community rating.

- *Gender Rate Bands*: Three States—Delaware,⁵⁶ New Jersey,⁵⁷ and Vermont,⁵⁸ limit the extent to which insurers may vary premium rates based on gender through a rate band.
- *Other*: One State, Iowa,⁵⁹ prohibits gender rating unless a small group insurance carrier secures prior approval from the State insurance commissioner.

It is important to note that with the exception of Montana, the States' group market gender rating regulations apply only to health insurance sold to *small* groups. Most States use an upper size limit of 50 members/employees to define a small group, though a few have established limits as low as 25 members.⁶⁰ In nearly all of the States with group market protections against gender rating, therefore, employers that exceed the State-defined size limit—including those with as few as 51 employees—are still subject to this discriminatory practice.

- **Maternity mandates**: The Federal Pregnancy Discrimination Act protects women in covered employer-provided health plans against the exclusion of maternity benefits,⁶¹ but no similar Federal protection exists for women in the individual market. A handful of States have recognized the importance of ensuring that maternity coverage—including prenatal, birth, and postpartum care—is a part of basic health care by establishing a “benefit mandate” law that requires insurers to include coverage for maternity services in all individual health insurance policies sold in their State. Currently, just five States have enacted mandate laws that require all insurers in the individual market to cover the cost of maternity care. These States are: Massachusetts,⁶² Montana,⁶³ New Jersey,⁶⁴ Oregon,⁶⁵ and Washington.⁶⁶ In New Jersey and Washington, individual insurance providers are allowed to offer bare-bones plans that are exempt from the mandate and exclude maternity coverage.⁶⁷

Beyond this short list of five, other States have adopted limited-scope mandate laws for the individual market that require maternity coverage only for certain types of health plan carriers, certain types of maternity care, or for specific categories of individuals. Limited-scope mandate laws address the provision of maternity care but may fall short of providing women with full coverage for the care they need. In California,⁶⁸ Illinois,⁶⁹ and Georgia,⁷⁰ for example, only Health Maintenance Organizations (HMOs) are subject to State laws that mandate maternity benefits in the individual insurance market.

With regard to the group market, some States have taken an additional step to guarantee that women who work for small businesses have access to employer-sponsored insurance that includes maternity benefits, since employers with fewer than 15 workers are not subject to the Federal Pregnancy Discrimination Act law requiring businesses to provide the same level of coverage for pregnancy as is provided for other medical conditions. By adopting laws that mandate the inclusion of maternity benefits in policies sold through the State's group health insurance market, States ensure that all women with group health plans have access to these important benefits, no matter how small the employer. Fifteen States have enacted such laws, though they may apply only to certain types of health plans such as managed care plans.⁷¹ Therefore, it is possible that in some States women who obtain ESI through a small business do not receive maternity benefits as part of that coverage.

- **State maternity coverage programs**: In a few instances, State governments have stepped in (at taxpayer expense) to fill gaps in private health insurance by establishing programs to assist pregnant women who have private coverage that does not meet their maternity care needs. At least two States have such programs: California's *Access for Infants and Mothers* (AIM) program is a low-cost coverage program for pregnant women who are uninsured and ineligible for Medi-Cal (the State's Medicaid program).⁷² New Mexico's *Premium Assistance for Maternity* (PAM) program is a State-sponsored initiative that provides maternity coverage for pregnant citizens who are ineligible for Medicaid.⁷³ According to program officials in New Mexico, PAM was established expressly because of the gaps that existed in private market maternity coverage. If maternity care was included as a basic benefit in comprehensive and affordable health insurance policies, such programs would be unnecessary.

RECOMMENDATIONS FOR HEALTH CARE REFORM

Health reform holds the promise of making affordable care available to millions of women who need it. As the legislation progresses in the coming weeks, however, it is essential that robust insurance market reforms are included, as well as other provisions to ensure that health care is truly affordable. If these key pieces are ab-

sent from the final legislation, health reform will provide inferior coverage and protection to the millions of women who are currently struggling to get the care they need. Specifically, to protect women and their families health care reform must:

- *Include insurance market reforms that protect ALL women, whether they obtain coverage on their own, get health benefits from an employer, or secure coverage from other types of plans.* Health reform must eliminate unfair and discriminatory practices, such as gender rating and preexisting condition exclusions, by applying reforms broadly across the individual market and for all groups of all sizes. It must ensure that reforms protect women from unfair practices regardless of whether they obtain coverage through the new Health Insurance Exchanges, from an employer of any size (not just a small business), or an association health plan. Limiting reforms to a subset of the health insurance market—such as for individuals and small groups only—creates a loophole for insurance companies and squanders an opportunity to ensure uniform and fair rules for all women with health insurance. It allows moderate-sized and large groups to continue facing unfair and costly insurance practices related to the sex, age, or health claims history of their employees.

Eliminating gender rating and other discriminatory practices for individuals and groups of all sizes is especially important given other potential health reform provisions, such as the proposed excise tax on so-called “high-cost” health plans. Plans—and ultimately individuals—may be subject to the tax due to the gender, age, or health status of the enrolled individual or group if unfair premium rating practices are allowed to continue.

- *Ensure affordable coverage.* Affordability in health reform is especially important for women. There are more than 14 million uninsured women (ages 18–64) with incomes below 400 percent of the Federal poverty level.⁷⁴ Without sufficient subsidies to help with the cost of health insurance, women in this income range would struggle to afford newly-available coverage and could even join the ranks of the underinsured. For a single mom with two children at 400 percent of poverty, the average premium cost for a Blue Cross standard policy alone would be almost 18 percent of her income.

Accordingly, there must be adequate sliding scale subsidies for premiums and out-of-pocket costs—as well as reasonable limits on total out-of-pocket costs—so that women can obtain health coverage that they can realistically afford. The legislation reported by the Health, Education, Labor, and Pensions Committee (S.1679) provides stronger affordability protections than the legislation reported by the Finance Committee.

- *Prohibit any annual or lifetime benefit caps for all individual and group health insurance plans.* Even benefit limits that appear to be high can be used up quickly if a woman faces a serious condition, leaving little or no coverage for a woman’s other basic health care needs. For example, a woman suffering from coronary artery disease, the leading killer of women in the United States, could spend over \$1 million over the course of her lifetime on related treatment alone,⁷⁵ and a condition such as multiple sclerosis—which affects twice as many women as men⁷⁶—costs an estimated \$2.2 million over the course of an individual’s lifetime.⁷⁷ This critically important protection will help women afford health care when they need it most, as well as avoid medical debt and bankruptcy.

CONCLUSION

Women’s relationship with the health system is characterized by many disadvantages, including continued discrimination by health insurance companies and increasing proportions who report cost-related problems with access to care. Quite simply, there is an urgent need for health reform now, to make affordable, high-quality health care a reality for women across the country.

The country is closer than ever been before to realizing this goal, but the debate over the scope of insurance market reforms and various other provisions to ensure affordable coverage is far from over. The protections that are of fundamental importance for women are essential components of health reform. For women and their families, health reform that assures affordability and fairness will mean the difference between securing access to quality health care, and going without.

REFERENCES

1. National Women’s Law Center analysis of 2008 data on health coverage from the Current Population Survey’s Annual Social and Economic Supplement (U.S. Census Bureau, 2009) using CPS Table Creator, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html.

2. *Id.*
3. *Id.*

4. This source is eHealthInsurance, available at <http://www.ehealthinsurance.com/>. Notably, eHealthInsurance may not represent all insurance companies licensed to sell individual health insurance policies in every State. However, the company bills itself as the leading online source of health insurance for individuals, families, and small businesses, partnering with over 160 health insurance companies in 50 States and Washington, DC and offering more than 7,000 health insurance products online. NWLC chose to use eHealthInsurance for this study because it presents the clearest available picture of the individual market across the country, and because it is the most readily available tool for individuals seeking private insurance who do not wish, or cannot afford, to employ the services of an insurance agent. Any limitations in eHealthInsurance's scope—in tandem with the basic fact that its services are only available online and therefore may not be accessible to individuals without a computer or Internet access or who are not web savvy—simply underscores the challenges women (and men) face seeking coverage in the individual market without a government-sponsored system to help facilitate their search.

5. While NWLC's review of health insurance plans examined coverage for maternity-related care, it was much more difficult to determine whether other pregnancy-related benefits, such as contraception or pregnancy termination, are covered under a plan; accordingly, our review did not include these important reproductive health benefits. For example, in many plan brochures, if information about either of the above benefits is available at all, it is visible only as part of a long list of exclusions. This obfuscation reflects another challenge women face in assessing the adequacy of a plan's coverage.

6. Lisa Codispoti, Brigitte Courtot and Jen Swedish, Nat'l Women's Law Ctr, *Nowhere to Turn: How the Individual Market Fails Women* (Sept. 2008), <http://action.nwlc.org/site/PageServer?pagename=nowheretoturn>.

7. *Id.*

8. Denise Grady, *After Caesareans, Some See Higher Insurance Cost*, N.Y. Times, June 1, 2008, at A26, available at <http://www.nytimes.com/2008/06/01/health/01insure.html>.

9. Women's Law Project & Pennsylvania Coalition Against Domestic Violence, *FYI: Insurance Discrimination Against Victims of Domestic Violence, 2002 Supplement 2* (2002), http://www.womenslawproject.org/brochures/InsuranceSup_DV2002.pdf. In the early 1990s, advocates discovered that insurers had denied applications for coverage submitted by women who had experienced domestic violence. *See, e.g., 142 Cong. Rec. E1013-03, at E1013-14* (June 5, 1996) (statement of Rep. Pomeroy) (“the Pennsylvania State Insurance Commissioner surveyed company practices in Pennsylvania and found that 26 percent of the respondents acknowledged that they considered domestic violence a factor in issuing health, life and accident insurance”). Since 1994, the majority of States have adopted legislation prohibiting health insurers from denying coverage based on domestic violence, but nine States and Washington, DC offer no such protection to survivors of domestic violence. Even though Vermont lacks legislation specifically prohibiting discrimination against domestic violence survivors, the State requires guaranteed issue of all individual insurance plans. *See infra* note 94 and accompanying text. Though the report identifies nine States, as well as the District of Columbia, which do not prohibit this practice, Arkansas Gov. Beebe recently signed into law ACT 619, which amends Arkansas Code § 23-66-206(14)(G), to add “status as a victim of domestic abuse” to the list of attributes that insurers may not use as the sole justification for denying an individual health insurance coverage.

10. It is quite common for a rider to limit the total maximum benefit to amounts such as \$3,000 (available only after a 10-month waiting period for a rider option identified in the District of Columbia) or \$5,000 (available only after a 12-month waiting period for an Arkansas rider option).

11. *Id.*

12. California Health Benefits Review Program, *Executive Summary: Analysis of Assembly Bill 98: Maternity Services, A Report to the 2009-2010 California Legislature* (Mar. 16, 2009), http://www.chbrp.org/documents/ab_98_fnlsumm.pdf.

13. *Nowhere to Turn*, *supra* note 6.

14. There are also non-employer based group plans that provide insurance, commonly referred to as association health plans.

15. *Id.*; Henry J. Kaiser Family Foundation, *How Private Health Coverage Works: A Primer, 2008 Update* (Apr. 2008), <http://www.kff.org/insurance/upload/7766.pdf>.

16. U.S. Bureau of Labor Statistics, *Women in the Labor Force: A Data Book, 2008 Edition* (2008), “Table 14: Employed Persons by Detailed Industry and Sex, 2007 Annual Averages,” <http://www.bls.gov/cps/wlf-databook-2008.pdf>.

