Testimony of

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"47 Million and Counting: How the Health Care Market Is Broken"

Good morning Chairman Baucus, Ranking Member Grassley and members of the Committee. Thank you for the opportunity to appear here today. My name is Ronald A. Williams, and I am the Chairman and Chief Executive Officer of Aetna Inc. Headquartered in Hartford, Connecticut, Aetna is one of the nation's leaders in health care, dental, pharmacy, group life, disability insurance and employee benefits. We provide products and services in all 50 states, serving over 37 million unique individuals. Our customers include employer groups, individuals, college students, part-time and hourly workers, health plans, governmental units, government-sponsored plans, labor groups and expatriates.

Aetna's Involvement in Public Policy

Aetna is very engaged in health policy, which reflects my belief that Aetna has an obligation to advance the public good and to be a key part of the solution to the challenges facing our health care system. Our involvement in the policy arena is also justified as a large employer with more than 35,000 employees who have a stake in the outcomes of health care reform. And, as one of the oldest and largest health insurers in America, we believe we can provide valuable insight and perspectives into addressing the inter-related challenges of access, cost and quality. You should know that we take pride in our public policy leadership. We go to great lengths to make sure our employees understand that, for Aetna, being a leader in health care means not only meeting business expectations, but also exercising ethical business principles and social responsibility in everything we do. This culture, in turn, has made possible our leadership on a variety of public policy issues, including racial and ethnic disparities, genetic testing, end-of-life care, the integration of medical and behavioral health, price transparency, personal health records, and health and benefits literacy. I would encourage the Committee to read our proposal, titled *To Your Health!*, which provides a framework for transforming the U.S. health care system.

The U.S. Health Care System at a Crossroads

I would like to begin by noting that I believe the U.S. health care system finds itself at a crossroads. Clearly, there is growing consensus here in Washington, D.C., and among the states that health care reform is as important as it is needed – and it appears that the prospects for meaningful reform are growing. Like you, I feel that we, as a nation, can and must do better to ensure all Americans have access to high-quality and affordable health care. In this testimony, I will outline some of what our experience has taught us can be done to fix the crisis of the uninsured, a crisis that is directly related to the rising costs of health care services. To tackle this will require considerable public-private collaboration to re-orient our delivery system toward value and prevention, to address problems plaguing the marketplace, and to unify the country in sharing a stake in a high-performing and inclusive health insurance system.

The Guiding Principles of Reform: Building Upon Strengths to Address Deficiencies

As we contemplate system reform from our respective vantage points, let us consider not only the health care system's deficiencies, but also its strengths as we determine what will be the guiding principles of reform. Though often unnoticed, or at least not always appreciated, our system has some real strengths and positive attributes. For example, the U.S. health care system

remains the world's pioneer in research and medical technology, leading treatment breakthroughs that benefit millions of Americans and people across the globe. It is telling that four of the six most important innovations in medicine in the last quarter century have come from the United States, as did an impressive 15 Nobel Prize winners in medicine in the past decade.[1] Our system is also characterized by first-rate physicians, state-of-the-art hospitals and top medical and research facilities, which pioneer drugs and develop treatments for people throughout the world. In sharp contrast to many other parts of the world, people in America demand – and get – routine and rapid access to needed specialty care. It is useful reminder that there are more than one million people waiting for medical care in Great Britain and more than 800,000 in Canada.[2]

It is also important to remember that more than 250 million people in America currently possess health insurance. Disrupting the coverage of hundreds of millions of people does not constitute progress; nor is it progress to dismantle the critical role employers play in offering health insurance. Of the more than 200 million people with private health insurance, nearly 88 percent receive coverage through an employer, making employers the single biggest source of coverage in America. These features of the current U.S. health care system – a large population *with* insurance and the significant role of employers in making health insurance available – are also strengths to be built upon.

These strengths and attributes are due, in large measure, to the competition inherent in our market-based system. I would submit that reforms ought to preserve and build upon this competitive marketplace, which fuels the kinds of innovations and breakthroughs that so many of us benefit from. This is not to say that government should sit on the sidelines; indeed, it is important that the government play a key role in enabling a robust marketplace and serving the nation's most vulnerable. But I am convinced that the marketplace itself is a core strength, and one of the principal challenges we face as a nation is to create a system that features both a competitive marketplace and a strong public health system – a true public-private partnership.

