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COVERING THE UNINSURED: MAKING HEALTH INSURANCE MARKETS WORK

HEARING

BEFORE THE

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COVERING THE UNINSURED: MAKING HEALTH INSURANCE MARKETS WORK

TUESDAY, SEPTEMBER 23, 2008

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:04 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Kerry, Wyden, Salazar, Grassley, and Hatch.

Also present: Democratic Staff: Bill Dauster, Deputy Staff Director and General Counsel; Billy Wynne, Health Counsel; Shawn Bishop, Professional Staff Member; and Yvette Fontenot, Professional Staff. Republican Staff: Mark Hayes, Health Policy Director and Chief Health Counsel; Michael Park, Health Policy Counsel; Kristin Bass, Health Policy Advisor; Susan Walden, Health Policy Advisor; and Rodney Whitlock, Health Policy Advisor.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

Let me begin today with a story of a young man named Jason. Jason is 30 years old and lives in New Mexico. He works at a hotel. He is the manager for a chain that does not offer health benefits. Last year, Jason temporarily lost his eyesight. The doctors said he had type II diabetes and that was the cause. After that, Jason applied for health insurance on his own. The insurance companies turned him down. Shortly after that, a serious case of the flu sent Jason to the hospital. His bills added up to $20,000. That is a lot of debt for Jason, especially on a hotel manager's salary.

Sadly, Jason's story is not at all unusual. States are the primary regulators of the individual health insurance market, but without strict rules insurance companies can, and often do, avoid risk by denying coverage to people who have health conditions like diabetes or a history of health problems.

Insurance companies often deny insurance to people who have had cancer, for example, until they show years of remission. Women often fare worse than men in the individual insurance market. New research shows that insurance companies often charge women much higher premiums than men of the same age and health status. In some States, insurance companies can deny women coverage if they have had a Cesarean section.

Some States have stepped in to make insurance policies more affordable, but insurance companies can still charge sky-high premiums that hobble family finances.

Let me read from a letter that I received from Ken and Shirley Wagner. The Wagners are sheep ranchers in central Montana. Here is what they say: "The insurance we managed to secure has a $5,000 deductible and a co-pay, meaning we will owe another $5,500. But we feel fortunate. Until June of 2005, we were paying nearly $1,000 per month for a policy with a $10,000 deductible and co-pays."

The Wagners, both middle-aged, say that they are looking forward to when they can get Medicare. They believe that their situation "isn't near as bad as young people who own small businesses, work for companies that don't pay insurance, or are in agriculture."

Like Jason, the Wagner's story is all too common. According to a recent Commonwealth Fund study, 3 out of 5 working aged adults found it difficult or impossible to find affordable coverage. Insurance companies turned down 1 out of 5 people who applied for individual coverage due to preexisting conditions, and almost 9 out of 10 working aged adults who sought coverage in the individual market from 2003 to 2006 ended up never getting insurance. Clearly, the individual market for health insurance is broken.

In group markets, Congress has enacted several laws to govern insurance practices. But small companies who want health coverage for their employees still have to struggle mightily to offer insurance. At our June 10 hearing, Ray Arth, the owner of a Midwest faucet company, told us that he has always provided health coverage to his employees. But offering coverage has become increasingly difficult because his employees are aging and premiums have grown. Even after switching everyone to a high-deductible plan, his company's premiums increased by more than 30 percent in 1 year. Why? Because one of his employees became seriously ill.

The insurance market for large groups appears to work better. That is because large groups naturally spread the risk. But I often hear from large employers that they, too, find it more difficult to afford coverage, especially with the retirees. Premium increases are forcing them to scale back benefits or to shift costs to employees.

Today we will explore ways to make health insurance markets work better. Let us improve these markets so that millions of people like Jason can buy insurance. Let us improve these markets so that millions of families, like the Wagners, can afford to keep it. Let us improve health insurance markets so that businesses that want to do the right thing for their employees can afford to do so.

Senator Grassley?

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. We have had a good set of hearings. We started off with two former secretaries of HHS. The committee has examined why costs are rising, but quality does not appear to be improving at the same rate. We have looked at who is uninsured and why they are uninsured. We have explored how the tax code impacts health care coverage and what changes could be made that

would increase coverage. We have considered delivery system and payment system reform.

In this hearing, we are going to look at health insurance markets. It seems as though they do not work very well. It varies widely depending on what State you live in. The price differences for health insurance between New Jersey and Pennsylvania, two bordering States, are typically cited as an example of the impact of State regulation on the market. And, while such criticisms are sometimes warranted, the issue seems to be much more complex.

States govern small group plans and individual plans. Those are the most expensive policies to sell, and that has nothing to do with State regulation. Those policies are expensive because the cost to sell and administer them is higher. When you sell to one person at a time, it costs more than when you sell to groups of hundreds or more.

It is expensive because people getting coverage that way often tend to be sicker. It is expensive because there is virtually no tax subsidy for an individual who is buying coverage in the individual market. Yet, if we simply require insurers to take everyone who applies, then of course people will wait until they are sick to get the coverage.

Now, Massachusetts has addressed this by requiring everybody to have insurance. That State's experiment is in its second year. We are going to hear how it is working. Time will tell whether having a law requiring people to buy health insurance means that people actually buy it. Many States require drivers to have car insurance, but that is difficult to enforce. So we will hear about how it is going in Massachusetts.

I am also interested in how insurers determine the rate they charge small businesses and the rate that they charge individuals. The National Association of Insurance Commissioners has two model acts that address rating in small group markets: one limits variation and premiums based on health status, in other words, using rate bands; another allows for variation based on age, geography, and family. More States have adopted the first model than the second model.

So, States are experimenting with different ideas in regulating health insurance. Some States have functioning high-risk pools, other States are thinking about trying reinsurance to help with very expensive cases. All are ideas that have merit, and all these ideas should be examined as we consider health care reform ideas.

As we know, in 1974 the Federal Government used ERISA to limit the ability of States to regulate pensions and health insurance provided by employers. To the extent that an employer provides coverage, it cannot discriminate against sick people. Everyone who takes group coverage must be charged the same rate regardless of age or health status. That is essentially guaranteed issue and community rating.

Every big business in America that offers health insurance must live under those rules. But when a State talks about imposing those same rules on the products it regulates, the State insurance market could disintegrate. As we look at health reform, we need to understand what works and what does not work in developing rules for the insurance market.

One last request, Mr. Chairman. I may have some additional information to insert into the record that is related to this hearing. If there is no objection, I would like to be able to insert this information at a later date, as long as the hearing record is still open.

The CHAIRMAN. Without objection.

Senator GRASSLEY. I am done.

The CHAIRMAN. All right. Thank you.

I would now like to turn to our witnesses. First, we will hear from Mr. John Bertko, who is currently adjunct staff at RAND and former chief actuary at Humana. The second witness is Mr. Andrew Dreyfus, executive vice president for health care services at Blue Cross Blue Shield of Massachusetts. The third witness is Ms. Pam MacEwan. She is the executive vice president for public affairs and governance at Group Health Cooperative. Finally, we will hear from Ms. Kim Holland, who is the Oklahoma Insurance Commissioner.

As a reminder, all written statements will be automatically included in the record. I would ask each of you to confine your remarks to 5 minutes.

Mr. Bertko, why don't you begin? And say whatever you want to say. Do not be bashful. Do not be shy.

STATEMENT OF JOHN BERTKO, F.S.A., M.A.A.A., ADJUNCT STAFF, THE RAND CORPORATION, AND FORMER CHIEF ACTUARY, HUMANA INC., FLAGSTAFF, AZ

Mr. BERTKO. Senator Baucus, Ranking Member Grassley, members of the committee, my name is John Bertko, and I am honored to have the opportunity to testify before you today about the rating practices of private health insurance markets.

The market is frequently described as having three separate segments: the individual insurance market, the small group segment of employers who have 2 to 50 employees, and a large group segment for employers of more than 50 employees. Each of these segments has different rating practices and regulations.

To give you an idea of the size of these markets, there are about 17 million covered individuals in the individual insurance market, about 30 million in the small group market, and more than 120 million in the large group market.

Rating practices differ for each of the segments and also differ by State. Premium regulation is mainly by State insurance law, but also follows the requirements of several Federal laws, including ERISA, COBRA, and HIPAA. I will provide a very brief summary.

For the individual insurance market, there are two distinct approaches to rating methods allowed by States. In five States, insurers must offer policies to all applicants called guaranteed issue, and are limited to rates that are similar regardless of health status, which is called adjusted community rating. So for these States, rates will vary by age and gender, but not health conditions.

In all the other States, individual health insurance policies are underwritten, meaning that the past health conditions of individuals are examined and rates are set accordingly. Generally, there are three possible outcomes for underwriting: an applicant answers a variety of health status questions and is underwritten as a standard risk and receives an offer of insurance at rates that are gen-

erally lower than those for employees because they are healthier at the time of issue; an applicant with some past or current health conditions might be offered a policy at higher rates, called a rate-up, or have certain specified conditions excluded, called a pre-ex offer; and finally, some applicants with more serious health conditions will be denied coverage.

In the underwritten markets, about 70 percent of applicants will generally qualify for standard policies, about 15 to 20 percent will get either rate-ups or pre-ex conditions, and between 10 and 15 percent generally will be denied coverage.

Individual health insurance rates in these States that allow underwriting can vary with age, gender, and health status. On average, for the under 65 population, rates may vary by an actuarial factor of 6:1, based on mainly their age. Then any rate-ups for health status generally yield rates that are somewhere between 110 and 200 percent of standard rates.

In 32 States, individuals who are denied coverage might be able to obtain coverage from high-risk pools if they can afford the high-risk premium and there is capacity in the pool. About 200,000 Americans now are covered in high-risk pools, and premiums in the high-risk pool are usually 200 to 250 percent of standard premiums, and also heavily subsidized by either insurance assessments or other funding sources. Access to the high-risk pool is generally limited by the amount of subsidy available in the State and by the ability of the applicant to afford the higher premium.

In the small group market, all States have followed the HIPAA provisions and require guaranteed issue. This means that any small employer will be made an offer of insurance as long as certain requirements are met, such as minimum employer contributions. Premium rates in the small group market are generally subject to rate band limitations, so rates are first determined based on case characteristics such as age and gender of employees, location, number of employees, and type of product. That determines an average rate.

Then in most States, a factor for health status or industry is applied to calculate premium rates within certain rate bands. Model legislation from the NAIC specifies that the rates may deviate from the manual rate by no more than plus or minus 35 percent, but there is a lot of variation. The most common rate band is plus or minus 25 percent. There are a few States that also specify adjusted community rating in which there is no variation by health status.

For the large employers with more than 50 employees, premium rates are determined mostly from the firm's claim experience or from a blended average with the average rates. Regulation of this market is split between limited State regulation and ERISA, and large self-insured employers use the ERISA exemption from State regulation to offer the same benefits for multi-state locations.

Thank you for the opportunity to provide this summary. I would be glad to answer questions about my testimony.

The CHAIRMAN. Thank you, Mr. Bertko.

[The prepared statement of Mr. Bertko appears in the appendix.]

The CHAIRMAN. Mr. Dreyfus?

STATEMENT OF ANDREW DREYFUS, EXECUTIVE VICE PRESIDENT, HEALTH CARE SERVICES, BLUE CROSS BLUE SHIELD OF MASSACHUSETTS, BOSTON, MA

Mr. DREYFUS. Mr. Chairman, Senator Grassley, and members of the committee, my name is Andrew Dreyfus, and I am the executive vice president of Blue Cross Blue Shield of Massachusetts.

Blue Cross Blue Shield of Massachusetts is a not-for-profit health plan that covers 3 million members. Our company and our foundation played a major role in developing and supporting our health reform law, and we remain committed to its success.