17. *Id.*

18. *Id.*
19. Jasmine McGinnis, Georgia State University and Georgia Institute of Technology, *The Young and Restless: Generation Y in the Nonprofit Workforce* (Working Paper, 2009), <http://www.utexas.edu/lbj/rgk/fellowship/2009papers/McGinnis.pdf>.
20. Women are more likely than men to require health care throughout their lives, including regular visits to reproductive health care providers. They are more likely to have chronic conditions that necessitate continuous health care treatment. They also use more prescription drugs on average, and certain mental health problems affect twice as many women as men. See: Elizabeth Patchias and Judy Waxman, *Women and Health Coverage: The Affordability Gap* (2007), National Women's Law Center. An issue brief prepared for the Commonwealth Fund, available at <http://www.nwlc.org/pdf/NWLCCommonwealthHealthInsuranceIssueBrief2007.pdf> (last visited May, 12 2008).
21. Sheila D. Rustgi, Michelle M. Doty, and Sara R. Collins, *Women at Risk: Why Many Women are Forgoing Needed Health Care* (New York: The Commonwealth Fund, May 2009).
22. U.S. Census Bureau (Sept 2009), *Men's and Women's Earnings by State: 2008 American Community Survey*, <http://www.census.gov/prod/2009pubs/acsbr08-3.pdf>.
23. National Women's Law Center calculations based on U.S. Census Bureau, "Table POV01: Age and Sex of All People, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race: 2005, Below 100 percent of Poverty—All Races." Current Population Survey Annual Demographic Survey March Supplement, (2006), available at: http://pubdb3.census.gov/macro/032006/pov/new01_100_01.htm. (last visited May 12, 2008).
24. National Women's Law Center, *Women's Private Health Coverage, Incomes Decline While Poverty Increases, Census Data Show* (September 2009 Press Release), <http://www.nwlc.org/details.cfm?id=3711§ion=newsroom>.
25. *Women at Risk*, supra note 21.
26. *Id.*
27. *Id.*
28. McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015 (2008).
29. *Nowhere to Turn*, supra note 6.
30. N.J. Dept. of Banking & Ins., *N.J. Individual Health Coverage Program Buyer's Guide: How To Select a Health Plan—2006 Ed.* (2006), http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcbuygd.html ("carriers may vary the rates for the B&E plan based on age, gender and geographic location").
31. On October 11, 2009, California governor Arnold Schwarzenegger signed Assembly Bill 119, which prohibits gender rating in the State's insurance markets, into law. The law affects insurance policies issued or renewed on or after January 1, 2011.
32. MN. Stat. § 62A.65(4) (2008) ("No individual health plan offered, sold, issued, or renewed to a Minnesota resident may determine the premium rate or any other underwriting decision, including initial issuance, through a method that is in any way based upon the gender of any person covered or to be covered under the health plan.").
33. MT. Code Ann. § 49–2–309(1) (2008) ("It is an unlawful discriminatory practice for a financial institution or person to discriminate solely on the basis of sex or marital status in the issuance or operation of any type of insurance policy, plan, or coverage or in any pension or retirement plan, program, or coverage, including discrimination in regard to rates or premiums and payments or benefits."). Montana's "unisexual insurance law" is not limited to health insurance; it prohibits insurers from using gender as a rating factor in any type of insurance policy issued within the State. See Mont. Code Ann. § 49–2–309(1) (2008) ("It is an unlawful discriminatory practice for a financial institution or person to discriminate solely on the basis of sex or marital status in the issuance or operation of any type of insurance policy, plan, or coverage or in any pension or retirement plan, program, or coverage, including discrimination in regard to rates or premiums and payments or benefits").
34. N.H. Rev. Stat. Ann. § 420–G:4(I)(d) (2008) (allowing insurers to base rates in the individual market solely on age, health status, and tobacco use).
35. N.D. Cent. Code § 26.1–36.4–06(1) (2008) (imposing a rate band under which age, industry, gender, and duration of coverage may not vary by a ratio of more than 5 to 1, but providing that "[g]ender and duration of coverage may not be used as a rating factor for policies issued after January 1, 1997"). Despite the statutory prohibition on gender rating in North Dakota, the only company offering individual policies through www.eHealthInsurance.com does use gender as a rating factor. In an attempt to understand this seeming inconsistency, NWLC contacted the North Dakota Insurance Department, which indicated that this company is a "hybrid situ-

ation” and thus permitted to rate its individual policies as if they were sold on the group market; gender rating is allowed within limit for groups in North Dakota. Telephone Interview with North Dakota Insurance Department (Sept. 12, 2008).

36. N.Y. Ins. Law § 3231(a) (McKinney 2008) (defining community rating as “a rating methodology in which the premium for all persons covered by a policy or contract form is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status or occupation”).

37. ME. Rev. Stat. Ann. tit. 24–A, § 2736–(2)(B) (2008) (prohibiting insurance carriers from varying the community rate due to gender or health status). ME. Rev. Stat. Ann. tit. 24–A, § 2736–C(2)(D)(3) (2008) (imposing a rate band under which insurance carriers may only vary the community rate due to age by plus or minus 20 percent for policies issued after July 1, 1995).

38. MA. Gen. Laws ch. 176M, § 1 (2008) (defining “modified community rate” as “a rate resulting from a rating methodology in which the premium for all persons within the same rate basis type who are covered under a guaranteed issue health plan is the same without regard to health status; provided, however, that premiums may vary due to age, geographic area, or benefit level for each rate basis type as permitted by this chapter”). Mass. Gen. Laws ch. 176M, § 4(a)(2) (2008) (imposing a rate band under which the “premium rate adjustment based upon the age of an insured individual” may range from 0.67 to 1.33).

39. 2008 N.J. Sess. Law Serv. Ch. 38, page nos. 12, 15 (Senate 1557) (West) (amending N.J. Stat. Ann. § 17B:27A–2 (West 2008) to define “modified community rating” as “a rating system in which the premium for all persons under a policy or a contract for a specific health benefits plan and a specific date of issue of that plan is the same without regard to sex, health status, occupation, geographic location or any other factor or characteristic of covered persons, other than age,” and amending N.J. Stat. Ann. § 17B:27A–4 (West 2008) to require individual health benefits plans to “be offered on an open enrollment, modified community-rated basis”). New Jersey law excludes bare-bones basic and essential plans from the modified community-rating requirement.

40. OR. Rev. Stat. § 743.767(2) (2008) (“The premium rates charged during a rating period for individual health benefit plans issued to individuals shall not vary from the individual geographic average rate, except that the premium rate may be adjusted to reflect differences in benefit design, family composition and age.”).

41. WA. Rev. Code § 48.43.005(1) (2008) (defining “adjusted community rate” as “the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities”); Wash. Rev. Code § 48.44.022(1)(a) (2008) (allowing insurers to only vary the adjusted community rate based on geographic area, family size, age, tenure discounts, and wellness activities).

42. N.M. Stat. § 59A–18–13.1(A) (2008) (allowing gender rating); N.M. Stat. § 59A–18–13.1(B) (2008) (providing that “the difference in rates in any one age group that may be charged on the basis of a person’s gender shall not exceed another person’s rates in the age group by more than 20 percent of the lower rate”).

43. VT. Stat. Ann. tit. 8, § 4080b(h)(1) (2008) (prohibiting the use of the following rating factors when establishing the community rate: demographics including age and gender, geographic area, industry, medical underwriting and screening, experience, tier, or duration); VT. Stat. Ann. tit. 8, § 4080b(h)(1) (2008), 21–020–034 VT. Code R. § 93–5(11)(G), (13)(B)(6) (2008) (providing that upon approval by the insurance commissioner, insurers may adjust the community rate by a maximum of 20 percent for demographic rating including age and gender rating, geographic area rating, industry rating, experience rating, tier rating, and durational rating).

44. MT. Code Ann. § 49–2–309(1) (2008).

45. CA. Ins. Code §§ 10714(a)(2), 10700(t)–(v) (West 2008) (prohibiting small employer insurance carriers from setting premium rates based on characteristics other than age, geographic region, and family size, in addition to the benefit plan selected by the employee).

46. CO. Rev. Stat. §§ 10–16–105(8)(a), 10–16–102(10)(b) (2008) (prohibiting small employer insurance carriers from setting premium rates based on characteristics other than age, geographic region, family size, smoking status, claims experience, and health status).

47. MI. Comp. Laws § 500.3705(2)(a) (2008) (prohibiting commercial small employer insurance carriers from setting premium rates based on characteristics of the small employer other than industry, age, group size, and health status).

48. MN. Stat. § 62L.08(5) (2008) (prohibiting the use of gender as a rating factor for small employer insurance carriers).

49. N.Y. Ins. Law § 3231(a) (McKinney 2008) (requiring all small employer insurance plans to be community rated and defining “community rating” as “a rating methodology in which the premium for all persons covered by a policy or contract form is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status or occupation”).

50. ME. Rev. Stat. Ann. tit. 24–A, § 2808–B(2)(B) (2008) (prohibiting small employer insurance carriers from varying the community rate based on gender, health status, claims experience or policy duration of the group or group members).

51. MD. Code Ann., Ins. § 15–1205(a)(1)–(3) (West 2008) (allowing small employer insurance carriers to adjust the community rate only for age and geography).

52. MA. Gen. Laws ch. 176J, § 3(a)(1), (2) (2008) (allowing small employer insurance carriers to adjust the community rate only for age, industry, participation-rate, wellness program, and tobacco use).

53. N.H. Rev. Stat. Ann. § 420–G:4(1)(e)(1) (2008) (prohibiting small employer insurance carriers from setting premium rates based on characteristics of the small employer other than age, group size, and industry classification).

54. OR. Rev. Stat. § 743.737(8)(b)(B) (2008) (providing that small employer insurance carriers may only vary the community rate based on age, employer contribution level, employee participation level, the level of employee engagement in wellness programs, the length of time during which the small employer retains uninterrupted coverage with the same carrier, and adjustments based on level of benefits). Overall Rate Band: ±50 percent

55. WA. Rev. Code § 48.21.045(3)(a) (2008) (providing that small employer insurance carriers may only vary the community rate based on geographic area, family size, age, and wellness activities).

56. DE. Code Ann. tit. 18, § 7205(2)(a) (2008) (allowing small employer insurance carriers to vary premium rates based on gender and geography combined by up to 10 percent). Age: DE. Code Ann. tit. 18, §§ 7202(9), 7205 (2008) (allowing the use of age as a rating factor if actuarially justified).

57. N.J. Stat. Ann. § 17B:27A–25(a)(3) (West 2008) (providing that the premium rate charged by a small employer insurance carrier to the highest rated small group shall not be greater than 200 percent of the premium rate charged to the lowest rated small group purchasing the same plan, “provided, however, that the only factors upon which the rate differential may be based are age, gender and geography”). Rate Band for Age, Gender & Geography: ±200 percent.

58. VT. Stat. Ann. tit. 8, § 4080a(h)(1) (2008) (prohibiting the use of the following rating factors when establishing the community rate: demographics including age and gender, geographic area, industry, medical underwriting and screening, experience, tier, or duration); VT. Stat. Ann. tit. 8, § 4080a(h)(2) (2008) (providing that upon approval by the insurance commissioner, insurers may adjust the community rate by a maximum of 20 percent for demographic rating including age and gender rating, geographic area rating, industry rating, experience rating, tier rating, and durational rating). Overall Rate Band: 20 percent.

59. IA Code § 513B.4(2) (2008) (prohibiting the use of rating factors other than age, geographic area, family composition, and group size without prior approval of the insurance commissioner).

60. In Louisiana, for instance, a small group has 35 or fewer members; Arkansas and Tennessee define a small group as one that has 25 or fewer members. (Unpublished research conducted by the National Women’s Law Center, 2009).

61. Pub. L. No. 95–555, 92 Stat. 2076 (1978).

62. MA. Gen. Laws ch. 176G, §§ 4(c), 4I (2008) (requiring health maintenance organizations to include maternity coverage); MA. Gen. Laws ch. 176B, § 4H (2008) (requiring medical service corporations to include maternity coverage); MA. Gen. Laws ch. 176A, § 8H (2008) (requiring non-profit hospital service corporations to include maternity coverage).

63. MT. Ins. Or. (Feb. 16, 1994); *Bankers Life & Casualty Co. v. Peterson*, 866 P.2d 241 (Mont. 1993). Mandated maternity coverage is not always imposed by State legislation or via administrative regulations. Montana’s mandate is the result of a 1993 State Supreme Court decision which held that a health plan excluding maternity coverage unconstitutionally discriminated based on gender.⁷⁴ In response to this court decision, the Montana Insurance Commissioner issued an order that all insurers in the State must include maternity benefits.⁷⁵

64. N.J. Stat. Ann. § 17B:26–2.1b (West 2008) (requiring all individual plans, except the bare-bones basic and essential plans, to include maternity coverage). N.J. Dept. of Banking & Ins., *N.J. Individual Health Coverage Program Buyer’s Guide: How To Select a Health Plan—2006 Ed.* (2006), http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcbuygd.html (“carriers may vary the rates for the B&E plan based on age, gender and geographic location”).

65. OR. Rev. Stat. § 743A.080 (2008).
66. WA. Rev. Code § 48.43.041(1)(a) (2008) (requiring all individual plans, except the bare-bones catastrophic plans, to include maternity coverage).
67. *Id.*; N.J. Dept. of Banking & Ins., *supra* note 8 (“B&E Plans do not provide comprehensive benefits like the standard plans described above,” which include pre-natal and maternity care).
68. CA. Health & Safety Code § 1367(i) (requiring health care service plans to provide basic health care services); A.B. 1962, 2007–2008 Sess. § 1 (Cal. 2008) (recognizing that, in practice, health care service plans are required to provide maternity services as a basic health care benefit).
69. IL. Admin. Code tit. 50, § 5421.130(e) (2008).
70. GA. Comp. R. & Regs. 290–5–37–.03(4) (2008).
71. HI, MD, MA, MI, MN, MT, NJ, NY, OR, VT, and WA have enacted laws requiring maternity benefits in all policies for employers in the small group market. ID requires that maternity benefits be covered for employers with five or more employees, and CA, GA, and ME have laws require that maternity be covered by managed care organizations in the small group market. See: Ed Neuschler, Institute for Health Policy Solutions, Policy Brief on Tax Credits for the Uninsured and Maternity Care 3 (March of Dimes 2004), <http://www.marchofdimes.com/TaxCreditsJan2004.pdf>.
72. Managed Risk Medical Insurance Board, Access for Infants and Mothers, <http://www.aim.ca.gov/english/AIMHome.asp> (last visited Sept. 17, 2008).
73. Insure New Mexico, Premium Assistance for Maternity (PAM) Frequently Asked Questions, <http://www.insurenewmexico.state.nm.us/PAMFaq.htm> (last visited Sept. 17, 2008).
74. National Women’s Law Center calculations based on health insurance data for women ages 18–64 from the Current Population Survey’s 2008 Annual Social and Economic Supplement, using CPS Table Creator, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html.
75. Leslee J. Shaw; C. Noel Bairey Merz; Carl J. Pepine, et al., The Economic Burden of Angina in Women With Suspected Ischemic Heart Disease, *Circulation* 114 (2006):894–904, <http://circ.agajournals.org/cgi/content/abstract/114/9/894?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=cardiovascular&searchid=1&FIRSTINDEX=20&resourcetype=HWFIF>.
76. Brigham and Women’s Hospital, “Focus on Multiple Sclerosis” (April 2008), <http://www.brighamandwomens.org/patient/healthmatters/multiplesclerosis.aspx>.
77. Kathryn Whetten-Goldstein, Frank A. Sloan, Larry B. Goldstein, et al., A Comprehensive Assessment of the Cost of Multiple Sclerosis in the United States, *Multiple Sclerosis* 4, no. 5 (1998):419–425, <http://msj.sagepub.com/cgi/content/abstract/4/5/419>.