But make no mistake about it – the picture is far from optimal. There are also severe and, frankly, unacceptable deficiencies within our nation's health care system. As everyone in this room is aware, there are now more than 47 million uninsured in the United States, which represents one in six adults under the age of 65. The uninsured come from a variety of ages, household incomes, citizenship statuses, work statuses, which means that no single solution will work across this heterogeneous population. But they share some common plights. The uninsured obtain less care, receive fewer preventive services, and often fail to obtain or adhere to recommended treatments. Studies have shown that more than 20,000 people die each year solely because they lack health insurance. There are important economic effects associated with uninsurance, as well. Tens of billions of dollars are spent each year treating those without health insurance, often in expensive emergency room settings for illnesses or chronic conditions that could have been prevented or treated earlier had they been part of a course of care typically associated with possessing health insurance coverage. Though those lacking insurance undoubtedly suffer most, it is a fact that we all pay the price. In 2005, for example, the average

[1] Cowen, Tyler, "Poor U.S. scores in health care don't measure Nobels and innovation," *New York Times*, October 5, 2006.
[2] Turner, Grace Marie, "Look at the data, not propaganda," Baltimore Sun, June 29, 2007.

family premium for employer-sponsored insurance incorporated an extra $922 – more than 8 percent of the total average premium – as a result of uncompensated care.[3]

Systemwide Challenges to Expanding Access

With these underlying principles as a guide, I would like to discuss four systemic challenges that I believe stand in the way of any effort to achieve universal coverage: 1) high and rising health care costs, which translate into expensive health insurance; 2) state regulations that preclude affordable health insurance options; 3) the flaws inherent to health insurance markets outside of the employer-based system; and 4) access problems associated with three specific segments of the uninsured population.

Recognizing the Inextricable Link between Access and Cost

Before describing each of these challenges, as well as some of Aetna's experience in grappling with them, it is important to point out that the goal of expanding access cannot be looked at in isolation. There are many reasons why people are uninsured, but rising health care costs and their attendant effects on affordability of health insurance are widely – and appropriately – viewed as *the* fundamental problems. The implication of this is clear: Unless we, as a nation, are able to address the underlying cost and affordability problems entrenched in the current health care system, our efforts to achieve universal coverage are doomed to failure. As Sen. Baucus foretold in his opening statement to these hearings last Tuesday, and I quote, "We must find ways to bend the cost curve. Otherwise, health spending will consume our entire economy."

(1) High and rising health care costs translate into expensive health care insurance.

There is universal agreement that health care costs and spending are high and rising. Today, the nation spends approximately $2.2 trillion on health care, which is up from $75 billion in 1970. If the cost of a car had inflated as much, a Buick Le Sabre, which cost $3,300 in 1970, would now cost $96,000. In terms of our nation's gross domestic product, health care spending now accounts for over 16 percent of GDP and it is expected to reach 20 percent, exceeding $4 trillion, by 2017. As this Committee undoubtedly appreciates, there are many reasons why health care is so expensive, though some of the most important drivers are a rapidly aging population; huge advancements in expensive yet important health care technology; prescription drug spending; and growing demand for costly services, which is fueled by growing prevalence of chronic disease and poor lifestyle choices.

High Health Care Cost Yields Expensive Health Insurance

Despite the overwhelming data pointing to the high cost of health care, there is strikingly little awareness about the connection between health care costs and the cost of health insurance. That so few immediately make this connection is, in some ways, understandable. Historically, Americans have been largely shielded from the true cost of health care. This is demonstrated clearly by the gulf between what consumers believe health services cost and their actual costs.

[3] Families USA, "Paying a Premium: The Added Cost of Care for the Uninsured." Publication No. 05-101, June 2005. Available at www.familiesusa.org.

For example, consumers believe that a hip replacement costs, on average, about $10,600 when in reality it costs $25,000. Similarly, most consumers believe a day or night in the hospital costs just over $1,000 when in fact it is over three times that amount.[4] This lack of awareness about the true cost of health care also stems from the fact employers typically subsidize 70 percent to 80 percent of their employees' health insurance premiums, meaning that many employees with employer-sponsored coverage are essentially insulated from knowing how expensive health insurance really is.

And finally, there are pervasive misperceptions about how private health insurers operate. While many people believe that a large percentage of each dollar of premium goes to profit, the reality is that, at Aetna, merely six cents goes to after-tax profit. For Aetna's Medicare Advantage business, our profit is three cents on the premium dollar. The shareholders of Aetna – individuals, public employers, retirement plans, mutual fund investors – rely on that reasonable profit when they put their investment dollars to work to accumulate monies for homes, college costs and retirement. Similarly, attacks on perceived "excess administrative costs" are largely misguided. While it is true that administrative costs include items like marketing expenses, salaries and benefits for our more than 35,000 employees, it is *also* true that administrative costs include critical investments that benefit consumers, such as information technology, coordination of care, and disease management. When one takes a look at the tools, information and personal support that are associated with the 11 cents that Aetna spends of each health care premium dollar for administration (and 7 cents for the company's Medicare Advantage business), it becomes clear that proposals to impose minimum medical cost ratios on private insurers represent misguided public policy. That Aetna is a trusted steward to the resources of 74 percent of companies on the Fortune 50 – among the most sophisticated purchasers in the health care system – speaks volumes about the value they see in what we do.