Under the leadership of our chairman and CEO Cleve Killingsworth, our company has also set a broader goal: to collaborate with others to transform the health care delivery system in Massachusetts to provide safe, effective, and affordable patient-centered care for all.

I would like to make four points in my testimony today. First, health care reform is working in Massachusetts. We believe that our experience has important lessons for State and national efforts to expand coverage. Second, insurance market changes played an important role in supporting our coverage expansions. Third, those coverage expansions are at risk if we do not slow the growth in health care costs. And finally, we believe that the most promising route to slowing costs is by changing our payment system to reward high-quality, efficient care. In other words, insurance reform is not enough, we need payment reform as well.

Let me touch on each of these points, briefly. Massachusetts's health care reform was signed into law 2½ years ago, and I am pleased to report that, while challenges remain, the law has been very successful thus far. Recent State reports document that 439,000 previously uninsured residents now have coverage. The latest U.S. Census report found that Massachusetts has the lowest rate of uninsured in the nation.

How did we achieve so much so quickly? We began with a fertile climate for reform. We had a low percentage of uninsured and strong employer-based coverage. We were already spending $1 billion annually on care for the uninsured. We were already operating in a regulated insurance market with guaranteed issue, prohibitions on medical underwriting, and modified community rating. We had a generous Medicaid program called Mass Health, thanks to a history of strong Federal support. Finally, we had a strong community and political commitment to the unifying principle of shared responsibility, and I want to thank Senators Kerry and Kennedy for their unwavering support of that principle.

This principle of shared responsibility provided the framework for the law's main coverage provisions, which included expanded Medicaid eligibility for children, a new subsidized program called Commonwealth Care, a requirement that all State residents purchase health insurance, and a separate requirement that employers pay a fee to the State unless they make a fair and reasonable contribution to the health coverage of their employees. Collectively, these programs and requirements have resulted in a dramatic drop in the number of uninsured.

In addition to these changes, the health care reform law also included three key provisions to allow private health plans to develop

more affordable insurance products. The most important change was the merger of the existing individual and small group markets. That merger resulted in an average 15-percent decrease in rates for individuals, and a modest 2-percent increase for small groups.

In addition to the market merger, reforms were enacted to allow greater flexibility in health plan design, including the creation of special low-cost products for young adults.

Finally, the law created the Massachusetts Health Insurance Connector, a new, independent, quasi-public entity to connect individuals and small businesses with affordable private health insurance plans. The Connector has several important roles: it administers the subsidized program; it determines a schedule of affordability and the minimum level of coverage required to meet the State's individual mandate; it certifies products of high value and good quality and makes them available to small groups; and, finally, it collects premium payments from those seeking coverage and remits those payments to the appropriate insurer.

In our experience, the Connector provides an important service by increasing awareness of insurance products and helping individuals compare products from different health plans.

But as I said, it is the cost challenge which is really facing the Massachusetts reform movement right now; higher than expected enrollment in the subsidized plan has created a shortfall in funding. But beyond these short-term budget issues, our new law faces the underlying challenge of growing medical costs which pose an increasing burden on consumers, employers, and government alike. Without enduring solutions to health care costs, our historic coverage experiment will be at risk. In Massachusetts, we view this new search for cost solutions as Health Care Reform Part II.

Let me just conclude by saying as I said in the beginning—and I know in your last hearing you spent a good deal of time on this issue—we believe that the best way to slow the rate of growth in costs is by changing the way we pay for care, by rewarding quality of care, not volume and intensity of care. We have a plan that we are working on right now in Massachusetts to do just that, and we would welcome your comments and questions on that plan.

Thank you for the opportunity to testify today.

The CHAIRMAN. Thank you, Mr. Dreyfus.

[The prepared statement of Mr. Dreyfus appears in the appendix.]

The CHAIRMAN. Ms. MacEwan?

STATEMENT OF PAM MacEWAN, EXECUTIVE VICE PRESIDENT, PUBLIC AFFAIRS AND GOVERNANCE, GROUP HEALTH COOPERATIVE, SEATTLE, WA

Ms. MACEWAN. Good morning, members of the Finance Committee. I am Pam MacEwan, executive vice president for public affairs at Group Health, an integrated health care coverage and delivery system based in Seattle, WA. Thank you for inviting me to be here this morning.

Let me begin by describing the Washington State insurance market. Washington's insurance market provides affordable, high-quality insurance products to consumers through the use of premium rating protections and the availability of a high-risk pool. In

Washington, insurance cannot be denied to any applicants for coverage if they are part of a group. This is called guaranteed issue. However, exclusions and waiting periods are allowable for preexisting conditions to prevent people from waiting until they get sick to enroll in their employer's coverage.

Washington has struck an interesting balance for the individual market. Everyone has access to coverage, either through the individual market or through the State's high-risk pool. Washington employs a State-mandated health status questionnaire for individual coverage.

Those without previous continuous coverage who score higher may be denied coverage on the individual market, but will automatically be offered enrollment in the State high-risk pool. Generally, people who have complex medical conditions such as AIDS or cancer, or a combination of conditions such as diabetes and chronic hepatitis, would score high enough on the questionnaire to be screened out of the high-risk pool.

For both the small group and the individual markets in Washington, monthly premiums are guided by what we call adjusted community rating, which means that carriers can only adjust premiums by demographic factors such as age, geography, family size, or by enrollees' participation in certain wellness activities. This system of rating constrains the amount of variability between the premiums different individuals or small groups can pay, thereby spreading the risk of the population's health status among more people.

For a brief time, our market was much more regulated than it is today. In the 1990s, I was a member of the Washington State Health Service Commission, working to implement the Health Services Act passed in 1993. Under the bill's sweeping reforms, everyone would have been required to have coverage through an employer or an individual mandate.

Unfortunately, things did not play out the way we had planned. The law allowed the insurance commissioner to implement certain changes before the full reforms took effect. This meant that some changes—guaranteed issue, reducing preexisting exclusion periods, and establishing a 3-month open enrollment period where people were allowed to sign up with no waiting or limitations—were put into effect without any of the underpinnings designed to make the system sustainable.

There was no requirement that people enroll before they got sick, no individual mandate, and no risk adjustment mechanism in place. Soon afterwards, a change in political climate resulted in the repeal of most of the law and the mandates, but the changes in the insurance regulation were allowed to stand.

As a result, many individuals with serious health care needs signed up for coverage. This rapidly led to a classic adverse risk spiral in the marketplace. In short order, claims costs for many health insurers were exceeding their premium collections.

Community rating in this context meant that everyone's premiums went up significantly. More individuals decided not to take coverage. The individual market collapsed when the two major carriers, Blue Cross and Blue Shield, closed enrollment in the indi-

vidual market. Group Health soon followed suit because of adverse selection.

We learned four things from this experience: first, that rules governing the insurance market must protect the consumer, but also must make allowances so that massive adverse selection does not drive insurers out of the market; second, that insurance reforms will only be successful if there is an individual mandate to balance risk in the insured population; third, as long as you have an individual mandate, some people will need financial subsidies in order to be able to purchase insurance; and, finally, we have learned that, in reforming the insurance marketplace, both individuals and small businesses want flexibility in what they purchase.

One of today's challenges is that States are playing by different sets of rules. Some States do not have high-risk pools. And, while Washington's adjusted community rating system keeps variation between premiums fairly low, a person with a severe medical profile in some other States would pay up to 9 times more than a healthy individual for the same coverage.

I am not saying that Washington is perfect—in fact, we are working hard to achieve further reforms. But the Federal Government can play an important role in studying what various State insurance rules have achieved, supporting those that work and State-based rules that work, while recognizing the unique nature of regional markets. This will be critical if the Federal Government considers implementing marketplace mechanisms like the Massachusetts Connector on a national stage. Absent sensitivity to regional markets, such an approach could squash regional innovation.

As the Federal Government considers insurance market reforms, it will be important to protect States like Washington that have developed markets that are more generous to the consumers and that work. Proposals allowing insurance to be sold across State lines based on the regulatory framework of the State of domicile of the carrier would severely destabilize our markets.

I want to tell a story that illustrates Group Health's unique perspective. Back in March, a man named Fred Watley from Spokane, WA needed a liver transplant. But when the time came for him to get his new liver, he found that since his employer, a small group, had transferred over to Group Health, he had entered into a new 6-month waiting period for a transplant.

Even though Mr. Watley had been continuously covered with health insurance for years, he would have to stand a new waiting period. Group Health doctors wanted him to receive the transplant, but legally that would have meant he was on the hook for the costs. Not only would that have been unfair, that would have been a death sentence for him.

So we decided to change our policies, to change the rules. We broke ranks with Washington State's insurers and we approved his transplant. He got his new liver, and over the following days we very proactively worked with our insurance commissioner and with other health carriers in the State and agreed to work on changing the rules going forward. In the next legislative session, we will be working to assure that others in Mr. Watley's situation will be able to get the care that they need.

A solution to Mr. Watley's case was relatively simple when we were willing to think differently, and thankfully it was also possible without waiting for a statutory change. As I hope I have illustrated, most problems in the insurance system are not so quickly solved by the private sector. Regulatory strategies will require delicate balancing between State and Federal Governments. We urgently need coordinated action to improve both the insurance market and our Nation's system of care.

Thank you.

The CHAIRMAN. Thank you very much, Ms. MacEwan.

[The prepared statement of Ms. MacEwan appears in the appendix.]

The CHAIRMAN. Next, Ms. Holland. Thank you.

STATEMENT OF KIM HOLLAND, OKLAHOMA INSURANCE COMMISSIONER, OKLAHOMA CITY, OK

Ms. HOLLAND. Chairman Baucus, members of the committee, thank you for holding these hearings. Thank you for allowing me to address you this morning.

My name is Kim Holland. I hold the elective office of Insurance Commissioner for the State of Oklahoma. Prior to this service, I spent 25 years counseling individuals and businesses on their health insurance purchases and served on various boards and commissions dealing with our health care delivery system, including Oklahoma's State Medicaid Agency Board.

I have developed a keen awareness of the myriad and complex issues that affect the cost of health insurance and, like you, some passionate opinions about what we must accomplish to improve health care access and quality for all Americans.

The written text of my testimony describes how States and State regulators are working to address the high cost of health insurance. I describe in detail the commonly adopted rating models that have effectively created State-wide pooling and explained States' concerns over multi-state pooling concepts that create adverse selection and market disruption, and on behalf of many of my colleagues at the National Association of Insurance Commissioners, offer suggestions on how the Federal Government can help us in our common goal to improve the quality of life of our citizens.

However, for the few moments I have to speak with you today I am going to talk to you about Oklahoma, not because our issues are unique, precisely because they are not. They are the issues that many States—and in some instances all States—are grappling with.

I love my State, but when it comes to the health and health care of our citizens, we are pretty sad. Oklahoma ranks dead last in terms of the overall health of our population and in the performance of our health care system. We have the 5th-highest number of uninsured in our Nation, with over 650,000 hard-working men and women worrying over whether they can get the care they need when they need it without insurance. We are a poor State in terms of wages. Our average per capita income is well below the national average.

The cost of treatment for our uninsured has had staggering consequences in our State, adding $954 million annually to the cost of

care and coverage, and perversely resulting in the growing numbers of uninsured. I adamantly support State-based health care reforms as the best means of meeting the distinct and diverse needs of our populations. Under our leadership, Oklahomans from all walks of life in all four corners of the State have, and are participating in the creation of a plan for systemic reform.

Similar initiatives are occurring in virtually every State in the Nation, but our progress is hampered by inequities in the distribution of Federal resources and archaic Federal laws that have created their own adverse selection among programs and between States, and contribute to our inability to improve access and care to our citizens.

To illustrate our challenges, first, Insure Oklahoma, our innovative premium assistance plan, is funded in part by a Medicaid waiver. This public/private partnership has made it possible for thousands of lower-income adults to afford private insurance through their small business employers.