Senator MIKULSKI. Ms. Buchanan.

STATEMENT OF AMANDA BUCHANAN, PATIENT/HEALTH CARE CONSUMER, WEISER, ID

Ms. BUCHANAN. Madam Chair, members of the committee, I would like to thank you for giving me the opportunity to testify before this committee today. My name is Amanda Buchanan and I live in Weiser, ID. I am the wife of a public school teacher and a mother to two young sons.

My husband transferred from a large school district to a small rural one shortly after my first son was born. The decrease in income this change created was a compromise for our desire to raise a family in a small town. We have always been great at living simply and frugally, which came in especially handy as I had decided to become a stay-at-home mom.

However, what we weren’t prepared for was the astronomical cost of putting myself and my infant son on my husband’s group insurance policy—\$760 a month on a \$33,000 a year gross income. For the first time I decided to get individual market coverage for the baby and me. I quickly learned that in Idaho as an individual searching for coverage I had two options, Regents Blue Shield of Idaho and Blue Cross of Idaho, and the limited options available

between these two companies were remarkably similar. In fact, every single policy available, despite the premium and deductible level, came with an additional maternity deductible of \$5,000 plus 20 percent of all remaining costs.

At the time, my focus was on being responsible, which to me meant having insurance. I wasn't planning on getting pregnant for some time and I really had no other choice. Several months later, my husband and I found ourselves answering the possibility of a second child. Instead of an intimate conversation between the two of us about goals and family, I felt like there were actually three of us at the table: myself, my husband, and our insurance policy.

We had to decide if we could even afford to have a second child, and not "afford" in the sense of clothing, food, et cetera, but could we afford to pay a hospital bill. There I was, paying a \$280 premium every month for the best individual market policy Regents offered, and I was having to debate if I could afford the medical bills from a routine pregnancy and delivery.

I was very angry that an insurance company could set up a policy in a way that would either discourage women from getting pregnant altogether or, if they did become pregnant, force them to pay for basically the entire cost of a typical delivery.

My husband and I came up with a plan. I would have a baby, then take myself off of insurance and use the money I'd save to pay down our medical debt, and this is exactly what we did. In the end, health care premiums, deductibles, and the medical costs from the pregnancy and delivery ate up 28 percent of our net income in 2008, and this is even after the hospital wrote off our bill.

As it stands, our medical debts are paid. I remain uninsured. You could argue that I'm being irresponsible and creating a potentially disastrous situation for my family, and I would agree with you. But it would be impossible for us to come up with \$300 a month to cover me. We would be sacrificing any ability to save money for emergencies and would most definitely be cutting into our grocery budget.

As a mother, my responsibility is to my children and family. My sons remain well-fed and insured. I also have the responsibility of taking care of myself. Fortunately, I am a healthy woman. Even so, my lack of insurance is a constant source of stress.

I am tired of the tactics insurance companies use to make quality coverage unaffordable, tactics that include outrageous separate deductibles for the common condition of pregnancy. I do not trust these companies and certainly do not believe that they will ever have the best interests of patients at heart. I want an affordable public option that will provide quality coverage and the assurance that out-of-pocket costs will be reasonable and fair. Health insurance premiums should be a part of every family's budget. However, they should not be a crippling part.

My family could live comfortably on my husband's salary if our insurance premiums were reasonably proportionate to our income. We have made many minor sacrifices in order for me to remain at home with our children. However, in this day and age and in this great country I should not have to sacrifice basic health care coverage as well.

Thank you for your time.

[The prepared statement of Ms. Buchanan follows:]

PREPARED STATEMENT OF AMANDA BUCHANAN

Mr. Chair, members of the committee, I would like to thank you for giving me the opportunity to testify before this committee today. My name is Amanda Buchanan, and I live in Weiser, ID. I am the wife of a public school teacher and a mother to two young sons.

My husband transferred from a large school district to a small, rural one shortly after my first son was born. The decrease in income this change created was a compromise for our desire to raise a family in a small town. We have always been great at living simply and frugally—which came in especially handy as I had decided to become a stay-at-home mom. However what we weren't prepared for was the astronomical cost of putting myself and my infant son on my husband's group insurance policy. (\$760 a month on a \$33,000 a year gross income.) For the first time, I decided to get individual market coverage for the baby and me.

I quickly learned that in Idaho, as an individual searching for coverage, I had two options: Regence Blue Shield of Idaho and Blue Cross of Idaho. And the limited options available between these two companies were remarkably similar. In fact every single policy available, despite the premium and deductible level, came with an additional maternity deductible of \$5,000 (plus 20 percent of all remaining costs). At the time, my focus was on being responsible, which to me meant having insurance. I wasn't planning on getting pregnant for some time and I really had no other choice.

Several months later, my husband and I found ourselves discussing the possibility of a second child. Instead of an intimate conversation between the two of us about goals and family, I felt like there were actually three of us at the table—myself, my husband and our insurance policy. We had to decide if we could even afford to *have* a second child. And not "afford" in the sense of clothing, food, et cetera; but could we afford to pay a hospital bill? There I was paying a \$280 premium every month for the best individual market policy Regence offered, and I was having to debate if I could afford the medical bills from a routine pregnancy and delivery. I was very angry that an insurance company could set up a policy in a way that would either discourage women from getting pregnant altogether, or if they did become pregnant, force them to pay for basically the entire cost of a typical delivery.

My husband and I came up with a plan: I would have a baby, then take myself off of insurance and use the money I'd save to pay down our medical debt. And this is exactly what we did. In the end, health care premiums, deductibles and the medical costs from the pregnancy and delivery ate up 28 percent of our net income in 2008. And this is even after the hospital wrote off our bill.

As it stands, our medical debts are paid. I remain uninsured. You could argue that I'm being irresponsible and creating a potentially disastrous situation for my family, and I would agree with you. But it would be impossible for us to come up with \$300 a month to cover me. We would be sacrificing any ability to save money for emergencies, and would most definitely be cutting into our grocery budget. As a mother, my responsibility is to my children and family. My sons remain well fed and insured. I also have the responsibility of taking care of myself. Fortunately, I am a healthy woman. Even so, my lack of insurance is a constant source of stress.

I am tired of the tactics insurance companies use to make quality coverage unaffordable. Tactics that include outrageous separate deductibles for the common condition of pregnancy. I do not trust these companies, and certainly do not believe that they will ever have the best interests of patients at heart. I want an affordable public option that will provide quality coverage and the assurance that out-of-pocket costs will be reasonable and fair. Health insurance premiums should be a part of every family's budget; however they should not be a crippling part.

My family could live comfortably on my husband's salary if our insurance premiums were reasonably proportionate to our income. We have made many minor sacrifices in order for me to remain at home with our children, however in this day and age, and in this great country I should not have to sacrifice basic health care coverage as well.

Thank you for your time.

For the record, I would like to submit a few additional points.

As I said, affordability is a key. As the Congress works to merge the House, HELP, and Senate Finance Committee bills, I hope you will put yourself in the shoes of families like mine. We need a good health insurance policy that is affordable and covers such life-events as childbirth. I've looked at the "comparison" Web site of Kaiser Family Foundation. I typed in our family's approximate situation and compared the different bills' results.

The Web site does not allow me to enter our exact situation. So I typed in a \$35,000 gross income for a 30-year-old in a family of four in a low-cost area of the country, not eligible for group coverage. Your committee's HELP bill would cost us about \$491 in annual premiums and we would owe on our medical bills about 7 percent in co-pays. The House bills would be about \$1,185 in premiums, and 7 percent of bills in co-pays. The Senate Finance Committee bill would be about \$1,728 in premiums and we'd pay about 20 percent of the bills in co-pays. The House and the HELP proposals' limits on out-of-pocket, in-network costs are lower than Senate Finance's. In a worst case situation, we could owe about 39 percent of our total income under the Finance bill—and a good chance of bankruptcy.

Please do as much as you can to move toward the best possible levels of affordability and catastrophic coverage.

Providing help to working families such as mine will take more money—or it will take more savings in the health sector. If the Congressional Budget Office says that a public option saves money, please include it in the new law. We need the extra competition. As I said, there is almost no real competition in my State.

Also, I've heard friends complain about the fine print, loopholes, and "got 'cha' aspects of health insurance policies. I hope the final law can retain the HELP and Senate Finance Committee provisions that define medical and insurance terms so consumers can compare apples-to-apples. I particularly like your idea of "scenarios" of what it would cost to be treated for certain common conditions.

And I urge you to consider adding an idea I've heard that might help save money. In whatever "exchange" or "connector" marketplace established to help people shop, make sure that the consumer is told not just the premium cost, but also the estimated annual *total* cost, based on past medical history or on one's own estimate of one's health condition—for example, "good health, fair health, poor health." Consumers Union has some data that shows that when consumers can see an estimate of their likely total cost, they make much better choices than if they only have premium information available. And if they make better insurance choices, they will need less subsidy help with premiums, deductibles, and co-pays. Total estimated cost data will help everyone win.

Senator MIKULSKI. Ms. Robertson.

**STATEMENT OF PEGGY ROBERTSON, PATIENT/HEALTH CARE
CONSUMER, CENTENNIAL, CO**

Ms. ROBERTSON. Thank you for giving me this opportunity to speak today. My name is Peggy Robertson. I live in Centennial, CO. I have two boys, ages 10 and 3.

Shortly after my youngest son was born, my husband and I began to research independent health insurance options because our current policy was increasing in price every year. My husband is self-employed and we are unable to get access to a group policy. We applied with Golden Rule and I was denied coverage based on having a Caesarian with Luke in 2006. I'm in perfect health and I was shocked that Golden Rule would decline my application.

I called Golden Rule and they said that if I would get sterilized they would then be able to offer insurance to me. I was shocked by their comments and I immediately contacted the Colorado Division of Insurance to file a complaint. After filing a complaint, I discovered that Golden Rule is allowed to discriminate against women who have had a C-section. There was nothing I could do.

I'd like to take a moment to read a couple of paragraphs from their letter of denial:

"The plan you applied for is an association group plan and it's medically underwritten. As a general rule, our underwriting guidelines require that we issue coverage with a rider excluding benefits for Caesarian section delivery for 3 years. However, the Colorado Division of Insurance no longer allows us to place that rider. Without the rider, we have decided that we cannot provide any coverage for the individual. Unfortu-

nately, we cannot collect sufficient premium to offset the risk of paying for a repeat C-section delivery during the first 3 years of coverage.

“In order to consider coverage without a rider, we require that certain requirements be met. One requirement is that some form of sterilization has occurred since the Caesarian section delivery. Also, women age 40 and over who had their last child 2 or more years prior to applying for coverage will not require a rider.

“Unfortunately, since you had not met either of these requirements, it would have been necessary to place the C-section rider.”

As a result, I then contacted International Caesarian Awareness Network to see if they could help me share my story and create change. They were able to do that and my story was covered on the front page of the New York Times. I discovered that in all but five States it is legal to discriminate against women because of a previous Caesarian, either by denying coverage, requiring sterilization, or charging significantly higher premiums than would be paid by a woman without a previous C-section.

My husband and I ended up accepting an insurance plan with a high deductible that honestly could financially ruin us if there was a family medical emergency. In addition, my youngest son has been denied insurance coverage twice and we have had to find alternative health insurance for him at a higher cost and a higher deductible.

As a result of my C-section, we were unable to have a third child. We attempted to get maternity insurance and discovered that the max we could receive is \$4,000, and in order to receive that full pay we would have to have been insured by the same company for 3 years. Also, once a woman has had a C-section it is almost impossible to qualify for a vaginal birth after Caesarian. As a result, most doctors would require me to have another C-section with a third child, which is financially impossible, much more expensive than \$4,000, and therefore this has limited our ability to have any more children.

Not only are women being denied coverage because of a previous Caesarian, but they are also being denied the opportunity to have a nonsurgical delivery with their next pregnancy because of widespread policies that ban vaginal birth after Caesarian.

Thank you.

[The prepared statement of Ms. Robertson follows:]

PREPARED STATEMENT OF PEGGY ROBINSON

My name is Peggy Robertson. I live in Centennial, CO. I have two boys ages 10 and 3. Shortly after my youngest son was born, my husband and I began to research independent health insurance options because our current policy was increasing in price every year. My husband is self-employed and we are unable to get access to a group policy.

We applied with Golden Rule and I was denied coverage based on having a cesarean with Luke in 2006. I am in perfect health and I was shocked that Golden Rule would decline my application. I called Golden Rule and they said that if I would get sterilized, they would then be able to offer insurance to me. I was shocked by their comments and immediately contacted the Colorado Division of Insurance to file a complaint. After filing a complaint, I discovered that Golden Rule is allowed

to discriminate against women who have had a C-section. There was nothing I could do.

I contacted the International Cesarean Awareness Network to see if they could help me share my story and create change. They were able to do that and my story was covered on the front page of the New York Times. I discovered that in all but five States, it is legal to discriminate against women because of a previous cesarean, either by denying coverage, requiring sterilization or charging significantly higher premiums than would be paid by a woman without a previous C-section. My husband and I ended up accepting an insurance plan with a high deductible that honestly could financially ruin us if there was a family medical emergency. In addition, my youngest son has been denied insurance coverage twice and we have had to find alternative health insurance for him at a higher cost and a higher deductible.