The point I want to drive home is that health insurance premiums are primarily a reflection of the overall cost of health care services. Premium increases trend with health care spending very closely. Over the period 1993 to 2003, for example, premiums grew at an annual rate of 7.3 percent, while the cost of health care services grew at an annual rate of 7.2 percent.[5] This evidence suggests that the salient question to ask is <u>not</u> "what can we do to lower the price of health insurance?" but rather, "what can we do to slow the rate of health care cost growth?"

Focusing on Value to Increase Affordability

So what can be done? There is a long list of potential policy interventions that could slow the rate of health care spending in the United States, ranging from much-needed investments in connecting the system via interoperable health information technology to greater use of generic drugs. But let me describe two fundamental interventions that would go a long way toward "bending the cost curve."

The first is to re-orient the health care system toward value. To be certain, the system's <u>lack</u> of focus on value is easy to see. Today's health care payment structure rewards the volume, rather

[4] Raskin, J.R., et al. Health Insurance and Consumerism, Lehman Brothers, May 22, 2006.
[5] PricewaterhouseCoopers, "The Factors Fueling Rising Healthcare Costs, 2006." Prepared for America's Health Insurance Plans. Available at www.pwc.com.

than the quality or efficacy, of services provided – a problem that results in pervasive overuse and misuse of health care resources. Health care quality and patient safety are wholly inadequate, despite the fact that the United States spends more per capita than any other country on health care. There is also tremendous variation in how patients with the same conditions are treated; unexplainable differences in costs across geographies; widespread preventable errors; and large and persistent discrepancies between actual and evidence-based recommended clinical practices.

Aetna's efforts to extract greater value for each health care dollar spent for our customers are instructive, and can help shape our discussion about controlling costs and improving access. We have been pioneers in increasing price and quality transparency, giving our members the tools and information necessary for making better, more informed decisions about their health care and spending. In 2005, for example, Aetna became the first insurer to begin providing physician-specific pricing for the most common physician services by specialty. Last year, we introduced the *Medical Procedure by Facility Cost* tool, which enables our members to review and compare health care cost information, from admission to discharge, for a specific procedure based on the type of setting in which the procedure is performed. The rapid growth in member utilization of these tools is particularly striking, and it demonstrates the high value members place on the availability of this information. Total hits for usage of the *Unit Price Transparency* tool grew from about 42,000 in 2006 to over 234,000 in 2007 and its usage rate has only continued to accelerate this year. Our *Quality and Efficiency* tool has averaged almost 9,000 hits a month since the start of 2008. And our *Medical Procedure by Facility Cost* tool has received nearly 107,000 hits since its release in November 2007 through April of this year.

These and other price transparency tools complement Aetna's ongoing leadership in quality transparency. Our performance network, *Aexcel*, helps members easily identify physicians whose performance meets nationally recognized standards for clinical quality and efficiency. And our *Hospital Comparison* tool provides information about hospitals with regard to specific diagnoses and procedures. Members and providers can access easy-to-understand reports that compare hospitals based on four important criteria: number of patients treated per year, complication rates, mortality rates and length of stay. Most recently, Aetna embraced the Leapfrog Group's "Never Events" policy, which includes an agreement not to pay for costs directly related to a list of serious reportable events, such as surgery performed on the wrong body part or leaving a foreign object inside a patient after surgery. We at Aetna believe these common-sense price and quality efforts will go a long way toward improving the value of health care.

In addition to the aforementioned tools and initiatives, our work with the Virginia Mason Clinic in Seattle represents a great example of how insurers, providers and employers can partner to improve quality and attain the highest possible value for each health care dollar. In 2004, Virginia Mason began to recognize inefficiencies in certain treatment protocols, including that of back pain. With Aetna's data analytic support, Virginia Mason re-engineered its protocol for the treatment of back pain. By involving physical therapists up front, rather than following a longer and more expensive period of primary care visits and neurology consultations, Virginia Mason was able to drastically improve outcomes on both quality and cost measures. The clinic saw a nearly 80 percent reduction in the average cost of treatment for back pain. Almost three-quarters

(73 percent) of patients were treated without medication, and 94 percent of patients were sent back to work with no time off. Wait times for physical therapy appointments went from up to one month all the way down to one day. These changes significantly reduced costs and this benefit is shared across stakeholders. Big employers saved $100,000 in the first year. Virginia Mason saw higher reimbursement for cost-effective treatments and was able to treat a higher volume of patients with fewer staff.