Our efforts for a much-needed expansion of the program to cover children of working families and college students has languished in the hands of CMS for 14 months, marking it as the longest waiver review process in our history and one that has been fraught with unlegislated policy changes at CMS. Particularly troublesome to us is that many jurisdictions have received approval for waivers during this same time period that do not meet CMS's own policies for use of Medicaid funds.

Oklahoma is second only to California in the number of residents identified as American Indians/Alaska Natives. Oklahoma's per capita health care appropriation for the Indian Health Service population is less than half of the nationwide average. The amount we receive represents only 44 percent of the actual need, and makes Oklahoma the lowest funded area within IHS.

Federal disproportionate share hospital funds, or DSH, provide financial support to hospitals that treat a disproportionately high percentage of low-income population. In spite of our high poverty rates, DSH allocations to Oklahoma are microscopically low, as they are in Senator Grassley's State of Iowa, while other States receive significant funding, in some instances more than they can use.

Lastly, self-funded health plans, exempt from my regulation due to Federal preemption under ERISA, do not pay the State taxes that could be used to fund health care reform, are preempted from the assessment that funds our high-risk pool although their employees have equal access to the benefits, and are known to dump employees into social programs through plan designs that would not be allowed by State regulators.

I am not saying we take from one to give to another; we have done that and it does not work. I am saying that real reform cannot occur until we get everyone covered, and that will not occur until we eliminate the vast funding disparities and inequities created by existing Federal policy. That should be the first step in any national reform plan.

I am saying that we must marshal the necessary political will and resources to ensure that every American, regardless of where

they reside, will have access to affordable health insurance and high-quality health care. Thank you.

The CHAIRMAN. Thank you very much.

[The prepared statement of Ms. Holland appears in the appendix.]

The CHAIRMAN. I would like to go back to, I guess, one point you made, Mr. Dreyfus, with respect to the Massachusetts plan. That is, one way to get at costs is to, I guess, better align payment.

Mr. DREYFUS. Yes.

The CHAIRMAN. Could you go into that in more detail and explain why you think that will cut costs? That is sort of the more, if not the concept of the day, it is certainly a concept that is getting more current note. I would like you to just explore that a little bit more, please.

Mr. DREYFUS. Absolutely. We are looking at the whole range of efforts to slow health spending, from e-technology to better management of patients with chronic illness. But the fundamental problem we see is that our payment system rewards volume, rewards activity, rewards complexity and intensity. I regularly talk to physicians and hospital leaders, and I ask them, what percentage of the care that you provide is unnecessary? In the quiet of a room, they will tell me 20, 30 percent.

The question is, how do we get that care out of the system because it is not clinically effective, and in some cases actually harmful, for patients? They say, well, what we are paid for is what we do. We are paid for visits and we are paid for hospital admissions and we are paid for tests. Yes, there are other factors that come in there, such as malpractice environments, but it is really the payment system.

So what we have done is, we have developed a new payment model which combines a fixed global payment, adjusted for health status and adjusted for inflation, with significant performance incentives. We are starting to pioneer this with several large physician practices and hospitals in Massachusetts. For those physicians and hospitals that see it as their strategic future to be the high value provider in their market, high quality and efficient, this system should help them thrive and grow, and they are open to it.

But what I would just add is that we would love to have a partner at the Federal level. So, when we talk to physicians and hospitals about our new payment model, they often say, well, this looks great, but Blue Cross, you only represent 25 or 30 percent of our revenue; Medicare represents another 40 percent.

So, if Medicare were paying us the way you were paying us, that would really change the way we practice care, allow us to be paid for telephone visits, for electronic visits, for group visits, for prevention, for home visits, for care management, all the elements of care that I think we would all say we would want for ourselves and our family.

The CHAIRMAN. Are you able to quantify that in any way, quantify the cost savings?

Mr. DREYFUS. Yes. We have done models and we have actuaries as well that have looked at this very carefully. Health care costs in Massachusetts are currently growing at about 11 percent per year, which again is one of the reasons why our health reform ex-

periment could be at risk over time. We believe that this new payment model could, over time, over a 3- to 5-year period, cut the rate of growth in half, to closer to 5 or 6 percent.

So, in other words, we are trying to bring medical inflation down to something more closely resembling overall inflation, and we think we could do that principally again by eliminating unnecessary care, by eliminating harmful care, and by providing the care that patients really need.

The CHAIRMAN. So more specifically, what would you suggest this committee ask of Medicare?

Mr. DREYFUS. Well, what we would ask of Medicare is, Medicare has had a few small demonstration projects and experiments, which in some cases are showing that new payment models can work. We would ask that we expand that, that we consider Medicare waivers in addition to Medicaid waivers to allow States to experiment with new payment models, and to kind of liberate the kind of constraints of the existing payment system. Especially if physicians and hospitals are willing to work under a new payment model, we think we should allow that to work.

The CHAIRMAN. All right.

Mr. Bertko, I am trying to get at what can be done in terms of individual market reforms. We mentioned guaranteed issue, community rating, and also guaranteed renewability. To what degree is a mandate required and necessary to accomplish these reforms?

Mr. BERTKO. Senator Baucus, an interesting question. I think that a mandate could be a clear and straightforward way to do that, but I do not think it is a necessary way to get there. States have tried a variety of ways. I applaud Massachusetts for what it has tried. In the absence of a mandate, though, if you have guaranteed issue, it means there will be risk selection. Ms. MacEwan described what happened in Washington State, and I think that is likely.

So you would need to take some other issues—for example, looking at waiting periods, looking at standard open enrollment periods, things like that. Use of either risk adjustment, which would spread the risk of enrolling one particular group of high-cost people, or reinsurance could be used. So I think there are a variety of tools that actuaries could use to make it work in either way. The mandate has a lot of appeal in some places, but it also comes with a number of complications.

Finally, application of whether you use rating bands or adjusted community rating also have implications on the amount of cross-subsidization between high-cost individuals and people at lower expense.

The CHAIRMAN. Well, my time has expired.

Senator Grassley?

Senator GRASSLEY. Yes. I am going to start with Mr. Dreyfus and Ms. MacEwan. We have a situation, Mr. Dreyfus, in your State. It chose to require all of its residents to have health insurance. In Ms. MacEwan's testimony, you imply that Washington State should not have repealed its individual mandate.

So the question is about enforcement. States have a terrible time even in enforcing drivers having car insurance. Mr. Dreyfus, would you remind us how Massachusetts is enforcing its mandate? Ms.

MacEwan, how would you have Washington enforce such a requirement?

Mr. DREYFUS. Thank you, Senator Grassley. The enforcement of the mandate was done in stages. It is done by our State Revenue Department. Initially, those who did not comply with the mandate would lose their personal tax exemption, which was worth about $500 a year. In the following year, the penalty increased up to about $950 a year.

There are exceptions. There is an affordability schedule, an appeal process, and some people have appealed. Certain people whose income was deemed not high enough to be able to purchase affordable coverage were excused from the individual mandate. So it is still early in our State, but the health reform law remains very popular. There has not been a kind of uprising. And, while we may not get 100-percent compliance and enforcement, as you point out with auto insurance, we think we will get very close.

Ms. MACEWAN. The 1993 Health Services Act, I think, was vulnerable in a couple of respects. One is that it did not have strong bipartisan support and there was not a good plan for enforcing the individual mandate. I believe that is why it was repealed. I think that the steps that Massachusetts has taken make a lot of sense. Washington does not have an individual income tax, which takes away some possibilities for enforcement.

So, first, I think you need broad bipartisan support so you have the sustainability of the rule, so that you have the support for people to move forward. Then you need to work through other mechanisms to encourage enforcement. But it is very challenging to enforce an individual mandate, and it is challenging to think about what the remedy would be for not complying.

Senator GRASSLEY. On another subject, Mr. Dreyfus, we have discussed the idea of a connector like that in Massachusetts. They have assumed it will improve the efficiency of the health insurance system. To pay for the Connector, it is my understanding that in Massachusetts there is a 4.5-percent administrative surcharge on every health insurance policy sold in the State.

Two questions: does the Connector reduce any of Blue Cross's administrative expense such as your advertising, sales, or enrollment functions; and two, will you please explain to me what advantage the Connector system brings to the system, if you say that there is an advantage?

Mr. DREYFUS. Yes. The Connector does reduce our costs somewhat in two respects. First, part of that 4 percent pays for broker fees and commissions, so that is not a payment we have to make. Second, the Connector actually contracts with what they call a sub-Connector that does the initial intake for the policies. So there is some lower cost, but I would say that that 4 percent ultimately is spread across our entire now merged individual and small group market.

In terms of the value the Connector plays, first of all, I think it has played an important role in helping to publicize the mandate and the need for coverage, and then enrolling people, particularly in the subsidized plan. They have played a very important role in that.

They have worked very hard to settle some very thorny public policy questions about what should be a minimum level of coverage and what should be a schedule for affordability that would allow people to be exempted from the mandate. I think in our case, the legislature set broad parameters and sent it to the administrative agency that has a board that is made up of both public officials and private sector leaders to work out some of these complex public policy trade-offs.

Senator GRASSLEY. All right.

And Mr. Bertko and Ms. Holland, there have been calls to require insurance to provide coverage to anyone who wants it and at a price that would not take into account health status. In States that have tried this, what has been the effect on the price of premiums and the choice of products in the market? Mr. Bertko, then Ms. Holland, and then that will be my last question.

Mr. BERTKO. Senator Grassley, in general when guaranteed issue is implemented, what happens is that in a previously underwritten market rates will generally go upwards. This is because the healthiest people would have gotten the lowest rates before, and now we are making an offer of insurance to anyone that comes in.

There is a secondary effect. When the healthiest people then find their rates go up, they may be less likely to purchase insurance—the economists call this elasticity—and so as a result the average rates go from insuring mostly the healthiest at issue to closer to an average rate. So, in general, rates are going to rise.

Senator GRASSLEY. Ms. Holland?

Ms. HOLLAND. And I will add to Mr. Bertko's comments, Senator, by just saying, in an environment where one does not have a highly insured population, what occurs when costs go up is, obviously, it has the consequence of having people drop off the coverage.

It also, in an environment where you do not have a requirement that people purchase coverage, you can have an adverse selection situation, where the people who do take up insurance—if you are transitioning to a guaranteed issue environment, the first people who are going to come to the table and purchase are those who are most likely to need to use the benefit first. So it can have significant consequences depending on where you start and where you are moving.

Senator GRASSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Thank you, Senator.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. I thank the panel.

The first question is for you, Mr. Dreyfus and Ms. MacEwan. I believe today's private insurance model is inhumane. I think it is essentially about shedding risk. That is what you have to do to be successful, so companies cherry-pick and they go out and take the healthy people and send the sick people over to government programs more fragile than they are.

So what we have done here in the Senate, 16 of us, in the Healthy Americans Act, 8 Democrats, 8 Republicans, is we said we have to have a new business model in private insurance—not a government-run health plan, but in the private sector. What we have said is, everybody is required to show personal responsibility. They have to buy coverage. We have changed the tax law so as to

better target the subsidies of people who are in the middle-income and the lower middle-income brackets. Then we say the companies have to take all comers. They have to compete on the basis of price, benefit, and quality.

My question for you two is, do you not think that that is the kind of model in which responsible private insurers can be successful in the days ahead with those elements? Mr. Dreyfus?

Mr. DREYFUS. Sure. Thank you, Senator. Well, certainly many of the provisions that you just mentioned exist today in Massachusetts in a system in which we have both employer and individual participation. So I would say there is no cherry-picking in Massachusetts. It is not allowed. It is restricted by State regulation.

So, we believe that we can operate successfully on our current business model in a way that protects consumers, protects employers, and so we think the mixed employer-based model is working for us. I cannot speak for the experience of other States that do not have the level of insurance regulation that we have in our States.