As a result of my C-section, we were unable to have a third child. We attempted to get maternity insurance and discovered that the max we could receive is \$4,000, and in order to receive that full pay, we would have to have been insured by the same company for 3 years. Also, once a woman has had a C-section, it is almost impossible to qualify for a VBAC. As a result, most doctors would require me to have another C-section with a third child, which is financially impossible, much more expensive than \$4,000, and therefore, this has limited our ability to have any more children.

Not only are women being denied coverage because of a previous cesarean but they are also being denied the opportunity to have a non-surgical delivery with their next pregnancy because of widespread policies that ban vaginal birth after cesarean.

Senator MIKULSKI. Ms. Ignagni.

**STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CEO,
AMERICA'S HEALTH INSURANCE PLANS, WASHINGTON, DC**

Ms. IGNAGNI. Thank you, Madam Chairwoman. We appreciate the opportunity to testify today.

In listening to the testimony of Ms. Robertson and Ms. Buchanan, our members are committed to policies that would get reform accomplished this year and would include a massive overhaul of the way the individual market works. We've testified to that before this committee. We remain committed to it, and specifically we are committed to policies where everyone gets covered, no one loses it, they would be portable, and no preexisting condition exclusions would be allowed.

We've also had considerable focus in our membership on the needs of women. We've supported and advocated for reform that gives women equal health care for equal premiums. We also support the important preventive services that this committee has worked on and we believe they are very important to the needs of women and maintaining their health.

We've provided research to this committee and other committees on what it will take to accomplish this objective, to achieve these goals in the individual market, and that is, encapsulating it, everyone participating in the system.

I wanted to take this opportunity, since there has been considerable discussion this week about a recent report we issued from the PricewaterhouseCoopers Group and the reason we issued that report when we did. In its markup, the Senate Finance Committee moved away from the policy that would have everybody participate in the system. At that time we raised concerns about that moving away and we sent a letter suggesting it would lead to significant increases in costs, which no one wants.

On September 29th, we asked PWC to look at this issue because in our own data we detected alarming trends by way of potential cost increases associated with this change. We received PWC's re-

port Saturday, as in this Saturday several days ago, evening and we shared it with our members on Sunday. At that time the Senate was expected to take up health reform next week.

The message of the study, which has been confirmed by another independent report released yesterday, is that costs are going to go up for individuals and working families if we don't have everyone participate.

So we are in the same place, Madam Chairwoman, that we were when we came to this committee in March. We strongly support health care reform. We strongly support insurance market reforms that a number of the panelists and the members of the committee have spoken to. But we want it to work.

During the summer we worked hard as part of a joint effort to bend the cost curve. If Congress were to commit to system-wide cost containment, then the costs would go down, not up. Madam Chairwoman, you challenged us specifically back in the winter to commit to administrative simplification. We have taken that very seriously. That is part of our efforts to bend the cost curve. That's what we control, that's where we contribute. I'm pleased to tell you that our members have supported mandatory requirements that we get this done. We've worked with doctors and hospitals. We're pleased to stand behind that support and we will continue to do so.

But if we're going to bend the curve, which would take pressure off purchasers, consumers, and the government, we need to have everyone participate and all stakeholders need to participate.

Our industry has committed to reforms that would address the important issues we are hearing about today. We have proposed no longer basing premiums on gender. We agree with that. We also have advocated for States to adopt legislation so that no one is denied coverage for domestic abuse. We agree with that. We've supported eliminating preexisting condition exclusions entirely. We agree with that. And we have proposed an essential benefit package that provides coverage for vital health care services, such as prevention and maternity coverage.

Our industry is committed to making these experiences that we've heard about today a thing of the past. It's the right thing to do and we stand behind that commitment.

Thank you very much for the opportunity to testify.

[The prepared statement of Ms. Ignagni follows:]

PREPARED STATEMENT OF KAREN IGNAGNI

I. INTRODUCTION

Chairman Harkin, Ranking Member 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 thank the committee for holding this important hearing, and we appreciate this opportunity to testify. Our members are strongly committed to meeting the health care needs of women, and we fully support efforts to ensure that women are treated fairly and equitably under our Nation's health care system. Our testimony today will focus on three key areas:

- AHIP's support for comprehensive health reforms that would correct flaws in the current system and address the coverage needs of women;

- innovative programs our members have implemented to improve health care for the women they serve; and
- research findings showing that private health insurance plans are enhancing the health and well-being of female enrollees.

II. FIXING THE HEALTH INSURANCE MARKET TO ADDRESS WOMEN'S HEALTH CONCERNS

AHIP's members have proposed far-reaching health insurance reforms. Our proposals directly confront the reality that the individual health insurance market, as currently structured, is seriously flawed and needs to be fundamentally overhauled.

To solve this problem, it is important to first recognize that insurance works only when people pay into the system both when they are healthy and when they are sick. This is not the case under the current system, since coverage is purchased on a voluntary basis and many young and healthy people choose to go without coverage. Within this flawed system, the adoption of preexisting condition exclusions and waiting periods for new enrollees is an approach that plans are forced to use to keep coverage affordable for those people who maintain coverage on an ongoing basis. By adopting these practices, health insurance plans are working to keep costs as low as possible for as many people as possible—while also recognizing very clearly that major changes are needed to replace this inadequate system with a reformed system that works well for all Americans.

Our members are aggressively promoting major reforms to accomplish this goal. The foundation of our proposal would eliminate rating based on gender and health status and, additionally, provide guaranteed coverage for preexisting conditions in the individual market. Prohibiting premium variation based on gender is a critically important step toward providing security and peace of mind to women and assuring that they receive equal health care for equal premiums. These reforms, when combined with a personal coverage requirement and premium assistance for low-income and moderate-income individuals and families, will ensure that no one—regardless of their gender, health status, or medical history—falls through the cracks of the U.S. health care system.

Establishing an enforceable coverage requirement is particularly important to the success of the insurance market reforms we are proposing. If the individual coverage requirement provides inadequate incentives to get everyone covered, individuals and families who are covered in the individual market are likely to experience unintended consequences similar to those experienced in several States where insurance market reforms were enacted in the absence of universal coverage in the 1990s. A Milliman Inc. report¹ released by AHIP in September 2007 examined the experience in the eight States that enacted various forms of community rating and guarantee issue laws in the 1990s, without establishing an individual coverage requirement. A significant number of individuals responded to these reforms by deferring coverage until after they encountered health problems and, as a result, the Milliman report found that these States experienced higher premiums for those with insurance, saw reduced enrollment in individual health insurance coverage, and had no significant decrease in the number of uninsured.

Other organizations—including the Commonwealth Fund² and the Urban Institute³—also have recognized the need, in the context of comprehensive health reform, to bring everyone into the system with an individual coverage requirement.

More recently, AHIP commissioned a report⁴ by PricewaterhouseCoopers because of our concerns about the workability of the current legislative proposals. We wanted outside verification of the trends we were seeing in our own analyses, suggesting that the reform construct in the Senate Finance Committee bill could lead to alarming unintended consequences during implementation. This study confirms that the current legislation will make coverage less affordable for individuals, families and employers, and make it harder to get all Americans covered. It shows that costs will go up even faster than they would under the current system.

Health insurance plans are strongly committed to working with Congress to avoid this outcome. Our Board of Directors has endorsed major proposals for expanding coverage, improving quality, and reducing the growth rate of health care spending. These reforms—which we outlined in our testimony for the committee's March 24

¹The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets, Milliman, Inc., August 2007.

²The Path to a High Performance U.S. Health System, Commonwealth Fund, February 2009.

³The Individual Mandate—An Affordable and Fair Approach to Achieving Universal Coverage, New England Journal of Medicine, Linda Blumberg, Ph.D. and John Holahan, Ph.D., June 2009.

⁴Potential Impact of Health Reform on the Cost of Private Health Insurance Coverage, PricewaterhouseCoopers, October 2009.

hearing—build upon the strengths of the current system and recognize that both the private sector and public programs have a role to play in meeting these challenges.

Health insurance plans also are contributing to the reform debate through a system-wide simplification effort to streamline administrative procedures and achieve cost efficiencies for physicians and hospitals, and by committing to help fund a reinsurance mechanism during the transition to the market reforms. Together, these contributions will decrease costs across the health care system, reduce paperwork and duplication, and ensure that everyone can obtain high quality coverage that is portable across the entire system.

Another critically important priority in the health reform debate is improving access to preventive services, which are particularly important for women. We support pending legislation that would eliminate cost-sharing for preventive services rated “A” or “B” by the U.S. Preventive Services Task Force (USPSTF) and for immunizations recommended by the Advisory Committee on Immunization Practices (ACIP). Providing first dollar coverage of proven preventive services is an important strategy for keeping people healthy, detecting diseases at an early stage, and avoiding preventable illnesses.

Our members have been pro-active in designing wellness and prevention programs that promote healthier lifestyles and preventive screenings, identify and monitor patients at high risk for certain conditions, help ensure early diagnosis and treatment, and address the unique needs and circumstances of women. These programs help to improve quality of care and should be supported by the health reform process, including the flexibility for plans to offer premium discounts based on an individual’s or an employee’s participation in wellness programs.

III. HEALTH PLAN INNOVATIONS ADDRESSING WOMEN’S HEALTH CARE NEEDS

Health insurance plans, in addition to supporting health reform, have been very active in developing innovative programs to improve health care quality and health outcomes for women. These programs—including several that we discuss below—focus on a wide range of women’s priorities and health care needs.

Geisinger Health Plan’s Health Management Program for Osteoporosis

Geisinger Health Plan has implemented a program that analyzes claims to identify patients whose medical histories and demographic characteristics place them at risk of the disease, as well as those who have a history of bone fractures. Under this program, registered nurse case managers contact members at risk by phone or arrange office visits to provide them with key information about osteoporosis prevention and treatment. During these phone calls and meetings, case managers explain risk factors for osteoporosis, discuss ways to prevent the condition, and discuss the benefits of bone mineral density testing and medications for osteoporosis.

When Geisinger determines that patients’ age and health profiles place them at high risk of osteoporosis, case management nurses review the patients’ prescriptions to avoid use of medications that could increase the risk of falls, and they follow up with physicians as needed to identify safer alternatives. Case managers work with pharmacy assistance programs as needed to help low-income members obtain needed osteoporosis medications. They may coordinate with Area Agencies on Aging to conduct home safety inspections to remove items that could lead to falls, and they can help arrange for transportation to doctor visits. Besides working with patients on an ongoing basis, Geisinger’s case managers maintain regular contact with primary care physician offices by phone and e-mail and in person to discuss the needs of members with osteoporosis and help ensure that they receive recommended care.

In 2009, 21 percent of Geisinger members age 65 and older are enrolled in the health plan’s osteoporosis health management program. The percent of women age 67 or older with histories of bone fracture who had either undergone bone mineral density testing or had taken osteoporosis prevention or treatment medications rose by 9.4 percent from 2008 to 2009.

Kaiser Permanente’s Domestic Violence Prevention Program

On October 10, Kaiser Permanente and Dr. Brigid McCaw received a national award from the Family Violence Prevention Fund for creating and implementing an innovative and comprehensive approach to domestic violence prevention.

This innovative program by Kaiser Permanente uses health education materials, posters, flyers, and other information to encourage people to speak up about domestic violence. Under this program, clinicians receive training so they are comfortable raising this issue, providing a caring response, referring patients to on-site domestic violence services, and offering information about community resources.

The program is enhanced by Kaiser Permanente HealthConnect®, which enables the organization’s more than 14,000 physicians to electronically access the medical

records of members nationwide. It includes tools that make it easier for physicians to identify victims of domestic violence, provide a consistent caring response based on clinical practice recommendations, and make referrals to other Kaiser Permanente services and community resources.

Passport Health Plan's "Tiny Tot" Program for Healthy Pregnancies

Passport Health Plan has created a "Tiny Tot" program to help mothers with preterm newborn babies to ensure a healthy transition from the hospital to the home. Under this program, a registered nurse is assigned to focus on the welfare of the newborn and to work as a liaison between the family and members of the infant's health care team, including neonatologists, pediatricians, neonatal intensive care unit nurses, and home care providers. The nurse helps the family with the paperwork for obtaining any necessary medical equipment, such as ventilators, and with the logistics for getting to appointments with specialists.

The program also includes a strong focus on educating new mothers about infant care and the importance of creating a healthy home environment. The program's goals are to:

- decrease the average length of stay in the hospital;
- decrease or prevent hospital re-admissions and emergency room visits within 30 days of discharge;
- increase the percentage of members who follow up with their primary care physician within 30 days of discharge;
- identify newborns in need of ongoing case management services; and
- coordinate discharge needs.

Enrollees participating in the "Tiny Tot" program have a 98 percent compliance rate in obtaining a newborn screen within the first 30 days. Also, since the program began in 2001, hospital re-admission rates for preterm babies have decreased in the range of 1 to 4 percentage points.

This program—and the CIGNA program discussed below—are particularly important, given that the rate of preterm births in the United States has increased by 18 percent since 1990, according to the March of Dimes. Babies who survive a premature birth face the risk of serious lifelong health problems including learning disabilities, cerebral palsy, blindness, hearing loss, and other chronic conditions such as asthma. Also, the health care costs associated with a preterm birth typically are 12 times as much as those for a full term, healthy birth.

CIGNA's Healthy Pregnancies, Healthy Babies Program

To address the rise in preterm births, many of which are preventable, CIGNA implemented its *Healthy Pregnancies, Healthy Babies* program in 2006 to provide educational and care management services to women who are pregnant or considering pregnancy.

Participants in the program undergo an initial risk assessment and routine follow-up assessments throughout their pregnancy. Based on these assessments, participants will receive appropriate prenatal education and care management, and those considered high risk will be assigned to a Specialty Case Management Nurse. Clinical assessments, risk stratification and history are managed through a single tool so that any member of the care team can speak to a participant knowledgeably about her condition. Participants receive one-on-one counseling and support from a health coach, who can help the mother-to-be manage the physical and emotional demands of pregnancy.