Shifting the System's Focus Toward Wellness, Prevention and Early Intervention

Another fundamental intervention needed to control the growth of health care spending – and thus health insurance premiums – is in the area of wellness, prevention and early intervention. While the United States has made substantial improvements in its overall public health over the past century, the system is principally oriented toward treating sickness rather than promoting health. One only needs to look at obesity patterns in the United States to see that this orientation is flawed; the prevalence of overweight children has tripled over the past two decades, and today more than a quarter of all Americans are obese. The prevalence and cost of chronic disease is also a striking indicator of a broken system. Today, more than half of the American public is living with at least one chronic disease, such as diabetes, hypertension, stroke, heart disease or pulmonary conditions. More than 1.7 million people die each year from chronic disease and, according to a recent report, the United States spends more than $200 billion in direct costs in treating chronic disease, alongside the more than $1 trillion in lost productivity.[6] These data point to an obvious conclusion: there are substantial opportunities to achieve cost savings and improve health through preventive care, early detection, wellness and the management of chronic disease. In short, the nation needs to place as much – if not more – emphasis on prevention and wellness as it does on the treatment of disease. At Aetna, we have taken steps to ensure our members have the tools they need to achieve better overall health. We do this by providing access to preventive care free of co-pays and deductibles, smoking cessation and weight loss programs, and disease management tools that encourage people to get and stay healthy. These kinds of innovations in value-based insurance design mean that we make it easier for people to do the right thing when it comes to their own health.

I am pleased to report that Aetna has a number of positive outcomes on this front to share with you. Our *Health Connections Disease Management* program, for example, averages a 2.5 to 1 return on investment, and the program has made a remarkable difference in reducing expensive emergency room visits (e.g., reduced by 7 percent for asthma patients) and inpatient admits (e.g., reduced by 13 percent for those with coronary heart disease).[7] Our *Healthy Lifestyles* program, which provides Aetna employees working 20 or more hours with an opportunity to earn up to $600 by making healthy food choices and engaging in physical exercise, has also shown impressive results. Over 50 percent of participants have shown an improvement in their body mass index; the return on investment for the program's physical fitness component is 3.4 to 1.[8]

[6] DeVol, R. et al., "An Unhealthy America: The Economic Burden of Chronic Disease – Charting a New Course to Save Lives and Increase Productivity," October 2007.
[7] AHC Disease Management Performance Survey – Aetna Health Analytics Survey, March 2008.
[8] 2006 Aetna, Inc. study, published in 2007; National Business Group on Health, "Healthy Lifestyles: A Best Practices Case Study," February 2007.

These kinds of results provide compelling support for the importance of prevention, wellness and early intervention.

(2) State regulations often exacerbate affordability challenges

The second major impediment to expanding health insurance coverage is state regulations, which often exacerbate affordability challenges. Regulations like guaranteed issue, community rating, and benefit mandates, although presumably designed to help consumers, often place affordable insurance products out of their reach.

Negative Consequences of Guaranteed Issue, Community Rating and Benefit Mandates

A recent report by America's Health Insurance Plans and the consulting firm Milliman, Inc. highlighted the impact of guaranteed issue and community rating reforms adopted in eight states.[9] Although results varied widely among the states analyzed, the report found that in terms of market size, level of premium and availability of insurance options, individual insurance markets deteriorated after the introduction of guaranteed issue and community rating reforms. For example, following the 1994 and 1996 reforms passed in Kentucky, which included guaranteed issue and modified community rating, more than 40 insurers left the individual market by January 1998. Many of Kentucky's reforms have since been repealed, and there are now seven companies selling insurance in the individual market.

Mandated benefits also do their part to raise insurance premiums. While there is no doubt that certain benefits should be available to everyone, mandates effectively tell consumers that if they cannot buy the Cadillac, then they cannot buy anything, even if they can afford a Ford or Chevrolet. Though there are many mandates that have minimal impact on premiums (i.e., less than 1 percent), the typical insurance mandate raises premiums 1 percent to 2 percent.[10] Considered alone, this may seem insignificant, but with an average of 39 mandates per state and with some states having upwards of 60 mandated benefits and providers, the impact can be substantial. Although I do not advocate for the complete elimination of benefit mandates, it would be valuable to create state-level benefit mandate review commissions, so as to limit mandated benefits that are purely politically driven.

A Comparison of Neighboring States

It is important to note, first and foremost, that complying with divergent state regulations undoubtedly raises administrative costs for everyone in the system. For this reason, Aetna has long advocated for the standardization of these regulations into a single federal charter. However, the absence of such uniformity leaves us with some instructive tools for understanding the impact of different types of regulation and reforms on the affordability of premiums in different states.