Senator WYDEN. Ms. MacEwan, do you think that the model I described is the kind of model in which private insurers can be successful?

Ms. MACEWAN. I think that many of the elements that you described could work. I think that a lot of different regulatory models can work. I think, really, the devil is in the details and in building the political consensus to move towards a different model.

In Washington, we do take all comers. They either can go into the individual private market or they can go into the high-risk pool. One of the things that becomes, I think, inhumane in Washington is not the regulatory model, but that people cannot necessarily afford the cost of the high-risk pool and there are not really subsidies available to help them. So, it is complicated. I think the cost issue also drives problems. I thought the comments about what we needed to do about our payment system will help us all move towards a more humane system.

Senator WYDEN. Mr. Bertko, a question about cost containment. I think the story of the States—and we are all, of course, rooting for Massachusetts—is that they are doing a terrific job, given the fact that they have very little bandwidth. The major cost containment tools are all owned by the Federal Government. We are talking about the tax code, we are talking about ERISA, Medicare, Medicaid, even the graduate medical education program. Massachusetts is having this big challenge of getting enough workers, and the Federal Government controls, to a great extent, the workforce supply.

Do you share that view that, in order to really contain costs, the Federal Government and these Federal tools are going to have to be redeployed in a new partnership with the States because of this cost containment issue?

Mr. BERTKO. Senator Wyden, I share much of what you have said. I would describe it more as a partnership. I think perhaps, as Mr. Dreyfus said, about 50 percent of health care costs at the provider level—hospitals, for example—come from the private sector and about 50 to 60 percent from government programs. I am a MedPAC commissioner. I think you heard from Mark Miller, perhaps, in a previous session.

There are many things that need to be done on the Federal level. Medicare, in particular, can be a leader in all this. But then I would also suggest that the private sector, insurers like Blue Cross of Massachusetts and the Group Health cooperative, need to join in those efforts. They become combined efforts as opposed to only Federal efforts.

Senator WYDEN. I thank you.

One question for you, Ms. Holland. We admire very much the work you are doing at NAIC. I think probably the thing I have been proudest of in the health field was the work in the Medigap law back in the 1990s, where we got some standardization so that you could really compare private choices, and did it with the 10 alternatives, as you know, in the Medigap law. I still think some standardization of benefits—not complete, run-from-Washington standardization—is going to be important in health reform. What do you think?

Ms. HOLLAND. Thank you, Senator. Actually, I think there is some merit to that. One of the challenges I think that we are struggling with in terms of standardization of benefits comes from the lack of standardization in the delivery of medical care. They are all so intrinsically tied.

If I could give you an example of something I just dealt with in Oklahoma that was really heartbreaking. I had a family who had a daughter who was diagnosed with a type of brain cancer that was in a particular area of her brain, and the treatment for that was considered experimental because it did not provide any curative treatment and really offered only a small hope of continuation of her life. It was denied, in terms of the contract policy and the medical evidence, not inconsistent with what we see across the board. So, she did pass away a very short time afterward. The surgery might have cost $150,000, and was a stem cell replacement, but she was denied that care.

At the same time, I have a person in Oklahoma who is an HIV AIDS patient, an HIV hemophiliac who acquired AIDS through a transfusion. He decided, in spite of very, very poor health, he wanted a knee transplant. Against a doctor's orders, he said, I am entitled to this, my insurance will pay for it, I am going to have it. He had the surgery. He had all the consequential problems that his doctor warned him against. He is on medication that costs between $6 and $10 million every year—$6 and $10 million every year!

So I have on one hand the life of a 17-year-old that, for $150,000 we would not do that because of all the reasons, it is experimental or whatever, and at the same time a plan is paying $6 to $10 million a year on medication for the voluntary actions of an individual, because our system can. That is in the health care environment. I mean, that is not about insurance, that is about health care. I do think that it is so critical.

You have heard that point made already today that we understand how the two are tied together. Until we resolve the high cost of health care and grapple with some of those issues about how we do deliver the necessary and critical care to our citizens in an equitable way, we are going to continue to struggle with being able to afford health insurance, and all of these issues are going to be moot.

The CHAIRMAN. Thank you very much.

Senator, I regret that I have to leave to go manage a tax incentive bill on the floor in about 5 minutes, but Senator Rockefeller will take over.

Senator Salazar, you are next.

Senator SALAZAR. Thank you very much, Chairman Baucus.

My concern, frankly, for this committee is, we have spent so much time working on this health care reform issue and see it as being one of the major things that we would be working on in 2009 as a committee and trying to move forward with health care reform in a meaningful way, and yet this ominous cloud of $700 billion that we are trying to struggle with today, I think, may end up creating huge challenges for us as we try to deal with health care reform and other important priorities of the Nation into the coming year. So, it is something which looms large and ominous over all of us.

I have a question for any of you who want to respond to this. Mr. Dreyfus, you said that in Massachusetts, as you move forward with the implementation of your plan—and I applaud Massachusetts for moving forward with the kind of innovation and the pilot that it moved forward with—you are still facing the reality of these runaway costs. Eleven percent, you said, was the cost of health care this last year.

I think that we still do not know exactly how we are going to somehow bring those runaway costs under control. If you look back in terms of health care costs and how they have been rising from 1960 until today, it is this runaway train that we simply cannot slow down.

So I would like, starting with you, Mr. Dreyfus, and any of the rest of you, just give us some elaboration on how it is that you think we can get our hands on this runaway train.

Mr. DREYFUS. Well, I think one place to start would be to look much more closely at the variation in costs and quality in the Nation and within communities. So we know, for example, there are regions of the country that spend much less than, for example, we do in Massachusetts and achieve equal or better outcomes. What are they doing there? We know actually, within individual physician practices, there is great variation, for example, in how commonly a group of surgeons will perform back surgery.

Senator SALAZAR. So let me push you on that, though. We know that and we know the regional variations and we know the variations even within States.

Mr. DREYFUS. Right.

Senator SALAZAR. Do we figure out a way of setting up some kind of Federal medical protocol board that can help us standardize some of these treatments? How do we ultimately get at that disparity?

Mr. DREYFUS. I think, two things. First of all, I know this committee has looked at the issue of establishing a comparative cost effectiveness institute at the national level, and we think it is time for that kind of Federal intervention. But at the local level, there is a lot we can do.

We are beginning to experiment with—often health plans have much better data than physicians and hospitals themselves do. So

we are starting to experiment with giving physicians their own information about the variation and in their own practice because, when they have that information, they actually often want to change.

So, if we can give a group of surgeons comparative information about how often they are using MRIs and other high-tech imaging, how often they are prescribing expensive medications, how often they are performing surgery as opposed to considering less expensive interventions, their behavior would actually change.

Senator SALAZAR. Would that be better done at the State level and let 50 States go ahead and do their own thing, or would it be better for us as a national initiative to say this is what we are going to do across the country?

Mr. DREYFUS. What I would say is, I think the Federal Government can set standards, such as could be done by a comparative cost effectiveness institute, and then let, not even State communities, but local communities—it's really practice-by-practice, hospital-by-hospital—go in and help show people their variation, how they perform, how they compare to their peers, and I think we will get change. I think, national standards with local interventions.

Senator SALAZAR. Mr. Bertko?

Mr. BERTKO. Yes. Just to add to that, I will use a different phrase for what I think Mr. Dreyfus said: using resource use information. MedPAC is on record for saying we should use the Medicare data files to do that. I suggest that, at a Federal level, that is more practical, because in most States information is split among 4, 5, 10 different insurers. The amount of data that is in the Medicare file is enough to look at everyone and determine which physicians are using more imaging, which are using more of other things.

I would also suggest, and I think this is a similar statement, that we need to change the payment incentives. Most private insurance, as well as Medicare, is done on a fee-for-service basis. We have had discussions about bundling payments together so that hospitals and physicians work together, driving primary care as being one of the important parts of the system's capacity.

Then lastly, I, too, would recommend establishing a comparative effectiveness board to take care of where a health care trend is going—that is, the inflation factor—over the long run, because we need to know better what works and what is evidence-based and what is an appropriate use of services.

Senator SALAZAR. With the permission of the chair, may I have each of the other witnesses respond for 10 seconds or so?

Senator ROCKEFELLER. Yes.

Senator SALAZAR. Ms. MacEwan?

Ms. MACEWAN. I would agree with what Mr. Dreyfus and Mr. Bertko said. I think the only thing I would have to add to it is, we are currently rewarding the system for doing more, doing what is unnecessary. That is really how to earn more. I am not saying that all physicians and systems make those decisions, but there is nothing to discourage them to think differently or to deliver care in a different way. So fundamentally changing the payment mechanism, combined with delivery system reform, will be what ultimately

makes changes. We know at Group Health that primary care is a much more efficient way to spend our dollars.

Senator SALAZAR. Thank you.

Ms. MACEWAN. But currently very few doctors are choosing primary care.

Senator SALAZAR. Ms. Holland?

Ms. HOLLAND. Just one thing to add, and that would be the use of health information technology, which actually can do a great deal to improve the transition of care from one physician to another or one medical setting to another. So that, combined with different incentives and payment mechanisms, I think can go a long way to helping.

Senator SALAZAR. Thank you very much.

Senator ROCKEFELLER. Are you done?

Senator SALAZAR. My time has expired, Mr. Chairman.

Senator ROCKEFELLER. That was a long time ago.

Senator SALAZAR. I know. I have seven more questions, but I know you will not let me ask them.

Senator ROCKEFELLER. Yes, I will.

One thing which I think is often overlooked is, one of the reasons that the Connector works in Massachusetts is that, well before those reforms were made, you had already redone the small group and individual markets, making the requirements—community rating, all of the good stuff that has to happen—and then you did your State-wide reform.

So my question, in a sense, is, do you have to have those parts in place, which are controversial, before you do State-wide reform as you have? And also, Ms. MacEwan, if you would comment, please.

Mr. DREYFUS. That is a very good point. In fact, one of the unwritten stories about Massachusetts's health care reform is that there were actually a series of laws over a number of years which built the foundation for the reform law. I think you are absolutely right, it was much easier to introduce and implement a Connector when we already had significant insurance market reforms such as modified community rating.

I think it would be challenging. It was challenging in Massachusetts, as successful as we have been, to implement as much as we did within a relatively short period of time. I think it would have been much, much more challenging to do it all at once. Again, although the big insurance market reform that was part of this law was the combining of the individual and small group market, and that in itself has been successful thus far, I agree, the other insurance rules were foundational to our reform law.

Senator ROCKEFELLER. And in the reforming of the first part, was that particularly difficult or did it just happen to hit a good period?

Mr. DREYFUS. You know, they were somewhat controversial. But you also have to remember that in Massachusetts, almost all the health plans are not-for-profit. There was a strong kind of emphasis on protecting the community. We had had a regulated hospital payment system in the 1970s and 1980s, so there was kind of a history of a strong government involvement in health care, so it

was not as surprising or unusual as it might be in a State without that legacy.

Senator ROCKEFELLER. That is interesting.

Yes?

Ms. MACEWAN. Yes. I agree. I think that we are actually experimenting with a Connector model in Washington State, where it is very difficult. Basically it will become a way to deliver subsidies to small businesses that want health care to be more affordable.

In the Massachusetts model, when they moved the individual and small groups together, the rates for a small group went up. Individuals came down, small group went up. You know the voice and power of small business in the States. You cannot do that unless you have broad support to move ahead, unless people really see that there is something to gain as well as to sacrifice in moving forward. So I fully agree, you need to build step-by-step and get the reforms in place and build the support before you start making the big changes.

Senator ROCKEFELLER. Is there also a part of that which is true simply because people are a little bit more comfortable if you do not try to do too much and if you do it piece by piece, and each piece makes sense to them or the second piece becomes more sensible because you have done the first piece?