Because early intervention can help prevent prematurity and other poor pregnancy outcomes, the program offers a tiered incentive that is higher for women who enroll early in their pregnancies. To help assure that pregnant members participate actively in the program, payment of the incentive is contingent on program completion. CIGNA also offers free tobacco cessation programs, as there is indisputable evidence that links smoking with preterm birth and low-birth weight babies. Extra dental care also is part of the program, as pregnancy can affect teeth and gums, and infections and other oral health problems can lead to preterm birth.

More than 90 percent of the women who enroll in the program complete it, and more than 97 percent report a high level of satisfaction with their experience in the program. Improved outcomes for mothers and babies have led to savings of more than \$6,000 per pregnancy for participants of the program.

Centene Corporation's CONNECTIONS Plus Program

A program by Centene Corporation, known as CONNECTIONS Plus, offers free cell phones to Medicaid members who do not have safe, reliable access to land line phones. As of last year, the health plan had provided cell phone service to 160 pregnant women since the program's inception in 2007. Program participants use the

cell phones to call their doctors, case managers, 911, and the health plan nurse line when they need help, and they can speak regularly with nurse case managers affiliated with Centene's disease management programs.

Under this program, cell phones can be customized to member needs and may include numbers for transportation services, specialty pharmacy services, housing and shelter, parenting support, emergency crisis numbers, counseling, special needs services, food pantries, utility assistance, clothing banks, parenting support, and family support. High-risk pregnant women are allowed to keep their cell phones for a transition period (about 6 weeks) following their babies' birth.

There is strong evidence that low-income women are at increased risk for preterm births. The average gestational age at delivery for the babies of pregnant women who have participated in the Centene Corporation program since 2007 is 37.79 weeks, which is well within the normal range.

Keystone Mercy's Healthy Ministry Program for Women

For more than 9 years, Keystone Mercy Health Plan has offered the Health Ministry Program for Women, a faith-based health education and awareness program to reduce health disparities among minority women. The program helps women incorporate positive health behaviors into everyday life to prevent, reduce, and reverse chronic diseases and stress. By partnering with and bringing local health care providers to churches, synagogues, and mosques, the Health Ministry Program provides women with a safe and supportive setting in which to learn about their health.

The program's goals are to:

- educate women and their families about the importance of prevention and early detection of disease through community-based partnerships;
- promote regular health screenings and check-ups to identify and target women at risk;
- increase participants' knowledge of stress triggers and stress management techniques; and
- empower women to be their own health advocates by knowing the risks and warning signs of chronic diseases.

As part of the Health Ministry program, Keystone has partnered with six Philadelphia-area churches for the past 3 years on an initiative called the Forty-Day Journey. The initiative emphasizes nutrition, exercise, water intake, and medication compliance. It includes education on topics such as healthy cooking, and it features a Gospel aerobics class and walking clubs.

Approximately 2,500 people, including 825 Keystone Mercy Members, participated in the Forty-Day Journey from 2006 to 2008. Among program participants with diabetes, Keystone measured the following improvements over 2 years:

- A nearly 20 percent drop in triglyceride levels;
- A 22 percent decline in LDL, or bad cholesterol, overall, and a 31 percent decline for people with Type 1 diabetes;
- A 17 percent reduction in blood sugar levels;
- A 4.6 percent reduction in weight overall, and a 3 percent decline for people with Type 1 diabetes.

Program participants reported reductions in pain and improvements in mobility and flexibility. They also said that their overall mood had improved and hope for the future had increased since participating in the program. In 2008, the Health Ministry Program won the "Recognizing Innovation in Multicultural Health Care Award" from the National Committee for Quality Assurance (NCQA).

Group Health Cooperative's Teen Pregnancy and Parenting Clinic

Group Health Cooperative has established a Teen Pregnancy and Parenting Clinic that provides education and support to help pregnant teens avoid risky behaviors—such as smoking, alcohol, and recreational drug use—that can lead to premature birth, low-birth weight, and cognitive impairments. Program participants range in age from 13 to 25.

Two family physicians, along with family practice residents from Group Health's Family Medicine Residency program, provide care at the clinic, including antepartum care, delivery, postpartum care, primary care, and pediatric follow-up. The clinic team also includes a registered nurse, a social worker, a nutritionist, a representative from the U.S. Department of Agriculture's Special Supplemental Nutrition Program for Women, Infants and Children (the WIC program), and a health educator. The nurse meets with patients during every visit, helps assess their needs, and coordinates care with other team members. The social worker addresses psychosocial issues and helps program participants obtain community resources such as housing and transportation. The nutritionist helps teens create a diet appropriate

for pregnancy; the WIC provider helps participants obtain vouchers for free groceries; and the health educator teaches parenting classes.

The clinic provides care to approximately 50 teens and their children each year. Participating teens visit the clinic every 1 to 3 weeks throughout their pregnancy and have follow-up visits for 2 years after delivery. Their children receive services through the clinic for up to 5 years. Health outcomes among program participants have exceeded those achieved among comparable populations served by Seattle-area community health centers.

Since the clinic's opening in 1990, program staff have delivered 736 babies and the percent of low-birth weight babies (those less than 5 pounds) has been 6.7 percent, compared to a national rate of 8.3 percent.

Prevention and Wellness Initiatives

In a recent AHIP report⁵ entitled "Innovations in Prevention, Wellness, and Risk Reduction," we outline case studies of health insurance plans that are working with other stakeholders to create healthier workplaces, schools, and communities, help families make better choices about diet and physical activity, and overcome economic, social, and cultural barriers to the adoption of preventive practices and healthier lifestyles. This report highlights a wide range of health plan initiatives that are combining personal health assessments, health coaching, changes in the work environment, and lifestyle incentives to help employers and their employees tackle health risks that lead to illness, absenteeism, lost productivity, and higher health care costs.

IV. RESEARCH FINDINGS SHOW WOMEN BENEFIT FROM PRIVATE SECTOR INNOVATIONS BY MEDICARE ADVANTAGE PLANS

AHIP recently released a study⁶ showing that Medicare Advantage enrollees spent fewer days in the hospital, were subject to fewer hospital re-admissions, and were less likely to have "potentially avoidable" admissions for common conditions examined by the study. While this study focused broadly on both women and men, the findings indicate that women are particularly well-served by participating in private health plans offered through the Medicare Advantage program.

The study's findings demonstrate that the innovative programs developed by Medicare Advantage plans—which place strong emphasis on preventive health care services that detect diseases at an early stage and disease management programs for seniors with chronic illnesses—are working to help keep patients out of the hospital and avoid potentially harmful complications.

The median scores for the eight plans included in this study show that Medicare Advantage plans improved health care for women by:

- reducing emergency room visits by 35 percent;
- reducing hospital re-admissions by 50 percent;
- reducing potentially avoidable hospital admissions by 16 percent;
- reducing inpatient hospital days by 18 percent; and
- increasing office visits (e.g., for primary and preventive care) by 20 percent.

A related AHIP study⁷ shows that women enrolled in Medicare Advantage spent fewer days in the hospital, were subject to fewer hospital re-admissions, and were less likely to have potentially avoidable admissions, for common conditions ranging from uncontrolled diabetes to dehydration. This study analyzed statewide datasets on hospital admissions in California and Nevada compiled by the AHRQ. The unique data in these States allows for direct comparisons of utilization rates among enrollees in Medicare Advantage plans and in FFS Medicare. The female-specific data for this study indicate that:

- Women Medicare Advantage beneficiaries in California spent 30 percent fewer days in the hospital than those with FFS Medicare, and in Nevada, women in Medicare Advantage plans spent 26 percent fewer days in the hospital.
- Women Medicare Advantage enrollees were re-admitted to the hospital in the same quarter for the same condition 16 percent less often in California and 33 percent less often in Nevada, compared to FFS Medicare.
- In both States, women enrolled in Medicare Advantage plans were less likely—by margins of 8 percent in California and 9 percent in Nevada—than those in FFS

⁵ Innovations in Prevention, Wellness, and Risk Reduction, AHIP, 2008.

⁶ A Preliminary Comparison of Utilization Measures Among Diabetes and Heart Disease Patients in Eight Regional Medicare Advantage Plans and Medicare Fee-for-Service in the Same Service Areas, AHIP, revised September 2009.

⁷ Reductions in Hospital Days, Re-Admissions, and Potentially Avoidable Admissions Among Medicare Advantage Enrollees in California and Nevada, 2006, AHIP, September 15, 2009.

Medicare to be admitted to the hospital for conditions described by AHRQ as “potentially avoidable,” such as dehydration, urinary tract infection, or uncontrolled diabetes.

These findings demonstrate that by reducing the need for hospitalizations and emergency room care, health insurance plans are not only improving the health and well-being of their female enrollees—but also achieving greater efficiencies and cost savings.

In both AHIP studies, utilization rates were calculated on a risk-adjusted basis. Risk scores for Medicare Advantage and Medicare FFS enrollees were based on age, sex, and health status.

V. CONCLUSION

Thank you for this opportunity to testify on these important women’s health issues. We look forward to continuing to work with committee members to advance meaningful health reforms to expand coverage, improve quality, and slow the growth rate of health care spending.

Senator MIKULSKI. The way we’re going to proceed is I’ll be the wrap-up questioner. I’m going to turn to Senator Merkley from the Democratic side, then to Senator Burr, and then I’ll be the wrap-up. I know time’s moving along and, Senator, you were here. Senator Merkley, you will go first. Then we’ll turn to Senator Burr and then I’ll be the wrap-up.

STATEMENT OF SENATOR MERKLEY

Senator MERKLEY. Thank you very much, Madam Chair.

Ms. Ignagni, I wanted to ask you a little bit about your testimony. You noted your members are strongly committed to meeting health care needs of women and support efforts to ensure women are treated fairly and equitably. But AHIP has supported a 5 to 1 rating band for older Americans, which is in the Finance Committee bill, meaning that older Americans would be charged five times the cost to their younger counterparts.

The HELP bill has a 2 to 1 rating band, and a higher rating band would put a disproportionate burden on older women, many of whom outlive men. I was wondering if you could just address and explore that point.

Ms. IGNAGNI. Yes, sir. I appreciate the question and I’m happy to clarify exactly where we are. This is a question about how to equitably distribute costs. I want to make it very clear, in supporting the rating bands that we have we are not insensitive to the needs of older workers. What we have proposed is a rating system that would lighten the load on Ms. Robertson and Ms. Buchanan in terms of where they are in the age cohorts.

At the same time, we have not ignored older workers. What we have suggested is a special targeted subsidy that would decrease the cost and the burden for individuals in the 55 to 65 cohort, so that we wouldn’t have to impose—if you go to two to one, it means that individuals and women at the lowest age cohorts would face disproportionately higher costs.

I can tell you what that means very specifically. Someone in the 30 to 34 age cohort would face an increase of 38 percent compared to where they would be in the 5 to 1 category. We have tried to be very thoughtful about commenting both how to distribute the cost equitably, not to put too much pressure on younger families, but at the same time also responsibly add a suggestion on what to be done for older workers.

Senator MERKLEY. I thank you for your comment. I just note that it remains a concern for this Senator.

Ms. IGNAGNI. Yes, sir.

Senator MERKLEY. Ms. Buchanan, to clarify, were you saying that your insurance company would not cover a vaginal birth after you had had a Caesarian and that that is a common practice in the industry?

Ms. BUCHANAN. That's very common practice.

Senator MERKLEY. I just wonder if any members of the panel can comment on that and how we might tackle that problem.

Ms. IGNAGNI. Would you like me to comment, Senator? I'd be happy to.

Senator MERKLEY. That would be great.

Ms. IGNAGNI. We have spent a great deal of time looking at the individual market. Approximately 18 million people are covered in the individual market, as you know. We believe that having everyone participate would allow any type of preexisting condition requirements to end. We support that. We think it's the right thing to do. We do not think there should be any differentiation in terms of gender payments. We support that. And we don't believe that people should be paying according to their health status.

Senator MERKLEY. So this type of requirement would be eliminated as far as you're concerned?

Ms. IGNAGNI. Yes, sir.

Senator MERKLEY. Very good.

Ms. FURCHTGOFF-ROTH. The reason it's originated, if I might add, the reason it's originated is because of the lawsuits and the vast amounts of malpractice insurance associated with obstetrics. Obstetricians pay some of the highest malpractice premiums in the Nation. There's a big chance of being sued, and that's why it's regarded as safer to have a Caesarian, because that gets the baby out right away. If there were malpractice reforms accompanied by the health insurance, then these kinds of problems could be diminished.

Senator MERKLEY. Mr. Guest, I wanted to turn to you for a moment. In your testimony you describe ways to help consumers make apples to apples comparisons of health plans and suggest that insurers explore ways to help consumers gauge their estimated annual total cost. Can you elaborate on how that sort of consumer-friendly information could be presented?

Mr. GUEST. Well, just in general, it covers a variety of things. I'll give you one example of something Consumer Reports is doing and then I'll also give you a longer answer for the record in terms of the very specific ways that one can look at the total, as opposed to just the premium. We have something called Consumer Reports Best Buy Drugs, where we've worked with a consortium of researchers looking at clinical evidence, researchers from 15, 16 States, where we have identified drugs that are equally effective, equally safe, and we've overlaid that with cost information, with price information. So we're saving consumers in some cases thousands, \$500, \$1,000, more than \$2,000 a month. That's just one kind of information.