[9] Wachenheim, Leigh, and Hans Leida, "The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets," Milliman/America's Health Insurance Plans, July 10, 2007.
[10] Cubanski, Juliette, and Helen H. Schauffler, "Mandated Health Insurance Benefits: Tradeoffs Among Benefits, Coverage, and Costs?" Center for Health and Public Policy Studies, University of California, Berkeley, July 2002.

Let us take, for example, New Jersey and Pennsylvania. New Jersey's individual health insurance market is more heavily regulated than Pennsylvania's. New Jersey requires guaranteed issue of health insurance policies in the individual market, as well as community rating of those policies with no rate bands allowed for health status. In sharp contrast, Pennsylvania neither requires guaranteed issue nor imposes rating restrictions on insurers. New Jersey has 26 mandated benefits, while Pennsylvania has 17.[11] Now there is no doubt in my mind that legislators implemented these market rules with an eye toward consumer protection, but these good intentions have had a marked negative impact on the affordability of insurance.
In Pennsylvania, an HMO plan with a relatively rich benefit package (i.e., no deductible or coinsurance and office visits priced at $10 to $20) costs $196 a month (or $2,352 annually) for a 35 year-old male.[12] After allowing for potential rate-ups of up to 50 percent based on health status, the cost of this plan in Pennsylvania would be $294 a month (or $3,528 annually). A comparable plan in New Jersey costs $674 per month (or $8,088 annually). An Aetna high-deductible plan in Pennsylvania costs the same person $118 a month (and up to $177 with possible rate-ups), while a comparable high-deductible plan offered by a different carrier in New Jersey costs $460 a month.

These data lead us to a crucial question that legislators and regulators must grapple with when considering health care reform – which is better? We might look at New Jersey and consider it only fair that healthier individuals subsidize less healthy ones, with the outcome being that everyone can get, albeit more costly, private insurance. But this reasoning is flawed in the absence of an individual coverage requirement. Why, in fact, would I, as a healthy individual in New Jersey, choose to pay somewhere between $5,500 and $8,000 a year for insurance when I know that I can always wait until I get sick and then hand over that $8,000? In essence, the outcome of New Jersey's regulations is an individual insurance market filled with sicker and sicker people.

On the other hand, we might say fairness means that healthy individuals ought to be able to purchase affordable health insurance coverage. As a healthy Pennsylvanian, I might not mind paying $100 to $200 a month for the peace of mind of knowing that I will have health care at my fingertips when I need it. Incidentally, those insured Pennsylvanians can also stop by their doctors every year for routine check-ups and preventive care so they can avoid getting sick in the first place.

Ensuring Pathways to Coverage for High-Risk Individuals

The follow-up question is how do we make sure that even high-risk people get insurance? And this is where new approaches and government intervention are so important. Pennsylvania, for example, has an insurer of last resort, and many states have high-risk pools and reinsurance programs. But these safety nets are woefully inadequate; the 34 state high-risk pools collectively cover fewer than 200,000 people. We need to increase funding for these types of programs in order to ensure access to coverage for high-risk people. We also need to develop alternative pooling mechanisms, so that employer-based groups are not the only ones that can pool risk.

[11] Bunce, Victoria C., J.P. Wieske, and Vlasta Prikazsky. "Health Insurance Mandates in the States 2007," Council for Affordable Health Insurance, 2007.
[12] www.ehealthinsurance.com; Rates accessed for a 35 year-old male on May 2, 2008.

Innovative arrangements, like association health groups that are created and administered by insurers, can offer important new market-based options for people with a full range of health statuses and risk profiles. Such pools can offer valuable alternatives for both individuals and small businesses.

While the main forces in keeping the employer-based system affordable are diverse risk pools and the employer subsidy, the main factor that drives affordability in the individual and small group markets is the ability of health insurers to put in place tools for preventing adverse selection. In the absence of mechanisms that connect pricing to the expected use of health care services, we end up with dysfunctional insurance markets. In other words, insurance is fundamentally about people paying for coverage on a sustained basis and *before* they know they need treatments and services. When this fundamental tenet of insurance is compromised through misguided public policy or other means, we end up with insurance markets where everyone can hypothetically get insurance, but few people can actually afford to buy it.

(3) The benefits of employer-sponsored insurance are not available elsewhere

The employer-based system of health care is a real strength, but its benefits are not available to all, leaving those without employer access at a distinct disadvantage. There are a couple of approaches that can co-exist: one approach to addressing this shortfall rests in increasing the number of employers offering health benefits to their workers, a second approach involves exporting some of the benefits of employer-sponsored insurance to other health insurance markets. These benefits include large and diverse risk pools and preferred tax treatment, both of which enable individuals to access more benefits at a lower cost. We have to build on the employer-based system, which serves so many already, to reach all Americans and not "throw the baby out with the bathwater" by enacting reform that weakens the core of this system.