Ms. MACEWAN. Right. In health care—like so many things—we are very willing to reform someone else's health care, but when it comes to our own arrangements, our health plan and our physicians, people are loathe to change those, as I am sure everybody at this table would agree. So, yes, absolutely. You have to really take it step by step.

Senator ROCKEFELLER. It is interesting, because we are facing that here. I mean, all the candidates are promising complete health reform by the end of 2009. Of course, there is no way that is going to happen, financially or otherwise. So do you do the building block? Now, when you say "incremental," it is now kind of a wimpy word but, if you do Children's Health Insurance and a few other things, you sort of create a sense of momentum.

The other argument is, if you do something like Children's Health Insurance, which we could do, I think, rather easily, that you take away from the sense of momentum of working towards a larger reform, and I do not buy that. I think that you have to show that you can get stuff done, and that is what creates momentum.

Do you have views on that?

Ms. MACEWAN. There is nothing wimpy about Children's Health Insurance. We passed it in our State, and it was a lot of work, and it is an incredibly important reform. So I agree, I think that sometimes the more courageous thing to do is to take the smaller steps, building towards something that is longer-term.

Senator ROCKEFELLER. Building confidence.

Ms. MACEWAN. Right.

Senator ROCKEFELLER. Because we have been through this before and it did not work, so the confidence is lacking.

Ms. MACEWAN. I have tried it the other way.

Senator ROCKEFELLER. It was not health insurance for children that I was calling wimpy, it was the word "incremental" that I was calling wimpy.

This other is just sort of nasty. But in part of the preparation for this, I see Blue Cross of California, Blue Shield of California, HealthNet, Pacific Care, these are massive programs. They have rescinded, in a number of cases, care for individuals just as they happened to become sicker, and therefore a higher cost for the insurer to cover.

I come from a relatively small State where those things seem to happen, but I just do not associate that with companies like that. There was an example where a California hair salon owner was awarded $9 million after HealthNet canceled her insurance policy in the middle of chemotherapy treatment. I do not understand how that happens. Obviously the current regulatory structure is not strong enough, but how does that happen? I mean, how would a big company like that do something like that? Nobody is going to sue you for answering the question.

Ms. MACEWAN. I think it is California law.

Mr. BERTKO. Senator Rockefeller, let me try to answer. I have no business in California, and have not for a while. These, I believe, were part of the individual insurance market. As I described in my testimony, there is generally an underwriting questionnaire at the start of it that says, what conditions do you have. A person presumably fills that out to the best of their ability, truthfully.

When they then have some incident, a cancer claim, some of the companies would have done what I think was called post-claim underwriting, and looked back and said, you must have known about that condition, and hence, rescinded the policy. I think that is a matter for State regulation. I would look to Commissioner Holland here to make a comment, but I think I probably described the correct mechanism.

Senator ROCKEFELLER. Before you answer, let me just say one more thing. In HealthNet, the employees who created this practice of, we cannot do this, they were given bonuses because they identified expensive cases for rescission. I mean, that just has no place in America. Help me understand.

Ms. HOLLAND. I cannot help you understand that, Senator, because I do not understand it. I mean, quite frankly, State regulators would find that practice appalling were we to identify it.

The issue with post-claim underwriting, as was mentioned, is in large part in determining the veracity of the individual who is applying for coverage. If they knowingly and willingly did not disclose information, then insurers protect themselves against taking a risk that they would have otherwise had the opportunity to underwrite reasonably had they known about a situation.

There are so many gray areas, though. The complexities of an application can allow one to, perhaps not intentionally, not share information. A simple example would be someone who in their early years was diagnosed with mitral valve prolapse, never had any problems, was not ever treated, and then all of a sudden has heart palpitations. Is that non-disclosure because they did not say on their application that they had a heart condition? Well, I would say that that was not intentional misinformation. They were not treated for it.

So we are working as regulators to tighten up those situations. The rescission issue seems fairly isolated to California. In my State

of Oklahoma, we did not have those problems. The National Association of Insurance Commissioners, in response to this issue, is not only surveying States in terms of what kind of complaint activity they have had about rescissions, but also insurance companies on their policies. We hope to have that complete soon. But I can tell you and speak for our organization, that that is an unacceptable practice.

Senator ROCKEFELLER. So, when the National Association gets those things worked out, will that stop these California companies from doing those things?

Ms. HOLLAND. I think California has already passed legislation that prohibits——

Senator ROCKEFELLER. To stop it?

Ms. HOLLAND. To stop that. Yes. Yes. But it——

Senator ROCKEFELLER. When?

Ms. HOLLAND [continuing]. Certainly would give us the tools then to——

Senator ROCKEFELLER. When did they do that?

Ms. HOLLAND. Just recently, just this last session.

Mr. BERTKO. Yes. I believe it was this past summer.

Ms. HOLLAND. About 3 months.

Senator ROCKEFELLER. All right.

Senator Wyden?

Senator WYDEN. Thank you.

Senator ROCKEFELLER. Thank you very much.

Senator WYDEN. Thank you, Mr. Chairman.

I am very much in favor of most of the suggestions that we have heard this morning. I think, Mr. Dreyfus, you talked about the new payment models. Several of you mentioned comparative effectiveness training. Put me down as for all of those kinds of things.

The harsh reality, though, is that when legislation gets scored—and here we have this Congressional Budget Office—they really do not score much of that as savings, if any. We just went through this with the Healthy Americans Act, and we have legislation that includes most of that. They said our bill was revenue-neutral in 2 years, and then in the third year it would start bending the cost curve downward. They, for all practical purposes, did not score any of the things that you are talking about. They basically said the savings were because we changed the incentives that drive individual behavior.

So what I want to ask you is, I want to ask you to give me your assessment of a statement that Peter Orszag, who runs the Congressional Budget Office, gave to me when I asked him a question about cost containment and see what your thinking is about it.

What Dr. Orszag has been talking about is that the inefficiencies are so enormous that, unless you involve the individual in a different way, you are never going to drive the costs down.

So I asked Dr. Orszag this question. I believe the only way to bend the cost curve downward is to take two very concrete steps: (1) to demonstrate to our people directly how much the inefficiencies cost, for example, in reduced take-home pay; and (2) to pass health reform legislation so that in a more efficient, fairer system our people have a new financial incentive to select health care

more carefully. Would you agree with that? And Peter Orszag said yes—a one-word answer: yes.

Let us just go down the row, starting with you, Mr. Bertko. Would you agree with Peter Orszag on that two-part test of what it is going to take to hold costs down?

Mr. BERTKO. I would certainly agree on the second part, that there are new incentives that are needed. I am a believer in the Alain Enthoven model of managed competition. On the first part, I think it is necessary, but not sufficient. That is, people have a difficulty in determining, particularly at the time of urgent service, where the most efficient care should be. I think some of the things Mr. Dreyfus described——

Senator WYDEN. Well, the first part is simply the wake-up call, knowing what they lose out on in terms of reduced take-home pay as a result of the inefficiency. That is not anything else other than just, here is the information.

Mr. BERTKO. I would respond to that by saying, when I was with Humana, we had examples of that that operated on our 20,000 or so employees. The wake-up call affected, in its first year, only about 6 percent or so of the employees. It took a while to disseminate all of that through there, so it is a slow process.

Senator WYDEN. Mr. Dreyfus, your thoughts about whether Peter Orszag is right?

Mr. DREYFUS. I think there is truth in both statements. I think the thing I would add is that we do need to provide much stronger incentives to individuals to promote their own health, but I think we also have to provide equal, if not even more powerful, incentives to the delivery system, to physicians and hospitals, and we have to find a way to align those incentives so they are working together. I think only then will we get the cost savings that we need to fund expanded coverage, both locally and nationally.

Senator WYDEN. Ms. MacEwan?

Ms. MACEWAN. I would agree. I think that consumers, patients, look to the systems to provide the information and the answers about what it is that they need, and that is why the incentives are so fundamentally important. But there is a new area that is being explored called shared decision-making, in which consumers are involved in making decisions about their health care and their treatment. The evidence shows that, when people are engaged in that way, the way that you are describing, they actually make more responsible decisions that result in better outcomes.

Senator WYDEN. Ms. Holland?

Ms. HOLLAND. Just to support Ms. MacEwan's comments, we initiated a State-wide consumer opinion drive, basically, which went around our State to elicit our citizens' opinions on what should be included in a basic health benefit plan within a certain financial framework.

When we did that, again, to support what she was saying, as we informed them about the costs of the uninsured population to them and their current costs of insurance and gave them an opportunity to understand the components of the benefit plan and the decisions that policy makers make in trying to provide the broadest coverage within some kind of financial constraint, we found them to make very, very wise decisions.

So I do think that the information to policy holders, to any individual out there about their health care choices, is a wise one, and the cost-shifting has a dramatic impact on business, as well as individuals. The more they know about that the better, and I think the more inclined they are going to be to support reforms.

Senator WYDEN. Mr. Chairman, I have one additional question, but I can wait until after your next round.

Senator ROCKEFELLER. No. Mine is so good that I will let you go ahead. [Laughter.]

Senator WYDEN. I want to ask one question about insurance reform. Senator Rockefeller touched on this, of course, as being discussed in the presidential campaign about the individual market. There has been considerable back-and-forth on this.

I have come to the conclusion that it is an absolute prerequisite to holding costs down, to make it possible for people to join large groups. If you are essentially out there by yourself trying to figure out how to traipse around and get coverage, it is almost impossible to do. It is hard to comparison-shop for the reasons we are talking about when you do not have a lot of bargaining power.

So what we do in the Healthy Americans Act is, we make sure that everybody is part of a large group—they will be in a position to have more clout in the marketplace—but still have a chance to have some of what people have talked about who advocate the individual markets, which is the chance to gain individually when they make a careful purchase.

Just conceptually, I would be interested in your thoughts about that approach to insurance reform, where you start with the proposition that people ought to be part of a large group so you have more bargaining power, but still be in a position to have marketplace forces where individuals benefit from a sensible purchase.

Mr. Dreyfus? Actually, we can just go right down the row.

Mr. BERTKO. Senator, I think there is some advantage to having either a large group or organizer. If I look at the Connector or health insurance exchanges, something that tries to line up benefits so they are easy to compare, and then in some of the models bargains for them, I think that can be useful.

The second part of this is, I think benefit choice is very important. I lived in California for a number of years. Many people there liked Kaiser, other people cannot stand it because they want to be able to go to anyone. That kind of difference in benefit choice is important.

Third, an organizer like that which has multiple models can also make it possible for the health care delivery systems—and Group Health of Puget, I think, is one of these—to make investments in, say, disease management or care coordination that may take many years to pay off, but, if the person can stay in that system for those years, there is a greater incentive for the companies to make those investments.

Mr. DREYFUS. I agree, Senator. Let me just throw out a few numbers. When our State considered bringing together our individual and our small group markets, there were about 65,000 people in our individual or non-group market and about 700,000 in the small group market. When we brought them together, as I said earlier in my testimony, the rates for individuals fell by about 15 percent,

some people found their premiums cut in half, while the small groups went up modestly, a little under 2 percent. And so I think that is an example of larger groups working.

Now, within that, however, I think you are absolutely right: we still want to preserve both some individual choice and incentives for individuals to choose high-value health care. I think one of the promising developments is that the measures that we can use today to measure quality and efficiency in care have improved so dramatically over what was available only a few years ago.

So whereas before some of the literature suggests that consumers were not looking at public information when they made health care decisions, I think that is going to change and I think a younger generation that is used to shopping for all sorts of goods and services online and looking at comparative information will start to approach the health care buying question differently.

Ms. MACEWAN. I agree. I think that any of us who benefit by being in a large pool for insurance know that that is better. It is advantageous to the individual. But I think that there are other ways—much of what we have been talking about this morning, Senator, is about protecting the vulnerable in our system, people who have much higher health care costs needs. There are other ways to do that, other ways besides doing medical risk adjustment—the high-risk pool does that—and reinsurance are other approaches that take care of the cost of the sickest.