But more generally, I think what would be really important is, also as a way to reduce costs and improve quality, we have been

engaged in an effort for requiring hospitals to disclose their hospital-acquired infection rates. Now 26 States have laws requiring that. In Senator Casey's State of Pennsylvania, what they've shown, what they've found, is with the public disclosure of those rates it puts pressure on hospitals to do a better job, it enables consumers to make choices of where they may want to go for procedures in a hospital, and infection rates have come down.

Whether it's infection rates, whether it's other adverse events, there's a variety of things around quality of care as well as cost that can help to make informed decisions.

Senator MERKLEY. Thank you very much. My time is up. Thank you very much as a panel for your testimony. Oregon is one of the States that has banned gender discrimination. I think it's so important in health care reform that we have fairness for women across our entire Nation.

Thank you.

Senator MIKULSKI. Senator Burr.

I'd like to comment that Senator Burr and I are the chair and the ranking member on this committee and have worked a lot on public health initiatives. Right now we're focusing on insurance reform, but because this is the HELP Committee and we don't have jurisdiction over the payment system, there's a lot we feel we need to do in terms of public health and issues around the management of chronic illness—the prevention of diabetes, heart disease. Senator Burr has been a real leader for these issues, and I thank him for his comity and insights on so many things.

Senator Burr.

Senator BURR. Thank you, Madam Chairman.

I would ask of the chair unanimous consent to enter into the record a *Washington Post* article that is entitled "Malpractice Premiums, Rate of C-Sections Rise Together." I think that highlights for all of our witnesses as well as the members that there's a direct correlation here, and that if you want to have true reform then you've got to reform all aspects. You can't leave the tort challenges unchecked if you want to address the concerns of Caesarian birth.

The chair referenced earlier to the report, Ms. Greenberger, about battered women and pointing out eight States. Now, I've had an opportunity to look at the report and from what I can gather from the report you relied heavily on the Women's Law Project and Pennsylvania Coalition Against Domestic Violence that was published in 2002 for a lot of the data that you put into your report.

I guess my question is this. Did your staff go back to North Carolina to see if any of these things were accurate for North Carolina today?

Ms. GREENBERGER. Yes, Senator, we did, and we know that the issue of domestic violence as a preexisting condition can manifest itself in a number of different ways. It can be that an insurance commissioner—

Senator BURR. Did your staff find specific cases where people had been denied access because of domestic violence?

Ms. GREENBERGER. That's a very fair question, and what we know—we know that this has come up in a conversation with insurance commissioner staff in North Carolina—is specifically that women are being denied across the country.

Senator BURR. Ms. Greenberger, let me address North Carolina specifically. I'll read a letter from my insurance commissioner, Wayne Goodwin, and I would ask the chair unanimous consent to put into the record his letter to me in its entirety, and I'll just read a couple of sections:

"In North Carolina if a company or policy wants to exclude something, they must declare it in an application by asking the applicant directly about the exclusion. Because exclusions are listed on the application form and the department reviews and approves the forms, we would know if a company tried to consider domestic violence as a preexisting condition.

"My department—we are unaware of any company or forms that have asked to exclude domestic violence as a preexisting condition. If they did, we would have denied it. My department has been unable to find a single example of a company asking an applicant if they have been a victim of domestic violence or a consumer complaint about being asked for this insurance purposes.

"However, the issue is far too important to leave any possibility that it could happen. So to create further protections, I have filed an administrative rule for adoption in the North Carolina Administrative Code. This is the most effective way to address these concerns and add to our insurance regulations."

Again, Madam Chairwoman, I would ask that that be included into the record.

They say there's not been an example of it.

[Editor's Note: The letter referred to may be found in additional material.]

Ms. GREENBERGER. If I could answer, Senator. First of all, I'm very glad to hear the insurance commissioner recognizing that the most effective protection is to have an explicit protection. But if I could get back to your question about the specific examples, they manifest themselves in many different ways. For example, if a woman ends up in an emergency room with cuts, bruises, broken arms, black eyes, typical injuries that result from domestic violence, we know of instances where women are being denied insurance coverage and neither the insurance company—

Senator BURR. Ms. Greenberger, my question is specifically on North Carolina—

Ms. GREENBERGER. I'm trying to answer it specifically.

Senator BURR. And the insurance commissioner tells me: We haven't had a case, we haven't had anybody.

Ms. GREENBERGER. Well, I'm trying to explain. First, I think it's great that he is now explicitly having a rule, which, as our report pointed out, didn't exist before. That's really excellent.

Second, because of the way insurance companies deal with this issue in particular, they will often deny the coverage of victims and survivors of domestic violence without saying that that's the reason. So it's difficult.

Senator BURR. Ms. Greenberger, I'm just going by your report.

Ms. GREENBERGER. And I'm trying to—you asked a question about did we follow up and we did.

Senator BURR. I would encourage my colleagues—well, I found out more information in my one phone call to North Carolina than I think your report did. I would point out to my colleagues the important part of the report is to read the end notes. In the end notes it specifically says that you relied on the 2002 study done in Pennsylvania for the data.

Now, my point would be this. If you read on, you would find out that that 2002 study used early 1990 data to come up with their report. The conclusion that I have is that the data you've used to present this case is almost 20 years old, and I just point out the fact that the chairwoman, having read the report, referred to eight States that have, North Carolina being included with it, denied for the purpose of battered women. And in fact that's not what the State officials in North Carolina say.

Ms. GREENBERGER. Actually, Senator, I really disagree with what you said, because what that letter just said was that your insurance commissioner has just changed the rules.

Senator BURR. No, ma'am. It says they have thoroughly examined and had had no case where a company had had that on an application and no complaint from a person.

Ms. GREENBERGER. Well, we talked in the report—yes, Senator.

Senator BURR. My question is, can you present to us today a person who this happened to in North Carolina?

Ms. GREENBERGER. Well, let me say two things. No. 1, the first issue that you raised is are the eight States and the District of Columbia current data and information? And the answer is yes, and I believe that the insurance commissioner's letter to you underscores that they are, that it is currently accurate. We have checked and that number is currently accurate. That's the first question you asked and I give you an explicit answer.

Senator BURR. I think we'll agree to disagree, based upon how I read the letter. But I'll leave it for my colleagues.

If the chair would indulge me for 2 additional minutes. I did not mean to get caught up for that much time and I just want to ask Ms. Ignagni something.

Senator MIKULSKI. Please, go ahead. Then we'll turn to Senator Franken.

Senator BURR. I thank the chair.

Dr. Coburn and I introduced a bill and it focuses specifically on wellness prevention and chronic disease management. I believe these are essential features that we're going to have to exercise to hold down health care costs. What are some of the programs your member companies have put into place to implement these three critical elements?

Ms. IGNAGNI. This is a very good question. We included, Senator, in our testimony a list of very specific programs, but let me highlight a couple of them for you. No. 1, we have quite a great deal of work going on across the country in large plans and small plans to intervene for women who may have very problematic and high-risk pregnancies. Case management and support services; there are a myriad of programs around the country. They've won numerous awards and I think they're path-breaking.

No. 2, for women who have high risks of certain chronic illnesses, there are similar kinds of programs going on across the country.

And No. 3, for women who need transportation services, particularly low-income women, we've, particularly in our Medicaid health plans, we've pioneered a range of very specific services. You're right, wellness is important. Early intervention is key and coordinate care is the difference between having good health care and not having good health care. And particularly for women, it's very, very important.

Senator BURR. Thank you.

I won't ask my second question. I'll just make a general statement, because several of you referred to the expansion of Medicaid where I think the Finance Committee bill expands the coverage to 14 million Americans. I believe that through this health care debate we have to be as concerned about expansion of coverage as we are about access to care.

When you take 14 million Americans and you put them into a health care system that MEDPAC says is denied care, or at least the ability to be seen, by 40 percent of our health care professionals, I think you have flunked on the access.

Hold our feet to the fire to come up with a way to provide coverage to every American, not just shove them into a system that today 40 percent of the health care professionals choose not to see them based upon reimbursement. I think the expansion of Medicaid is a flunk to what the President suggested, and that's quality and access have to be linked. So I would point that out.

The chair has shown tremendous indulgence and I thank you.

Senator MIKULSKI. Senator Bennet.

STATEMENT OF SENATOR BENNET

Senator BENNET. Madam Chair, thanks. I will be very brief because I was late. We were on the floor talking about health care.

I first wanted to just thank Peggy Robertson for being here from my State and sharing her story, your story. It's a story I know well and it's one of hundreds, if not thousands, of stories that we've heard from across the State of Colorado, millions of stories across the country, of people whom the current system let down in a fundamental and profound way.

I wonder, Ms. Robertson, I'll just ask you first. As you think about the health care reform that we're considering here in Washington and imagine a world post the reform discussion, what do you most hope to see as a consequence of the work that we're doing?

Ms. ROBERTSON. I think the big thing for me is that there should be all options available to women. We shouldn't be cornered into having to go a certain route. If I wanted a vebac, I should be allowed to get one. If a Caesarian was a better choice for me due to my health, that should be the route I should be able to take. But I feel right now that my options are very limited. So all options for women everywhere.

Senator BENNET. Well, I want to thank you again for being here.

Ms. ROBERTSON. Thank you.

Senator BENNET. Ms. Greenberger, just along those lines, I just have one question for you, which is, why is gender rating important to address in the affordability context?

Ms. GREENBERGER. Basically, it means for those who have to go to the individual market, women who have less resources, less earnings to begin with, being charged more, which makes health care even more inaccessible for women. And second, because of the combination of the higher premiums they are charged because of gender rating and then the exclusion for maternity-related care, which in the instance of Caesarian sections can be even more expensive, and in some instances the requirement of having to buy a rider. In others, the rider's not even available. The expense can be so astronomical, or the coverage even in the rider so limited, that it basically takes away the ability to get insurance for maternity altogether, and especially if there may be some additional costs involved, like Caesarians.

When you combine the gender rating and then the exclusion, and certainly the most obvious is the maternity-related exclusion, which can be a problem even if you do not have to face a Caesarian section, let alone if you do, it can be a very toxic, literally toxic situation for women, and as a result their families.

Senator BENNET. Thank you.

Madam Chair, I just wanted to say thank you to you for holding this hearing and for your leadership throughout this debate. Thank you.

Senator MIKULSKI. Thank you, Senator Bennet.

Well, this was an outstanding panel and I want to thank everyone for participating and really putting a great deal of thought into it.

I want to lead off my questioning with both Ms. Robertson and Ms. Buchanan, who are young moms and who've obviously had significant issues. Ms. Robertson, I'm going to ask a question of you. I was a little taken aback by the letter you quoted, I believe from the Golden Rule insurance company. You read that letter. Are you saying that they said in that letter that you should have a sterilization? Did I not hear you well?

Ms. ROBERTSON. You heard that correctly. They said it in the letter, and actually a woman said it to me on the phone when I called as well.

Senator MIKULSKI. Well, on the phone's one thing, but a written document is another.

Ms. ROBERTSON. It's in the letter, yes.

Senator MIKULSKI. Could you read that?

Ms. ROBERTSON. Sure.

"In order to consider coverage without a rider, we require that certain requirements be met. One requirement is that some form of sterilization has occurred since the Caesarian section delivery."

Senator MIKULSKI. In other words, that you would have to document that you had had some form of sterilization.

Ms. ROBERTSON. Yes.

Senator MIKULSKI. That gave me goose bumps.

Ms. ROBERTSON. It was unbelievable.

Senator MIKULSKI. First of all, that phrase, just that phrase, that concept, I mean, I found that bone-chilling. I don't know how everybody else felt about it in the room, but it put me on the edge of

my chair. Knowing Ms. Ignagni the way I do, I think she's not too crazy about hearing that either.

I think we need to, apart from reform, we need to follow that up. No one, no one in the United States of America, in order to get health insurance should ever, ever be coerced into getting a sterilization. I find it offensive and I find it morally repugnant. I intend to do something about that, whether it's in this reform package or not. I just don't think it's our country's—I do not think it's our moral and ethical framework.

Coerced? We rail against what we ask China to do about coerced sterilizations. But I don't want to see it in our American insurance industry. Just know I feel very strongly about it.

Ms. ROBERTSON. Thank you.

Senator MIKULSKI. The second thing is, let's go to the young mothers. Are you both working or are you stay-at-home moms? Ms. Robertson?

Ms. ROBERTSON. I'm a stay-at-home mom.

Ms. BUCHANAN. I'm a stay-at-home mom as well.

Senator MIKULSKI. So essentially, your insurance comes through your husbands, is that correct?

Ms. ROBERTSON. We have independent health coverage, so it's just an independent plan. We can't get coverage through his work because he's self-employed.

Senator MIKULSKI. Your husband is self-employed and that's part of that individual market.

Ms. ROBERTSON. Exactly.

Senator MIKULSKI. You actually don't have anyone to bargain for you, or you didn't have a major or even a minor employer to be able to be an advocate for you.

Ms. ROBERTSON. Not at all.

Senator MIKULSKI. Do you—what about you, Ms. Buchanan?

Ms. BUCHANAN. My husband is employed. He has a group policy, but it turned out that the insurance, individual market, was less than half the premium than what his group policy offered.

Senator MIKULSKI. In Idaho the individual market was cheaper?

Ms. BUCHANAN. Yes.

Senator MIKULSKI. Than the teachers' insurance?

Ms. BUCHANAN. It's divided by school district and it's a small district.

Senator MIKULSKI. How many people are in Idaho?

Ms. BUCHANAN. I don't know. Over a million, I think.

Senator MIKULSKI. A million. Well, we're not going there. Some of our best friends are from Idaho, Wyoming, Utah, et cetera.