The Critical Role of Employer-Sponsored Insurance

Before delving into the two approaches to expanding the reach of the employer-based system, several numbers illustrate its important role. With regard to Aetna's business, the employer-based system is undoubtedly a key area of focus, with 15.7 million of our medical members receiving coverage through this system. Indeed, throughout the country, 177 million people with private insurance access this insurance through their employers,[13] and when given the choice, 82 percent of workers who are eligible for employer-offered coverage participate in their employers' health plans.[14] While these data emphasize the desirability of employer-sponsored insurance, we must also note that such insurance is clearly not available to all. Not all employers offer health benefits, and not all employees can afford to accept their employer-offered coverage. In fact, 22 million (46.8 percent) of the people who were uninsured in 2006 were also full-time workers.[15] Finally, people who are not employed – comprising 22 percent of the total uninsured population in 2006 – lack direct (e.g., nondependent) access to employer-sponsored insurance.[16]

[13] U.S. Census, "Income, Poverty, and Health Insurance Coverage in the United States: 2006," Issued August 2007.
[14] Kaiser/HRET Survey, 2007.
[15] U.S. Census.
[16] U.S. Census.

Expanding Access to Insurance by Increasing Employer Benefit Provision

As noted above, a first strategy for expanding access to the benefits of employer-sponsored insurance is to increase the number of employers offering their employees access to insurance. This problem is particularly acute among small employers. According to the Kaiser Family Foundation's 2007 Annual Health Benefits Survey, only 45 percent of the smallest firms offer their employees insurance options, and of those employees not offered coverage, 45 percent are uninsured. Seventy-two percent (72 percent) of surveyed small firms (3-199 workers) not offering coverage cited high premiums as a very important reason for not doing so, while 61 percent cited small firm size as a very important reason.[17]

Making available more affordable health insurance options for small businesses and increasing the pooling mechanisms available to them are two crucial steps for expanding access for uninsured workers of small businesses. Pooling mechanisms need not be limited to the public sector, as private players could also offer significant benefits to small businesses by allowing them to pool risk on a larger scale.

At Aetna, we have taken steps to provide employers such affordable options to offer their employees. For example, in December 2007, Aetna launched the New York City Community Plan, which provides insurance options specifically designed for small businesses with employees living or working in New York City. Our network of over 14,000 local care providers reflects the diversity of New York City. More than half of these providers speak at least two languages, and altogether, more than 96 different languages are spoken within the network. Through this diverse network, the NYC Community Plan also strives to decrease widely acknowledged racial and ethnic disparities in the way health care is delivered and received. The product includes no co-pays for preventive care, a variety of wellness programs, online access to health resources, and most importantly, financial protection and peace of mind. Because the product was only launched in December 2007, it is too early to provide membership data. However, the NYC Community Plan is showing promise as a solution.

Exporting Key Benefits of Employer-Sponsored Insurance to Other Markets

Again, because not all individuals are able to access employer-sponsored insurance, it becomes vital to export some of the benefits of the employer-based system to other markets, especially since certain elements of the individual insurance market pose challenges for a range of people attempting to access insurance coverage.

One of the distinct advantages of the employer-based system is its large and diverse risk pooling, with premiums set on the basis of group experience. The absence of large pooling mechanisms in the individual market means that insurers have to perform medical underwriting on an individual basis. This market feature poses a potential problem for several key constituencies: older individuals (e.g., early retirees); less healthy individuals and those with chronic diseases; and individuals with pre-existing conditions. In many cases, the only options available to individuals with poor health status are government programs like state high-risk pools, which, as noted earlier, tend to be chronically underfunded and have limited enrollment capacities. There

[17] Kaiser/HRET Survey, 2007.

are, however, various private sector-oriented approaches that could bring pooling to new markets and provide options to those groups who are most affected by medical underwriting. For example, new pooling mechanisms (e.g., association health groups, discretionary groups) represent a sensible way to provide insurance coverage to both healthy individuals and high-risk individuals with limited access to coverage in the individual market.