Ms. HOLLAND. The only thing I would add to that, Senator, is I actually support the notion of a State-wide pool. Every jurisdiction is different, however. We have different tolerances within our State in terms of benefits and taxation and other things that make it challenging to go beyond a State-wide pooling process, I think, or State-wide effort, except, perhaps, in the area of reinsurance. I think the notion and the idea of a national reinsurance pool that allows the very high risk to be pooled across a very broad population has some real merit, and I would be interested in seeing how that might work.

Senator WYDEN. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Wyden.

My question comes out of the blue. I have to then go, and you being senior, Senator Kerry, will be chairing, and you can ask probably 30 or 40 questions if you wish. [Laughter.]

This is out of the blue, and that is why I like it. Everybody is talking about cost containment. We all know the fact that 25 percent of the entire cost of Medicare is spent in the last 6 months of life. It brings up something called end-of-life care, which brings up several other subjects. Doctors take the Hippocratic Oath that says "Do No Harm." I have a mother who died from Alzheimer's over a period of 12 years. The doctors insisted on keeping her going when she clearly did not want to go on, and her children did not want her to go on in that state. It was humiliating for her. This was repeated over, and over, and over.

Now, there are some people who can live to be 91, 95 and they are just jogging every day, practically. But there are a lot—the majority—who cannot. So my question to you is, where is the intersection in the Hippocratic Oath of "Do No Harm" when you keep people living, and under the threat of suit—when the doctor came to

visit at our house when we took her out of the hospital, I mean, he was sweating. He was really sweating. Where is the intersection of "Do No Harm" on getting somebody to live longer and allowing somebody to live longer when perhaps that is doing harm? Philosophical. Please?

Mr. BERTKO. Senator, that is one of the most difficult questions. My mother-in-law passed away 2 years ago under somewhat similar circumstances. One thing I would point out that is available these days is advanced medical directives to indicate your personal choices on all this, and perhaps having those more used, more readily available would be one.

Senator ROCKEFELLER. But you know, we have been working on that since 1989. They were all there, charts at the end of the bed. They were all there. They are overridden by this determination to do no harm, therefore to cure no matter what.

Mr. BERTKO. I will have to turn that over to someone else, then.

Senator ROCKEFELLER. No, no. You have an opinion.

Mr. BERTKO. Again, in the case of where we were, we worked through hospice care and palliative care, reduced the medications for my mother-in-law, and she passed away very peacefully with her family around. That, in my mind, was a good outcome for what was a very debilitating disease to her. But thought had gone into it. My in-laws had signed their directives. It was, like I said, a peaceful and organized process for them.

Senator ROCKEFELLER. Mr. Dreyfus?

Mr. DREYFUS. I also had a similar situation with my mother-in-law. Unfortunately, it resembled more your story than this story, where despite DNRs and despite advanced directives, there still were interventions that I think the family felt uncomfortable with. I guess what I would suggest is not only for end-of-life care, but for the larger health care system, we need to change the culture from a culture of blame to a culture of care and protection and safety. I think when we do that over time—and it will take a while, and I think there are instances of this across the country where the wishes and interests of families become more prominent.

If you go, for example, as I have gone, to Cincinnati Children's Hospital, which is one of the most advanced improvement organizations in the country, when you enter, your child enters, they hand you the medical record and they say, this is your record, not our record. You can enter notes in it every day if you want. We may have greater medical expertise, but you know your child the best. I think they have created a culture there, and I think there are other cultures which would make it less likely to have the kind of experience that sounds like we both had in our families with sometimes people getting medical care that they did not need, they did not want, or ultimately was harmful.

Ms. MACEWAN. I think those situations are extremely difficult to navigate. We also had a story with my mother-in-law, and it was a better experience because she and my father-in-law, who is a physician, had spoken for many years about their wishes, and her wishes. They had those recorded, and the family understood them. But most important, I think her physicians understood her wishes.

I think that health care is also a relationship of trust. One of the things that we were talking about earlier on the cost of health care,

a primary care physician in that situation can be the family's advocate. I think physicians tend to see death as a failure, and, if they do not know the family, that is how they will behave. So, I think a relationship of trust can help in that situation.

Senator ROCKEFELLER. Thank you.

Ms. HOLLAND. I have no answer, Senator, but an observation. I think, and I have thought for a while, that our technological advancements have surpassed our ability to deal with the social consequences of those advancements when you look at our aging community and the cost of treating people at various stages of their life. I think, first and foremost, we have to get people to take better care of themselves during their lifetimes so that they can enjoy a higher quality later in their life, and perhaps counsel with families on a "good death," if you will. But I think that is the challenge, and will be the continued challenge of the whole health care environment to grapple with those costs and our opportunities to continue.

Senator ROCKEFELLER. It is a huge thing which we somehow avoid discussing. That has to cease.

Chairman Kerry?

Senator KERRY. Thank you very much. I promise you, there will not be 30 or 40 questions. But I thank the chair. I apologize for not being able to be here sooner. I am not going to keep you long, either.

Andrew Dreyfus, thanks for coming down. I appreciate what you are doing in Massachusetts. Thank you, all of you, for taking time to be part of this panel.

The success of the Massachusetts effort is actually, I think, fairly significant. I think there are some good lessons to draw from it. As Andrew I know testified, there are nearly half a million previously uninsured folks who are now being covered with quality health insurance. What is interesting in all of the arguments we have around here is, those folks have not just joined a government plan. There has been a huge increase in the number of individuals getting private insurance through their employers.

And yes, it does require some serious investment, but the reports of the costs being "out of control" and so forth really misrepresents the reality. I am not sure, Andrew, whether you discussed some of that previously already.

The fact is, health care reform in Massachusetts has been a little bit more expensive than people thought, simply because there were more uninsured than people thought. But we have maintained and supported the parts of the system that are effective, while filling in some other gaps creatively. We did not gut employer-based health insurance, which I think is really important as we consider on this committee what we are going to do next year.

We had a breakout session when we did our session over in the Library of Congress regarding employer-based insurance, and there seemed to be a consensus that it is a very critical base that is already working and would be very difficult if you suddenly deregulated the marketplace.

In fact, the events of the last week on Wall Street, which are now consuming us this week here in Washington, underscore what happens when an ideological belief in deregulation is excessive. I do note that there was an article written by Senator McCain advo-

cating for a similar approach to health insurance, so I hope the committee will work carefully as we think about sort of what the best approach is here and what is not.

I know from staff that you were already asked about the consumer protections and market regulations in Massachusetts as they affected the community rating and price and quality issues. Let me follow up by asking a question about New Hampshire's experience with that deregulation.

As I understand it, the State of New Hampshire moved away from an adjusted community rating system in the small group market and allowed significantly more premium variation, which is what comes when you get deregulation, you let people go out and set their premiums and target their markets.

As one would have expected, the premiums for smaller firms with older and sicker workers and firms in certain geographic areas faced large premium increases, while larger firms with younger and healthier employees saw their premiums fall. Among firms with 2 to 9 workers, 41 percent of employers faced premium increases of 30 percent or more. New Hampshire then literally stepped back, repealed the law 2 years later because it was not working in that deregulatory atmosphere, and went back to the community-based rating system that it had before.

Share with me, if you would, Mr. Dreyfus, first of all, what does this tell us about the most sustainable way to approach insurance market reform, if anything?

Mr. DREYFUS. Sure. Well, first, thank you, Senator Kerry, for all the work you have done to support our health care reform law in Massachusetts, as well as the work you have done on other important health care issues, most recently e-prescribing in the Medicare bill, which is going to be a really important step for us and demonstrates how the Federal Government can put incentives and rules in that can help the payment and delivery system improve. I think the New Hampshire example is an instructive one.

In Massachusetts, we were able to stabilize, not destabilize, our insurance market by putting in thoughtful regulations that were acceptable to the private health plans, acceptable to the business community, often developed in a bipartisan way in the State, and that has really been the foundation or the backbone of our health care reform law.

The fact is, many individuals in Massachusetts are paying less today than they would have otherwise for their insurance as a result of the insurance protections that were built into the law. So we think a fundamental concept of insurance is the spreading of risk fairly among different parties, and I think we have been able to achieve that.

Senator KERRY. Mr. Bertko?

Mr. BERTKO. Yes. I would only add, Senator Kerry, that adjusted community rating is one method for applying subsidies. These are then inter-group subsidies. Other tools might also be useful depending on where a State starts from, such as using risk adjustment across that particular market or even reinsurance with subsidies. Then last, of course, you might have low-income subsidies which would help, again, some of the lowest-waged of those kinds of employers.

Senator KERRY. I accept that. I think the key here is that you create some sort of stability and spread that risk adequately through the system, which a completely deregulated system does not necessarily do.

One of the challenges here is, as people talk about this deregulation concept and allowing people to sell across State lines, there is a lot of fear that that is just going to result in a kind of rush to the bottom and you lose the quality or standards that you have and some of the mandates you have today.

Do you want to comment on that?

Mr. DREYFUS. Yes. We would be very concerned about new rules which would allow insurers to sell across State lines, to not protect the integrity of the mandates and regulations that existed within a State like Massachusetts, and that could really disrupt the reforms and progress we have made.

Senator KERRY. Does anybody else want to comment on that?

Ms. MACEWAN. Well, I would just say that the story you told about New Hampshire, I am not familiar with the details, but I think it illustrates the vulnerability of the small group and individual markets and how important it is to maintain the stability. A lot of times the rules that are set up, no matter what we may think about them, there is almost an ecosystem that occurs that keeps the markets together. I would agree with what Mr. Dreyfus said, that selling across State lines based upon the State you are domiciled in could be——

Senator KERRY. Well, what happens, essentially, is people start competing to woo the plans, and that takes them down in terms of what becomes attractive to the plan itself, not necessarily the consumer. Correct? Yes, Ms. Holland?

Ms. HOLLAND. Senator, in terms of the rating bands, I do want to reassure you that, on the rating band models, there are basically one of two models that are adopted by States. Both are regulated and both are intended to make sure that you limit—effectively, pool—within limits and constraints.

The rate band model is no doubt a broader model than the adjusted community rating. But for a State like Oklahoma, for instance, where I have a high population of uninsured, it is really important for me to be able to attract as many healthy young people as I can in my existing marketplace.

So those models are effective only to the extent that they are coupled with other things—guaranteed issue, mandates such as Massachusetts is doing to ensure that you get as much of your population insured as possible. Thus, your point is exactly right in terms of how a competing model, a national insurance policy, pool, or whatever can have a very disruptive effect on local markets and actually adversely select against our markets.

Senator KERRY. Right.

Ms. HOLLAND. So, regulators, too, have grave concerns about that.

Senator KERRY. Did you guys grapple with the question of mandate?

Ms. HOLLAND. Do we grapple with it?

Senator KERRY. Did you?

Ms. HOLLAND. Yes, we did, actually, this last session, extensively. Oklahoma is what most would consider a low mandate State under any circumstances. We have a conservative kind of pull-yourself-up-by-your-bootstraps mentality around there that does not support, really, laws that say you have to do this or that.

But I have to tell you, in talking to our business community, they are keenly aware of how much they are paying to cover the cost of care to those who are not insured. I think it does kind of affect their attitudes about providing inducements or creating inducements for people to be covered.

Senator KERRY. What percentage of that youthful population is uncovered, do you know?

Ms. HOLLAND. Well, in our State we have almost 20 percent of our population that is uninsured, and the majority of it is between 19 and 32.

Senator KERRY. And do you know what percentage of that 20 percent is employed?

Ms. HOLLAND. All of them, virtually. All except a very small percentage. They are working people.

Senator KERRY. Yes. So in effect, if they have a traumatic accident of some kind, everybody else in the State is going to pay for it?