Now this issue in our health reform is about the health exchange, where you could essentially go, as the President says, to "the shopping mall for insurance companies." Have you had a chance to look at it? You're raising a family. I'm not asking you to be policy wonks. But how did you find out about your insurance? Here you're trying to raise a family, balance your family budget, probably living far more frugally, and your mandate to us would be to be frugal as well as working on health reform.

Did you just spend hours on the phone trying to find insurance?

Ms. BUCHANAN. When I found out that it would cost \$760 a month for myself and a baby per month, it was pretty jaw-drop-

ping, and I just got on the Internet and just looked. The two companies—

Senator MIKULSKI. There were only two companies.

Ms. BUCHANAN. Yes, and the policies were basically identical. It was just like, well—

Senator MIKULSKI. In a small State, in an exchange, you only had two companies that were carriers in that State. But you went on the Internet.

Ms. BUCHANAN. Yes.

Senator MIKULSKI. What about you, Ms. Robertson?

Ms. ROBERTSON. We had an insurance broker come to our house and discovered that there was nothing helpful there for him. He couldn't help us. Then I also got on the Internet and I just started filling out applications. And every year I end up filling out more applications because my youngest son keeps getting denied. It is just this ongoing thing that never ends.

Currently my youngest son is insured by Cover Colorado, which insures people that can't get insurance anywhere else.

Senator MIKULSKI. I don't mean to be intrusive, but what is the reason? Or if you're hesitant to say, that's OK.

Ms. ROBERTSON. What's interesting is Cover Colorado actually is supposed to insure people that are terminally ill. There is nothing wrong with my son. The first time he was denied for being what they call a breath-holder. When he gets angry, he passes out, which is actually a common thing that lots of toddlers do.

This year they told me to reapply because they wanted to make sure he wasn't going to have a seizure due to being a breath-holder. He of course never had one. I reapplied this year and this year they said because he's in the lowest percentile—he's short and he doesn't weigh a lot, which my husband and I are both short, so of course he would be. But he's now been declined for being small.

Senator MIKULSKI. Oh, boy, that's another sensitive one with me.

Ms. ROBERTSON. Yes.

Senator MIKULSKI. Don't even go there.

[Laughter.]

You and I are going to have to bond after this hearing.

But really, this is no laughing matter. But as you know, if there was a one-stop shop that either of you could go to in order to buy across State lines—a one-stop shop for you to identify the coverage that best suited your family, both from the standpoint of anticipated medical situation or pocketbook issues, would that be of value to you?

Ms. ROBERTSON. Most definitely.

Senator MIKULSKI. Ms. Buchanan?

Ms. BUCHANAN. Yes, as long as it was affordable.

Senator MIKULSKI. But that would be it. In other words, you would be able to get a clear sense of what benefits are available and how affordable they are.

Ms. BUCHANAN. Then one of my problems is I have continually changed my son's policies as well because the premium keeps going up, in an attempt to get the most for my money. I mean, my 2-year-old has been on four different policies and my 9-month-old has been on three different policies. It's confusing and I just wouldn't want to have to keep doing that every time the policies went up

every year, trying to reevaluate how much we had to spend and how much we were going to get.

Senator MIKULSKI. Wow. You are your own broker in some ways, I understand.

I'm going to go to Ms. Greenberger—I know our time is getting short, I'd love to ask everybody—and then Ms. Roth, and then you, Ms. Ignagni, and then we're going to close. We're having a meeting on health care, surprise, surprise.

Ms. Greenberger, you wanted to say something about older women. Was there a particular point that you wanted to make?

Ms. GREENBERGER. In particular that the savings need to be made in the system, everybody recognizes. I think with respect to older women who are covered either through Medicare or Medicaid, one of the things that is of importance to us is that there are some very important innovative care models in the health care reform proposals, particularly in the HELP bill, that could provide much better care for older women than they currently have right now, and all patients that are covered.

There's a patient-centered medical homes provision, for example, that could mean improved care. We see the potential of health care reform as actually helping older women and older men who are covered under Medicare right now.

Senator MIKULSKI. Well, the concept of the medical home, of course, was in the Baucus white paper, and it's something Senator Harkin and I picked up on. Ironically, when I had this terrible fall, one of the reasons I was, you can say, happy that I was going to Mercy Hospital was that it is my medical home. It's where I had my gallbladder surgery. In other words, all my records were there.

Ms. Ignagni, you'd be interested to know, because it was my medical home as I arrived to the ER all my records were there, and my primary care doctor's records were also available, because, though not stationed at Mercy, he's affiliated with Mercy. It made a tremendous difference in the immediate response to a trauma situation, but then also on the ongoing medical management and the postdischarge.

We really want to, no matter what goes forward, do that. This is where we can work with the industry as well. You see, I think that there's a lot of consensus, particularly around administrative simplification, quality initiatives that we've worked on. We're going to come back.

But for you, what are the top three things that we need to get done in insurance reform?

Ms. GREENBERGER. We need to make sure that we deal with the problems of preexisting conditions, the insurance market reforms that deal with gender rating and other unfair bases of rating.

Senator MIKULSKI. Gender rating, preexisting conditions.

Ms. GREENBERGER. We also want to make sure that the gender rating applies outside the individual market, the protections against it, so that it also deals with the group plans, both employer-provided and association and other affinity group provided plans as well. That's one constellation of issues.

Preexisting conditions is a related issue that needs to be addressed, as well as exclusions of coverage, like maternity coverage.

That kind of reproductive health care that women need is very essential.

Another thing is the affordability, so that we get rid of lifetime caps, so that people like Ms. Buchanan can actually afford insurance, because she could be the best—and I suspect from what I've heard she is—the best investigator of what plans are out there as possible, but if none of them are really affordable and they have these other problems that's not—that's what we hope health care reform will help her with.

There are a variety of those affordability protections as well. And we want to make sure that there is the kind of competition in the market so that these reforms translate into actual quality, comprehensive and affordable health care for women and their families.

Senator MIKULSKI. Very good. Thank you very much.

We haven't even talked a lot about prevention. We could have this hearing now, we could come back this afternoon, we could then take a break and find consensus. But then this is going to be an ongoing debate.

Ms. Roth, what do you think—first of all, do you think we need insurance reform? I know you talked extensively about your concerns about the impact of both the HELP Committee and the Finance Committee. But do you think we do need insurance reform, and what do you think would be the three top elements?

Ms. FURCHTGOTT-ROTH. Well, I think that we definitely need insurance reform. We can see that the auto insurance, the home insurance, the life insurance markets, those are all working very well, although if we're putting in a plug for equal gender rating I have five boys and one girl and my three teenage boys have to pay far higher auto insurance rates than my teenage girl, and I think that that should be fixed, too, while we're at it.

Senator MIKULSKI. We're for that.

Ms. FURCHTGOTT-ROTH. But there's tremendous problems in just purchasing insurance. My husband is self-employed. I have a job. I have to stick to a job where the job provides insurance, so that my family has insurance. This just is not a way to run a system. I should be able to go out and buy insurance just like I can buy auto insurance.

What we need is a system where it's de-linked, insurance is de-linked from the employer, insurance companies compete, preferably over State lines, so that someone who lives in a State such as Iowa can also get offers from companies in New York or California, other kinds of companies. We need competition, and we also need malpractice reform to deal with these problems of high suits and high malpractice premiums.

What we need to do is try to make the health insurance market into the same market for other insurance. It really got messed up in the 1940s when there were wage caps, and so instead of offering higher wages employers offered health insurance.

They've continued to offer health insurance. We need to be giving individuals that tax credit. Ideally, we wouldn't give anyone a tax credit for health insurance, but we are stuck with that politically because people are used to it. We need to de-link it from the em-

ployer and give it to the individual American so everyone can shop around for their policy.

Some people might want a bare-bones catastrophic policy with a higher deductible. Others might want more of a managed care policy, and people should have the choice of different plans. And with competition, then we will find that if an insurance company does what they did to Ms. Robertson that would be publicized. They would hopefully lose market share, go out of business. People wouldn't use those.

I mean, I heard an ad on the radio for Nationwide. It said: "Well, have you been denied auto insurance coverage because of an accident? Call us up; we will give you insurance." We need people knocking down our doors to be giving us health insurance. We don't have that right now.

Senator MIKULSKI. Thank you.

Ms. Ignagni, we recall when you did come in March, and I think we've made a lot of progress and we really felt we were pretty much on the same wavelength with administrative simplification. I also thought we developed some excellent recommendations on our quality initiatives, because quality initiatives will help hospitals reduce preventable errors, particularly the infection issue, using incentives in both our Federal payment system as well as reimbursement in the private market for the adoption of things like Pronovost's Checklist; and also that significant issue of the management of chronic illness.

We feel that there is much that we have found in terms of common ground and welcomed your insights and recommendations in looking at these models. Now, I want to be sure that I understood your testimony. Are you saying that the industry, as a whole, is now ready to end the practice of gender rating?

Ms. IGNAGNI. Yes.

Senator MIKULSKI. Is that each company or will that be a general policy?

Ms. IGNAGNI. As a matter of where we stand on health reform, Senator, our membership has endorsed that as part of the guarantee issue, no preexisting conditions, equal premiums across the two genders. We have strongly embraced that as part of our basket of recommendations.

The only issue here, frankly, for us, but we're considerably concerned about it, is the issue of, if we don't have everybody in, potential hyperinflation. I know that many leaders and you yourself are looking at that. The committee here spent a great deal of time talking about getting everyone in. We think that you're definitely in the right place. But we are very concerned about the changes that happened in the Finance Committee, because we want to get away from the situation where it's a voluntary market, where the younger and healthier don't have incentives to participate or would be inclined to leave until they need health care, because then we won't solve the problems that Ms. Robertson and Ms. Buchanan so articulately emphasized.

From the beginning of the year we've been committed to a massive overhaul of how the insurance market works, and we've presented evidence of what happened at the State level when you

didn't have everyone in, and there were just—there was this hyperinflation.

I think there's a real opportunity to understand that now. We understand the sensitivity about penalties. We've offered some solutions and alternatives to that. We very much want to work with you. But if we don't end up with everyone in, we're very concerned that at the end of the process when things become available, people will feel very unsatisfied.

That is the issue we're pointing to, along with the issue of, since cost containment across the system has been pretty much taken off the table, we're worried about the underlying costs. And we're worried that Congress has been forced into some tax provisions that they wouldn't otherwise have had to be forced into because of the lack of system-wide cost containment.

Senator MIKULSKI. What you're saying is that the insurance industry, with or without legislation, but preferably with—you need a legislative framework, to end gender rating and the barriers related to preexisting conditions.

Ms. IGNAGNI. Yes.

Senator MIKULSKI. Those were your three. What you're saying, is that in order to do this, the market has to expand, and that means that the insurance industry is calling for an individual mandate?

Ms. IGNAGNI. Yes. We think—

Senator MIKULSKI. I just want to be sure—

Ms. IGNAGNI. Yes.

Senator MIKULSKI [continuing]. I understand, so I'm just saying it out loud.

And by an individual mandate, what we mean is that we will help to cover everybody, but everybody's got to participate?

Ms. IGNAGNI. Yes, Senator.

Senator MIKULSKI. Is that it?

Ms. IGNAGNI. Yes. And if there are concerns about the issue of penalties and securing a mandate in that regard, we've offered some alternatives to achieve universal participation. We are strongly committed to the market reforms and they need to happen.

Senator MIKULSKI. What would they be? Because, as you know, this is a very controversial issue.

Ms. IGNAGNI. It is, and that's why I wanted to make the point that I didn't want to come and suggest that we need universal participation without also recognizing what you've just observed. In our view, if Members of Congress were concerned about moving down the penalty path, that they might look at a basket of alternatives.

No. 1, in the Part D program and Part B program, as you know, there are provisions where if you don't participate in year 1, you pay more in subsequent years. That's one factor, together we've been looking at, and I know there's been—in Massachusetts, for example, one of the strategies that was employed in the beginning of that legislation, which was supported on a bipartisan basis, as you know, in Massachusetts, was that if you didn't participate you lose your personal exemption at the State level.

We have been thinking about ways to work in that concept so that one could couple a personal exemption consideration with perhaps some of the Part B, Part D types of penalties, or looking at

that way to encourage more people to participate. We've been looking at auto-enrollment for people who would be eligible for subsidies, and we'd be delighted to confer—

Senator MIKULSKI. Automatic enrollment, not the auto insurance?

Ms. IGNAGNI. No, it's a little different than that, that's right.

Senator MIKULSKI. The metaphors that we hear a lot of.

Ms. IGNAGNI. That's right.

But I think there are ways to solve those problems, and we're committed to working with you to solve the problems. But I think if you look at the experience in the States—and this is what our recent report has pointed out—is that without everyone in to secure the goal that everybody supports—and I believe everyone supports it and that's the right thing to do—we are going to have significant unintended consequences in terms of costs, hyperinflation, if we don't get everyone in.

We want to recognize that now. We don't want to let Americans down. It's very important. We promised that we are committed to this. Our industry is four-square behind it. But we have an obligation to explain how to get that, how to make that happen.

Senator MIKULSKI. Well, again we could have extensive conversations. I've got to get to a meeting with Senators Dodd and Harkin. But I really appreciate every single person's testimony. Each have added a very important dimension to the conversation. As you can see, our desire was to have a discussion, not a debate.

I think it's time—again, I'll come back to trying to find that sensible center. We will be having ongoing conversations with many of you at the table.

Ms. Ignagni, I'd like to talk with you about the issues that Ms. Robertson raised. Knowing you and your longstanding commitment on many issues related to women, I'm sure that raised your eyebrows as well.