Other approaches may focus on specific groups of individuals who traditionally face challenges accessing individual market coverage. At Aetna, some of our efforts have centered on facilitating access to coverage for older individuals. We have developed, in conjunction with the HR Policy Association, a group product offered through employers for pre- and post-65 retirees. Retiree Health Access (RHA) is a fully insured, guaranteed issue product with no employer funding requirement. There are currently 28 participating employers, almost half of whom are offering retiree health benefits for the first time. A second, newer product – available since January 2008 – is Aetna's AARP Essential Premier Health Insurance for individuals aged 50-64. It offers a range of benefit plans targeted specifically for this age bracket and their dependents. While premiums vary on the basis of a number of factors, a single female in Arizona or Colorado can expect to pay between $110 and $494 per month, and a single male can expect to pay between $105 and $471 per month. One important note about this product is that we have made revisions to our typical underwriting guidelines for our individual plans to be more liberal when considering AARP applicants with common conditions such as high BMI, high cholesterol and hypertension. We believe this will prove beneficial to individuals within this age group, by allowing us to accept a greater percentage of the targeted demographic into our plan.

Beyond expanding pooling mechanisms and targeting specific constituencies, there is another significant benefit of the employer-based system that many agree must be shared on a widespread basis – the tax treatment of health insurance. With both employers and employees receiving health insurance-related tax benefits, incentives are provided not only to offer insurance, but also to take it up. Such tax benefits are nowhere to be seen in the individual market. We think that it makes sense to equalize the tax treatment of health insurance for those who obtain coverage through their employer and those who purchase it directly in the individual market by extending favorable tax treatment to both sets of individuals, without changing the favorable tax treatment employers currently receive for offering benefits.

Current Performance of the Individual Market

As we discuss these shortcomings, it is also important to maintain perspective on the functioning of the individual and small group markets, as there are many false impressions about them. In the individual market, 89 percent of applicants undergoing medical underwriting were offered coverage in 2006 and 2007, with offer rates ranging from 96 percent among those under 18 years old to 71 percent for those aged 60-64.[18] Average annual premiums were $2,613 for single coverage and $5,799 for family coverage during the 2006-2007 period.[19]

[18] America's Health Insurance Plans, "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits," December 2007.
[19] America's Health Insurance Plans, "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits," December 2007.

At the same time, the absence of tax incentives and large, diverse risk pools from the individual insurance market makes it challenging one for certain groups of people seeking coverage. While there are important aspects of the employer-based system – like employer subsidization of health insurance premiums – that cannot be exported, new forms of pooling and favorable tax treatment in the form of advanceable, refundable tax credits could go a long way toward reducing uninsurance *and* smoothing the path to coverage.

(4) Some people and populations could be covered by private insurance and existing public programs – but they are not

A final challenge I would like to draw attention to rests among several segments of the population who could very likely be covered, but are not. I believe it is a useful exercise to look at the different segments of the uninsured, as doing so allows us to consider different solutions for these unique segments (e.g., about 40 percent of the uninsured are between the ages of 18 and 34; over 10 million uninsured are non-U.S. citizens). And while some people do not have insurance because they cannot access it, many others remain outside of the system because of enrollment challenges, affordability challenges, or a simple choice not to purchase coverage. I would like to address three key groups that fall into these categories: people who are eligible for public programs but not enrolled in them, students and young adults, and the higher-income uninsured.

Individuals Who are Eligible for Public Coverage but Not Enrolled

A report from the Kaiser Commission on Medicaid and the Uninsured found that about 11 million of the nation's uninsured – almost a quarter – are eligible for public programs but are not enrolled.[20] This eligible-but-not-enrolled issue is especially problematic among children. Approximately 6.1 million of the 8.7 million uninsured children in America are currently eligible for Medicaid or SCHIP. It is important to note that this is a group for whom private coverage is, in almost all cases, out of reach. This is why public programs like Medicaid and SCHIP were developed in the first place – to provide public options to those individuals the private sector cannot adequately serve.

This eligible-but-not-enrolled phenomenon needs to be addressed immediately, as there is no doubt that these 11 million people are truly in need of public programs. Some of the complications with nonenrollment of eligible individuals may be associated with frequent changes in eligibility status, leading many of those who are eligible to think they are not. A recent *Health Affairs* article reported that 48 percent of surveyed children from 1996-2000 experienced interruptions in eligibility for these programs.[21] This is one area where the public and private sectors can and should come together to develop effective solutions to streamline processes for enrollment and maintenance of coverage. Covering these additional 11 million

[20] Holahan, John, Allison Cook and Lisa Dubay. "Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage?" Kaiser Commission on Medicaid and the Uninsured, February 2007.

[21] Sommers, Anna S., Lisa Dubay, Linda J. Blumberg, Fredric E. Blavin and John L. Czajka. "Dynamics In Medicaid And SCHIP Eligibility Among Children In SCHIP's Early Years: Implications For Reauthorization," *Health Affairs*, 26, no. 5 (2007): 598-607, August 7, 2007.

uninsured individuals will cost money, and we need to convince stakeholders from all branches of government and from both sides of the aisle that this is money well spent. It also strikes me that enrolling people who are already eligible for public programs makes infinitely more sense than expanding the eligibility criteria to such a level that there is no longer an incentive for individuals to seek coverage on the private market even when they can afford it.