Ms. HOLLAND. If they have a traumatic accident or the flu, somebody is paying for it besides them.

Senator KERRY. So why is there a reluctance to not want to spread the risk more effectively? It is much more cost-effective. Everybody else's premium will go down.

Ms. HOLLAND. In part, I think it is education. I think it is helping policy makers really understand that the cost of care is being paid for. It is a hidden tax in our system that we need to extract and redistribute, and I am leading that initiative. But I have a conservative legislature, so——

Senator KERRY. No, I know you do. I understand that. But it just makes business sense. I mean, the conservative CEOs ought to be leaping at this——

Ms. HOLLAND. They are.

Senator KERRY [continuing]. Because it is a reduction in their drag on business. I mean, it makes good business sense.

Ms. HOLLAND. You are so correct. We started an initiative just recently to identify the top 25 corporations in the State of Oklahoma that are headquartered there, and the top 25 with the largest employment base. I have a presentation I am taking them that explains the cost of coverage and ideas on creating inducements, as well as taxation to support that.

Senator KERRY. Yes.

Ms. HOLLAND. And I can tell you, uniformly, regardless of whatever their political party is, they understand the impact to their business.

Now, they are asking the question, if I tax myself, am I going to see a commensurate reduction in my insurance costs? So some of my biggest employers are hospitals. I have to say to them, am I going to see a commensurate reduction in what you are charging in order to get a reduction in insurance costs? So, it is all tied.

Senator KERRY. Yes. Well, politics is about choices. That is what elections are about. People need to focus on the fact that this is not an advertisement for one candidate or the other, but they ought to focus on what each is proposing. Senator McCain has a plan that effectively is deregulation with tax incentives, which affects those who can benefit from the tax incentive, and the deregulation will have all the negative impacts you have described.

Senator Obama, on the other hand, has a plan that tries to use reinsurance, which we have just mentioned, as a means of lowering premiums and offering better structure in terms of quality, affordability, and accessibility. So, hopefully people will focus on it.

Just a couple of more quick ones. I might comment, incidentally, that Len Nichols, who is a moderate health economist at the New America Foundation, says that that cross-state selling race-to-the-bottom incentive to attract business will be such a disaster for ordinary Americans, that it will be the quickest way for the country to end up with single-payer health care. So I think that we need to look carefully at the cuts or maybe we should just all adopt it and solve the problem.

You spoke earlier, Mr. Dreyfus, about the new payment model and how it links payment to quality. Can you share with us a little more about how you structured the incentives to providers in a way that actually achieves their buy-in?

Mr. DREYFUS. Absolutely. Today, if a group of physicians working at an outpatient clinic at a hospital in Boston is successful in intervening early and preventing a patient with congestive heart failure from being admitted to the hospital, their reward for that good work is that they are paid less. So what we have done is, we have looked to the best national measures of quality, safety, and effectiveness. There is no black box back at Blue Cross. They are measures that have been vetted and approved nationally.

We have said to physicians and hospitals, if you are willing to come together and end the fragmentation of care that exists today and truly integrate your care around the needs of the patient, we will pay you up to 10 percent higher, 10 percent more, if you achieve the highest levels of quality.

So the early pay-for-performance experiments would often add a half a percent or 1 percent, and those are good ideas, and they often rewarded process measures. We are saying, if you achieve better outcomes for our members, for your patients, we will pay you substantially more. So that is the first piece of it.

The second piece is, we are paying what we call a global payment, and we specifically do not call it capitation because it is different than the capitation in the past. We adjust those payments for the health status of the patient so that there is no incentive for people to turn away or turn down sicker patients. By combining those two incentives together, you get up to 10 percent higher payments if you improve care, and fixed payments, adjusted for health status and for inflation. We believe that the best providers that are providing the best care will succeed, and that everyone has an incentive to be more efficient.

Senator KERRY. Have you actually seen a marked increase in capacity as a result of that?

Mr. DREYFUS. Well, we are just starting. We are just in the process of signing our first contracts. I would say one other interesting feature is that health plans, physicians, and hospitals tend to have adversarial relationships where, every year or every other year, they negotiate a contract and they tend to get stuck on the finances.

These are 5-year arrangements where we as a health plan and the physicians and hospitals are saying, let us work together as a partnership. We are optimistic. Not every physician or hospital is ready to accept these kind of payments for small practices. We are optimistic that there will be significant take-up of this new proposal.

Senator KERRY. A final question on the reinsurance issue. I have been a huge proponent of that, and in 2004 I proposed a national plan that used reinsurance as a central mechanism for reducing premiums all across the board. One of the criticisms that people come up with is just the cost. They say, wow, you are going to take X percentage of cases off the top and it is going to cost us a lot of money, so to speak, the government.

I believe, obviously, that the cost is well worth it because, if you remove those most expensive—I think that 1 percent of all the claims in the medical system equal 20 percent of the cost. That 20 percent of the cost is affordable to the Federal Government on an annual basis in X numbers of billions of dollars.

But if you take that off the system, you are then reducing the exposure of every business's employees. You know exactly what their full risk level is. Once the most catastrophic cases are gone, you can limit risk to any business in the country to save $50,000 or something. Once everybody knows, wow, that is all my premium is going to be actuarialized against is $50,000, the premiums sink across the board, which then helps small businesses to be able to buy in. You get more coverage, more individuals can afford to buy in. So are there not market benefits that come from the reinsurance pool that just outweigh that question of cost?

Mr. DREYFUS. Absolutely, Senator. We admired your proposal on that in 2004. In fact, I have described and have praised the Massachusetts law. The one provision of the law that we advocated for that unfortunately did not make the final bill was a reinsurance mechanism, particularly in the small groups. I described earlier the combining and merging of the individual and small group markets.

We had recommended that a reinsurance mechanism be placed on top of that for precisely the two reasons that you said: first, it provides some price relief to small employers; and second, it forces everyone to focus on those 1 percent of members who result in 20 or 25 percent of total spending. We have strong programs, care and disease management programs, for those patients today, but I think there would be an added incentive to the whole system to work on behalf of those incentives. So, we strongly support reinsurance.

Mr. BERTKO. Senator, I agree with Mr. Dreyfus's comments, which he characterized as reinsurance. Your numbers follow my actuarial experience. I would also, though, suggest considering risk-adjusted payments in addition to the components above $50,000, which are basically catastrophes, really bad happenings.

You might want to consider incentives for taking, say, the care of serious diabetic patients where the cost of those folks might be in the $20,000 range or so, and the risk-adjusted methods these days are good enough to identify and pay for those patients. Even some hybrid of your reinsurance mechanism with this could, in fact, be useful.

Senator KERRY. With respect to diabetes, I am told that, if we were to get more people covered, and therefore more people screened earlier, we would be able to intervene earlier and avoid unbelievable numbers of amputations and dialysis, which would save the system upwards of $50 to $100 billion on an annual basis.

So people need to begin to see both sides of the ledger here. It is not just an outlay. There is a cost benefit which, incidentally, OMB, in the scoring process, never takes into account. So all of our judgments here are based on a completely artificial balance sheet because we never get savings where there are savings, and we never get cost reductions where there are cost reductions, or plus benefits, anyway.

Does anybody want to add anything else before we wrap it up and send you back to Oklahoma?

Ms. HOLLAND. I might add, Senator, in terms of reinsurance, the NAIC invited Dr. Katherine Swartz from Harvard to speak to us on reinsurance. You may know, she has written extensively on that. She said yesterday that the cost of a national reinsurance pool that would allow ceding of risk by insurers for those extraordinary risks that are really hard to quantify, and as a result we pay for them in advance, that it would be somewhere around the neighborhood of $5 to $20 billion annually.

Senator KERRY. That is fair.

Ms. HOLLAND. I would just offer, that seems like a little, tiny amount these days, does it not?

Senator KERRY. When you are talking about laying out $700 billion on top of $1.6 billion, on top of $12 billion a month in Iraq, yes, it sure does.

No. Absolutely, it does cost that. We put out some very fair numbers on it. But again, the upsides on the back end, in so many different ways, I think begin to balance that out.

At any rate, we really appreciate your input. The committee will be digging deeply and quickly into this next year, regardless of who is President. We look forward to working with all of you. Thank you very much.

We stand adjourned.

[Whereupon, at 11:48 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

John Bertko, FSA, MAAA[1]
Adjunct Staff, The RAND Corporation
Former Chief Actuary, Humana Inc.

Health Insurance Market Rating Practices[2]

Before the Committee on Finance
United States Senate

September 23, 2008

Chairman Baucus, Ranking Member Grassley, and members of the Committee on Finance, my name is John Bertko, and I am honored to have the opportunity to testify before you today about the rating practices of the private health insurance market.

The private health insurance market in the U.S. is frequently described as three separate segments: the Individual insurance market, the small group segment for employers with 2 to 50 employees, and the large group segment for employers with more than 50 employees. Each segment has different rating practices and regulation. To give an idea of the size of these segments, there are:

- About 17 million covered individuals in the Individual Insurance market
- About 30 million in the Small Group market
- More than 120 million in the Large Group market.

Rating practices, or setting premium rates, differ for each of the segments and also differ by state. Premium rating is mostly regulated by state insurance law but also follows the requirements of several federal laws, including ERISA (for large employers mainly), COBRA (for extension of benefits coverage) and HIPAA (for certain provisions related to group insurance waiting periods and insurance continuation plans). I will provide a very brief summary of the rating methods used by private health insurers.

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[1] The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of RAND or any of the sponsors of its research. This product is part of the RAND Corporation testimony series. RAND testimonies record testimony presented by RAND associates to federal, state, or local legislative committees; government-appointed commissions and panels; and private review and oversight bodies. The RAND Corporation is a nonprofit research organization providing objective analysis and effective solutions that address the challenges facing the public and private sectors around the world. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors.
[2] This testimony is available for free download at http://www.rand.org/pubs/testimonies/CT315/.

Individual Health Insurance Segment

For the Individual health insurance market, there are two distinct approaches to rating methods allowed by states. For five states, insurers in those states must offer policies to all applicants (guaranteed issue) and are limited to rates that are similar regardless of health status, called adjusted community rating. For these states, rates will generally vary by age and gender but not with health conditions.

In the other states, individual health insurance policies are underwritten, meaning that past health conditions of individuals are examined and rates are set according to the health risk of the applicant. Generally, there are three possible outcomes:

- An applicant answers a variety of health status questions and is underwritten as a "standard risk" and receives an offer of insurance at standard rates that are generally lower than those for an employee or dependent in the employer market. This occurs since the person is found to be healthy at time of policy issue, rather than being of "average health" typical of an employee or dependent of an employee.
- An applicant with some past or current health conditions might be offered a policy at higher rates than average (called a "rate up" offer) or with coverage of certain specified conditions excluded for a period of time (called a "pre-ex" offer).
- Some applicants with more serious health conditions will be denied coverage since the insurer would not be able to charge a sufficient premium in an underwritten market to pay for the average claims for these individuals.

In underwritten markets, about 70% of applicants will qualify for standard policies, about 15-20% will be offered policies at higher rates or with pre-existing conditions not covered and about 10-15% of applicants will not be offered any coverage. Additionally, agents or brokers may inform some individuals interested in obtaining coverage that they are likely to be denied coverage, so there is another group of people who do not apply for individual insurance coverage at all.

Individual health insurance rates in states allowing underwriting can vary with age and gender and with health status. On average, rates for the under-65 population may vary by an actuarial factor of 6:1 (or so) without regard to health status, meaning that rates for the oldest group (say, in the 60-64 year old bracket) will be six times the rate for the youngest adults (18-24 year old bracket). Some states place restrictions on the total variance of premium rates, including health status, but generally rates offered to those with health conditions will not exceed twice standard rates offered to the healthy individuals of the same age.