Ms. IGNAGNI. Yes, Senator. I'm happy to talk to you at your convenience.

Senator MIKULSKI. If you have a way that we could deal with the situation raised by Ms. Robertson across the board, maybe we could work together on it before we develop the final legislation—you know, developing legislation takes a long time. But I think perhaps we can do some of these things.

I'm going to conclude this very important hearing and say that we will keep the record open for any members wishing to submit additional comments and questions. This committee, stands adjourned subject to the call of the chair.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF SENATOR ENZI

I believe we need to fundamentally reform the insurance market place and offer new protections to ensure that consumers—including people with pre-existing conditions—can buy affordable, high quality health insurance. I strongly support ending all discrimination based on pre-existing conditions, whatever their cause. Everyone should be able to get the health care coverage they need.

The bill I introduced in 2007, Ten Steps to Transform Health Care in America, ended discrimination based on preexisting conditions. Additionally, both the HELP Committee bill and the Finance Committee bill end discrimination based on preexisting conditions.

I believe there are many additional things we can do as health care reform moves forward to improve the health of women. Unfortunately, the bills the Senate is considering give with one hand and take with the other when it comes to women's health.

Multiple studies have shown, and CBO has confirmed that health insurance premiums will rise for many Americans if health care reform passes. Some studies have shown costs in the individual market will increase by 50 percent or more. This will have a negative impact on young, healthy women.

Additionally, many of the insurance market reforms, including the very restrictive age rating rules capped at 2:1 in the HELP Committee bill and 4:1 in the Finance Committee bill, will increase the cost of health insurance premiums for younger, healthier women.

Many economists believe enacting a “pay or play” employer mandate like the one included in the HELP Committee bill will have a negative impact on low-income women and minorities by lowering wages.

Additionally, the Finance Committee health care bill forces 14 million more people into the Medicaid and CHIP programs. MedPAC reports show nearly 40 percent of doctors won't see Medicaid patients because of the low reimbursement rates. Forcing women into a program but not providing them actual access to care is not progress.

In short, I don't think increasing health insurance premiums, cutting wages, and forcing 14 million more Americans into Medicaid is “what women want.” Madame Chairwoman, I believe we can do better, for women and for all Americans.

[The Washington Post, May 5, 2008]

MALPRACTICE PREMIUMS, RATE OF C-SECTIONS RISE TOGETHER*

(By Kathleen Doheny)

MONDAY, May 5 (HEALTHDAY NEWS)—As medical malpractice premiums increase, so do the rates of Caesarean sections, new research shows.

The study provides a small snapshot of the association, drawing on data from the University of Connecticut Health Center in Farmington. The findings, while not na-

*To learn more about C-sections, visit the *National Institutes of Health*.

tional in scope, could further fuel the debate about whether higher malpractice rates boost the C-section rates, or vice-versa.

"When I compared the malpractice rates to C-section rates prior to 1999, both were declining at a similar rate," says study author Dr. Jeffrey V. Spencer, a maternal-fetal medicine fellow at UConn. From 1999 to 2005, however, both were increasing.

The study was scheduled to be presented Monday at the American Society of Obstetricians and Gynecologists annual meeting, in New Orleans.

Spencer and his team reviewed the center's perinatal database from 1991 to 2005, noting how many vaginal deliveries and how many C-sections took place. They got the average malpractice rates from the primary carrier at their institution and adjusted them for inflation over the years.

"I can't say one led to the other or vice-versa," Spencer said. But he speculates the medical malpractice rates are driving up the C-section rates. "The theory is, doctors are practicing more defensive medicine. Maybe doctors are fearful of litigation," he added, perhaps likely to decide on a C-section at the first sign of any potential problems.

In all, 23 percent (15,021) of the 64,767 deliveries studied were C-sections. Spencer's team also looked at first and repeat C-sections and compared those with the average malpractice premiums by year and found a relationship between increased malpractice rates and both first and repeat C-sections.

In a second study, Spencer and his colleagues looked at the impact of increasing malpractice rates on what is known as "operative vaginal deliveries"—delivering a child by forceps or vacuum. They found that 16 percent (10,299) of the 64,767 deliveries were this type. From 1991 to 2005, average malpractice rates increased from \$50,345 to \$126,806.

The rates for malpractice rose, he said, even though both types of vaginal deliveries declined. Forceps deliveries declined from 11 percent to less than 1 percent, and vacuum deliveries went from 17.2 percent to 6.2 percent.

Nationwide, C-section deliveries accounted for 30.2 percent of all deliveries in 2005, according to the U.S. Centers for Disease Control and Prevention, a record high for the Nation. In 1996, in comparison, 20.7 percent of deliveries were by C-section.

Another expert said the findings are nothing new. "These two papers do nothing more than substantiate what we already know," said Dr. Marsden Wagner, a perinatologist and former director of Women's and Children's Health for the World Health Organization.

One of the reasons for what Wagner refers to as the "scandalous" rate for C-section is that "doctors are afraid of litigation."

"Any physician who picks up a scalpel and does major abdominal surgery, which is what a C-section is, because that doctor is afraid of litigation, is not practicing medicine but is practicing fear and greed," he said.

"The increasing C-section rate has not decreased the amount of litigation," Wagner said. "So their attempt to avoid litigation by doing C-section is not working."

Spencer agreed. "The only thing to my knowledge that has changed or lowered malpractice rates are States having legislation to place caps on malpractice settlements."

NORTH CAROLINA DEPARTMENT OF INSURANCE,
RALEIGH, NC 27699-1201,
October 14, 2009.

Hon. RICHARD BURR,
U.S. Senate,
Russell Senate Office Building, Room 217,
Washington, DC 20510.

DEAR SENATOR BURR: Since September, media nationwide has been reporting on a 2008 National Women's Law Center report that includes North Carolina on a list of eight States that allow domestic violence to be used as a preexisting condition for health insurance policies. These media reports have, understandably, caused

Sources: Jeffrey V. Spencer, M.D., maternal-fetal medicine fellow, University of Connecticut Health Center, Farmington; Marsden Wagner, M.D., perinatologist and epidemiologist, Tacoma Park, MD., and former director, Women's and Children's Health, World Health Organization; May 5, 2008, presentations, American Society of Obstetricians and Gynecologists annual meeting, New Orleans.

much confusion and concern from government leaders, women's advocacy groups, and individual consumers across not only our State, but also the entire country.

I want to state as clearly as possible, that the North Carolina Department of Insurance and I strongly disagree with any assertions that the status of being a victim of domestic violence is allowed to be considered a preexisting condition in North Carolina.

For Group Coverage, North Carolina General Statute 58-68-35 section A-1 specifically states that an insurance company may not discriminate against participants or beneficiaries on the basis of evidence of insurability, which would include conditions arising out of acts of domestic violence. This provides protection from allowing domestic violence as a preexisting condition for group plans.

For individual/nongroup plans—there is not a statute that specifically lists domestic violence; however, there are several broader requirements that we feel address this issue. North Carolina Law defines a preexisting condition to mean “those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within the 1-year period immediately preceding the effective date of the person's coverage.” Domestic violence does not meet the definition of a medical condition.

Further, in our regulatory oversight of health insurance policy applications, we would not approve a company's policy application form that attempted to use domestic violence in its underwriting decisions.

NCGS 58-63-15(7)b. gives the North Carolina Department of Insurance the authority to review all policy application forms to make sure that they are not unfairly discriminatory. In North Carolina, if a company or policy wants to exclude something, they must declare it on the application by asking the applicant directly about the exclusion. Because exclusions are listed on application forms, and the Department reviews and approves the forms, we would know if a company tried to consider domestic violence as a preexisting condition.

We are unaware of any companies or forms that have asked to include domestic violence as a preexisting condition. If they did, we would deny it.

My department has been unable to find a single example of a company asking an applicant if they have been a victim of domestic abuse or a consumer complaining about being asked this for insurance purposes. However, the issue is far too important to leave any possibility that this could happen, so to create further protections, I have filed an administrative rule for adoption in the North Carolina Administrative Code—this is the most efficient way to address these concerns and add to our insurance regulations. The new code forbidding domestic violence from being considered as a preexisting condition should become effective on March 1, 2010.

Should you have additional questions or concerns on this issue, please feel free to contact me directly.

Warmest regards,

WAYNE GOODWIN,
Insurance Commissioner.

CONSUMERS UNION,
October 16, 2009.

Hon. BARBARA MIKULSKI,
Senate HELP Committee,
Senate Dirksen 428,
Washington, DC 20510.

DEAR SENATOR MIKULSKI: Thank you again for inviting Consumers Union to testify at the October 15th hearing on issues in women's health insurance.

During the hearing, Senator Merkley asked for more information which I said I would provide for the record. If possible, I would like to provide the attached for inclusion in the Record in response to his question.

I hope the “total cost” information described in the attachment can be included in the final health reform legislation. It would truly help consumers make better choices while saving both consumers and the Treasury significant amounts of money.

Thank you again.

Sincerely,

JIM GUEST,
President and CEO.

RESPONSE TO QUESTION OF SENATOR MERKLEY BY JIM GUEST

Question. Mr. Guest, you talked about the importance of having apples-to-apples information for consumers to compare plans, including examples of total costs a person would likely face. Can you explain a little more about how that would work?

Answer. Thank you for the question. We believe that if you correctly structure the information given consumers in the Exchange-Connector system, you can:

- provide enormous help to consumers in ensuring that they pick the best policy for themselves, and
- save consumers and taxpayers substantial amounts of money by maximizing insurance coverage and minimizing consumer out-of-pocket costs and taxpayer subsidy costs.

The first thing that consumers need is standard definition of terms, so that they can comparison shop.

We have examples of consumers who thought they were buying hospital insurance coverage, but the fine print showed that the coverage started on the second day, after the huge costs of initial lab testing and use of the surgery rooms. Standard definition of terms that all insurers would be required to use would ensure that hospitalization meant hospitalization in all policies. Consumers often think they have pharmaceutical coverage and then find that chemotherapy and/or antiemetics necessary for chemotherapy are not covered. A definition of pharmaceutical coverage would prevent these kinds of “got ‘cha’ exceptions and allow consumers to shop on quality and price.

Insurance terms (e.g., co-insurance, tiers, etc.) should also be standardized.

Second, most people are unaware of the huge expense of major procedures, or even relatively common ones like childbirth. **It would be very helpful to require giving consumers “scenarios” of how the insurance plan they are considering covers certain common conditions.** These would be defined and developed by the Gateway administrator in consultation with medical experts and could include such examples as childbirth, treatment of a certain level of prostate cancer, compound leg fracture, etc. Not only would this show consumers why insurance is important, but it would allow consumers to see that actuarially equivalent policies can have wildly different levels of protection for specific conditions. Our May issue of Consumer Reports (attached)* showed two policies that appeared to be similar in premiums and deductibles, yet in a case of successfully-treated breast cancer, one policy left the consumer with \$37,767 out-of-pocket, while another one covered all but \$7,668.

The most important thing you can do to help consumers pick the best plan is to give them information, upon enrollment and at each open enrollment period, of the plan’s estimated total cost (premiums, deductibles, co-pays), based on their past year’s medical use or (on first enrollment) their estimate of their health status (e.g., good, fair, poor).

Consumers Union has just received a study by Destination Rx¹ of 92,000 Medicare Part D enrollees that shows that if people selected just on the basis of picking the lowest premium, their total spending on drugs (premiums, deductibles, co-pays, donut) would be about \$205 million annually. When other data is presented, such as the total cost of the plan (based on their recent drug usage and past history), they only spend about \$172 million—a savings of \$33 million among just 92,000 individuals. Of course, by selecting the best Part D plan for themselves, taxpayers also benefit through reduced low-income subsidies, minimized co-payments, and reduced catastrophic cost subsidies.

We believe that the same shopping “principle” applies to the non-Rx health insurance market: if consumers using the proposed “Exchanges” saw the total probable cost of premiums, deductibles, and co-pays based on their past year’s medical use or self-described medical condition (e.g., “excellent, good, fair, or poor” health status as defined through regulations), they would tend to select the lowest total cost plan—and thus minimize the deductible and co-pay subsidies needed for those under 400 percent of FPL.

We urge you to amend the health reform bills to require that among the information given to consumers in the insurance policy and/or in the ex-

*The Report referred to may be found at www.consumerreports.org/health/insurance/health-insurance/overview/health-insurance-ov.htm.

¹We have used data from Destination Rx in a number of our publications. They provided us with the data that showed that random assignment of LIS beneficiaries in Part D to low-cost premium plans often failed to ensure assignment to the best plan, from both the beneficiary and the taxpayer point-of-view. This led to the “intelligent assignment” amendment of 2007 that CBO scored as saving \$ 1.2 billion over 10 years.

change, there be “an estimate of the total annual cost for a person enrolled in the policy, based on the individual’s past medical cost or based on self-assessed health status (data and estimates to be developed by the Secretary through regulations and subject to all privacy safeguards). This would be similar to the Medicare “drug compare” Web site, where an individual can type in their medications and see an estimated total annual cost. Very often, the lowest cost plan is NOT the plan with the lowest premium.

Further immediate, scorable savings could be achieved in Medicare Part D (and probably Part C), if you required that in each open enrollment period, whenever possible beneficiaries were given an estimate of their total cost for the coming plan year, based on past Part D usage. They could then be shown the 5 or so lowest-cost plans (counting premiums, deductibles, and co-pays) that would meet that past usage. This could be achieved by amending 1860D-1(c)(3)(A)(ii). (This would be somewhat similar to the requirement in MMA that a pharmacist tell a beneficiary if their plan covers a lower cost generic.)

[Whereupon, at 12:30 p.m., the hearing was adjourned.]

○