Enhancing Access and Expanding Involvement for Young Adults

Young adults are another group that deserves our collective attention, as getting them into the health insurance system would improve the profile of the overall risk pool – which in turn would make health insurance more affordable across the board. There are approximately 13.7 million young people aged 19 to 29 who lack health insurance coverage.[22] Researchers have highlighted the impact of the 19th birthday on eligibility for health insurance, as many young adults become ineligible for Medicaid and SCHIP, while others lose dependent status on their parents' employer-sponsored coverage. Because their young age tends to lend them better overall health status, the uninsured among this age group are often dubbed "young invincibles." While some of these young adults may indeed be uninsured because they do not feel they need coverage, it appears that, as with many other segments of the uninsured, affordability challenges are an overarching issue.

With a range of incomes represented among these nearly 14 million uninsured, clearly there is no one-size-fits-all solution for this age group. About 41 percent (5.6 million) of uninsured young adults live in households with incomes below the Federal Poverty Level (FPL). For many of them, the solution may rest in expanding access to Medicaid to childless adults with incomes below 100 percent of the FPL. Another 31 percent (4.2 million) have incomes between 100 percent and 200 percent of the FPL, and 29 percent (3.9 million) have incomes above 200 percent of the FPL. Many of the young people in this group would likely be aided by subsidies for purchase of private coverage, as sixty percent of all uninsured young adults say they do not purchase coverage because they cannot afford it. Products specifically targeted at "young invincibles" tend to be relatively inexpensive, making the decision to spend limited resources on insurance coverage an easier one for young adults.

Aetna has made significant strides to engage young adults in the market through our college student plans. Aetna Student Health offers 450,000 students and their dependents health insurance benefits through 170 colleges and universities nationwide, which can select among different options. A critical component of Aetna Student Health's success is the large provider network – consisting of more than 807,000 network providers – available to students across the country. We have found this feature to be particularly important, since many colleges and universities have reported that over half of their student body is from out-of-state.

[22] Kriss, Jennifer, Sara R. Collins, Bisundev Mahato, Elise Gould and Cathy Schoen. "Rites of Passage? Why Young Adults Become Uninsured and How New Policies Can Help, 2008 Update," The Commonwealth Fund, May 2008.

Ensuring the Participating of Higher-Income Individuals

Let me highlight a third segment of the uninsured – the 20 percent (9.2 million) with annual household incomes exceeding $75,000. While their ability to afford health insurance depends on health status and family size, among other factors, there is no question that a significant proportion of this group could afford, or at least make sizeable contributions toward the cost of, health insurance. In particular, those with no high-risk health conditions should find health insurance especially accessible. To those for whom affordability remains a challenge, tax credits and other subsidies could be leveraged to facilitate their participation in the health insurance market.

The health care challenges associated with these groups represent a key reason why Aetna began speaking out in support of an individual coverage requirement back in 2004. We believe that universal coverage requires universal participation. Having the participation of all individuals is one of the most important tools, if not the most important tool, for drastically improving the performance of insurance markets. Insurance should not be something you wait to purchase until you know you are going to need medical care. Insurance is a mechanism for mutual aid, founded on the principle that each one of us pays into the system even when we are healthy, with the knowledge that, should we become sick, we will be taken care of, since currently healthy individuals are also paying into the system. Under this conception, insurers function as the conduit for this mutual aid mechanism, and at Aetna, we provide a long list of value-added services, including wellness programs, disease management, health information technology and transparency tools, all with the aim of keeping people healthier and helping them navigate the health care system. In order for health-related and financial benefits of health insurance to be realized, all people must be expected to participate in the system.

Conclusion

There is no question that solving the problem of the uninsured is a difficult challenge. But it is not an insurmountable challenge if we, as a nation, are willing to tackle it head on. If there is one point I would like to emphasize, it is this: We need to recognize that sustainable reform will require addressing the inter-related areas of cost, quality, *and* access. Solutions that purport to be a silver bullet – or solutions that tackle one of these pieces without addressing the others – will not transform the health care system in a way that Americans deserve. We need to find sensible pairings of policy interventions (i.e., companion solutions) so that one "fix" does not create a new problem. We must recognize that tough trade-offs are necessary. And we must recognize that the private and public sectors can work together in partnership and in creative ways to ensure the existence of both a competitive marketplace *and* a robust public health system.

I appreciate the Committee's attention to this critical issue, and I hope you will continue to call on me and my industry colleagues to help identify and shape solutions. Thank you for inviting me to join you this morning.

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Attachment: To Your Health! Aetna's Proposal for Health Care System Transformation