In 32 states, individuals who are denied coverage might be able to obtain coverage from High Risk Pools (HRPs), if they can afford the HRP premium and there is capacity in the HRP. About 200,000 Americans are covered by HRPs, with an average of about 6000 individuals in each state HRP. Premiums in the HRP are usually 200% to 250% of standard premiums paid by individual applicants and are heavily subsidized by insurance assessments or other funding sources in addition to the premiums charged. Access to a HRP is generally limited by the amount of subsidy available in a state and by the ability of a HRP applicant to afford the higher HRP premium.

Small Employer Segment

In the Small Group (SG) market, all states have followed HIPAA provisions and require Guaranteed Issue. This means that any small employer will be made an offer of insurance as long as certain requirements are met: typically, these include some minimum employer contribution requirement and participation or alternative coverage for all or nearly all employees.

Premium rates in the SG market are generally subject to rating band limitations, determined first based on "case characteristics," consisting of age and gender of employees, location, number of employees and type of insurance product, which determine the "manual" or average rate for a premium. Then, in most states a factor for health status or industry is applied to calculate premium rates within certain rate bands. Model legislation from the National Association of Insurance Commissioners (NAIC) specifies that rates may deviate from the manual rate by no more than + or – 35%. However, there are variations in many states and the most common rate band is +/- 25%. A few states also specify Adjusted Community Rating in which no variation by health status or other factors is allowed.

Large Employer Segment

For large employers with more than 50 employees, premium rates are determined either from an individual firm's claims experience or from a blended average of manual rates and claims experience. Firms with 500 or more employees are almost always experience-rated, meaning that their past year of claims experience is projected with health insurance trend to determine future premium rates. In addition, many of these firms are self-funded, meaning that the insurance risk for future claims is borne entirely by the employer, perhaps using re-insurance as protection against the possibility of catastrophic claims. For both these larger firms and for the smaller firms

choosing to purchase insurance, there are generally no restrictions on premium rates that are charged.

Regulation of the large employer market is split between limited state regulation and ERISA. Some states regulate all health insurance rates to assure that they are necessary and adequate, but without formal limits on rates that can be charged. Larger self-insured employers generally use the ERISA exemption from state regulation to allow them to offer the same benefits for multi-state locations.

Key Issues

There are at least two major issues in private health insurance market today: affordability and access. As you may know, the average health insurance premium this year is around $13,000 for a family covering two adults and children. Even with an average employer subsidy of 75%, this amounts to an employee payroll deduction for health insurance of over $3000 per year for the average employee. Out of pocket cost sharing generally amounts to about 20% of covered services in addition to payroll deductions for premiums.

Access to employer-provided insurance is generally on a guaranteed issue basis, except for waiting periods limited to no more than 12 months for employees who do not have a history of prior coverage. In the individual market, some individuals with health conditions may be denied coverage if they have serious conditions. For other individuals with less serious conditions, they may have coverage of these conditions excluded for a period of time or be required to pay more than for standard policies.

Thank you for the opportunity to provide this brief summary of rating and underwriting practices in the private health insurance market. I would be glad to answer questions about my testimony.

MASSACHUSETTS

Testimony of Andrew Dreyfus
Executive Vice President
Blue Cross Blue Shield of Massachusetts
September 23, 2008
United States Senate Finance Committee

Mr. Chairman, Senator Grassley, Senator Kerry and Members of the Committee, I am Andrew Dreyfus, Executive Vice President at Blue Cross Blue Shield of Massachusetts. I am pleased to be here to discuss our experience with health care reform in Massachusetts and how changes in the regulation of the insurance market contributed to that reform.

I would like to thank the Committee for convening the many hearings and roundtables over the past year to gain a deeper understanding of the issues surrounding health care access, quality and cost as it prepares for congressional action on health care reform next year. I hope my testimony about the Massachusetts experience and our lessons learned helps inform state and national efforts to expand coverage.

Blue Cross Blue Shield of Massachusetts is a not-for-profit organization that was founded 70 years ago by a group of community-minded business leaders. Our history – and our future – is one of collaboration with the community to improve the health of our members and the quality of care in the Commonwealth. At BCBSMA, our vision is a transformed health care system that provides safe, timely, effective, affordable, patient-centered care for all.

Our world-class member service, comprehensive product portfolio, care management programs and web-based tools help our three million members lead healthy lives and access the health care services they need allowing us – for the third year in a row – to be ranked as the best Blue Cross plan in the nation by NCQA.

Where is Massachusetts health care reform now?

Almost two and a half years ago, Massachusetts health care reform was signed into law and I am pleased to say that while challenges certainly remain, the law has been successful in expanding access to coverage for hundreds of thousands of Massachusetts residents.

- Recent state reports document that 439,000 previously uninsured residents now have health insurance.
- Care for the state's remaining uninsured financed by the Health Safety Net – formerly known as the Uncompensated Care Pool – has decreased markedly as insurance enrollment has increased. The state reports a nearly 40% decrease in the number of patients using the Health Safety Net in community health centers and hospitals, compared to the same time period last year.
- The latest US Census numbers reveal that Massachusetts has the lowest rate of uninsured in the nation and Massachusetts is responsible for 24% of the overall national decline in the number of uninsured. I believe our rate of uninsured has dropped further since the Census data was collected.

As a Company, we are proud of the contributions we made to help health care reform become a reality. The Blue Cross Blue Shield of Massachusetts Foundation, through extensive analysis, research and convening of leaders, played a major role in setting the stage for reform. I was the President of the Foundation at that time and appreciated the leadership of the Company and the Foundation Board of Directors on this important issue. Independently, as a

leading health plan in the state, Blue Cross Blue Shield of Massachusetts was also called upon many times to lend our expertise on subjects ranging from plan design to market reform as public officials contemplated the final design of health care reform. Under the leadership of our Chairman, President and CEO, Cleve Killingsworth, Blue Cross Blue Shield of Massachusetts remains committed to the success of our health care reform law.

And while we are proud of how far we have come in Massachusetts over the past two years, we are learning that coverage reforms cannot be sustained without a concurrent focus on cost and quality. While the state has made great strides in extending health coverage to hundreds of thousands of people -- a number we hope and expect to increase -- we have seen those gains threatened by continued increases in health care costs, which strain state, federal and employer budgets. Without durable solutions that slow the growth of health care costs, our historic coverage expansions will be placed at risk.

With this challenge lies an opportunity. We believe that by taking real, concrete steps to improve the quality of health care – by making it safer, more effective and more efficient – we will be able to slow the growth in medical trend. In so doing, we will address the greatest threat to health care reform at the state or national level – skyrocketing cost.

But before we outline our thoughts in this area, I want to speak to what you have asked us to testify about today.

What allowed Massachusetts to enact health care reform?

To understand why Massachusetts seized this historic opportunity, it is important to understand the climate in the Commonwealth that allowed health reform to take place. In Massachusetts:

- We had a relatively low number of uninsured – as compared with other states.

- Employer coverage in the state was already high (over 65%) as compared to the rest of the nation (56%).
- We were spending approximately $1 billion annually on services for the uninsured and underinsured.
- We already operated in what some may consider a highly regulated insurance market with requirements such as guaranteed issue, prohibitions on medical underwriting, and modified community rating.
- There is a strong not-for-profit tradition shared by health plans, hospitals and physicians.
- There was also the looming threat of losing over $385 million in federal funding if our Medicaid waiver was not renewed.

These factors, along with a strong community and political commitment to shared responsibility – from the business community to organized labor to hospitals and health plans to health advocacy and faith-based organizations as well as elected officials – created the dynamic that allowed health reform to become a reality. All shared the vision that through health care reform, the uninsured would have access to affordable health insurance and with that access – better health. Health reform also created an opportunity to reduce the cost of care while improving quality.

What did Massachusetts do?

While there are many important provisions to the 146 page law, I am going to focus on areas in which I believe you are most interested.

Massachusetts Covered the Uninsured.

In order to cover those residents that lacked health insurance, the law had several key provisions aimed at reaching those individuals.

1) Expanded Medicaid eligibility to reach those children in families earning up to 300% FPL (vs. 200%). To date, approximately 27,000 children have been added;

2) Expanded Insurance Partnership eligibility to reach those employees participating in our existing employer-based subsidy program to 300% FPL (vs. 200%); and

3) Created a new subsidy program ("Commonwealth Care") to be sold through the Commonwealth Health Insurance Connector that provides subsidies to low-income individuals with incomes up to 300% FPL to assist with the purchase of health insurance. To date, approximately 176,000 have enrolled in Commonwealth Care.

In addition to these public programs, many previously uninsured became insured either by enrolling directly with private carriers (173,000) or via Commonwealth Choice, the products available through the Connector (18,000). Currently six health plans sell products on this Connector platform, including Blue Cross Blue Shield of Massachusetts.

Massachusetts Implemented Private Insurance Market Reforms.

The law also contained several industry market reforms to allow private insurers to develop more affordable insurance products.

1) Merged the non- and small group markets as of July 2007 to create one risk pool leading to a decrease in non-group rates.

The effect of the merger was a decrease in non-group rates of approximately 15%. However, the small group experienced an increase of up to 2%, which we believe could have been moderated by a reinsurance funded outside of the health insurance system. A legislatively appointed commission that studied the issue concluded that $33 million would have been needed to offset each 1% increase to small groups in the merged market.

2) Allowed HMOs to offer high deductible health plans that are linked to Health Savings Accounts;

3) Allowed young adults to remain dependents for two years past the loss of their dependent status (or until their 26th birthday – whichever comes first);

4) Created special lower-cost products offered through the Connector designed for 19-26 year olds without access to employer-sponsored coverage;

5) Allowed insurers to rate individuals and small groups based on their smoking status and participation in wellness programs; and

6) Imposed a moratorium on the creation of new health insurance mandated benefits through most of 2008.

Massachusetts Imposed an Individual Mandate.

Massachusetts residents were required to have creditable health insurance coverage beginning in July 2007. The initial penalty for not doing so (and not obtaining a waiver) was the loss of the personal tax exemption on state income tax in the first year. Now and in the future, the requirement will result in a penalty of up to 50% of the monthly minimum insurance premium for creditable coverage for each month without coverage, currently up to a maximum of $912 annually.

For the 2007 tax year, preliminary data reflects that 95% of tax filers had coverage. Of the 5% (168,000) uninsured tax filers, 69,000 are exempt from penalties; 6,000 of the remaining 86,000 subject to penalties have appealed.

Massachusetts Required Employer Shared Responsibility.

Employers with 11 or more employees who do not make a "fair and reasonable" premium contribution to a health plan for their employees will be charged up to $295 per employee. Employers are also required to offer Section 125 "premium only" cafeteria plans to their employees – either under their own group health plans or through the Connector – so that employees may purchase health insurance products on a pre-tax basis. Failure to do so, when coupled with an

employee who utilizes free care services, could result in a surcharge from 10%-100% of the state's cost of services provided to the employees and their dependents.

Massachusetts Created a Connector.

The Connector was a new, independent, quasi-public entity created under the law and is overseen by a board of private and public representatives to "connect" individuals and small businesses (fewer than 50 employees) with affordable health insurance products developed by insurers.

- The Connector is empowered to certify products of high value and good quality and make them available to individuals and small groups ("Connector Seal of Approval").
- The Connector collects premium payments from those seeking coverage and remits payments to the appropriate insurer.
- The Connector is charged with determining the minimum creditable coverage (MCC) standard for the individual mandate, below which someone is considered "uninsured" and for establishing the schedule of affordability for enforcing the individual mandate and with granting waivers thereto.
- The Connector administers the Commonwealth Care Health Insurance Program.
- The Connector sets broker commission rates ($10 per subscriber/per month for groups).

The Connector is not yet open to small groups: Extending coverage to this population has proven more administratively complicated than originally anticipated. The Connector will begin implementing a pilot program for 100 firms (up to 1,000 members) on January 1, 2009. Measuring the success of this program in the small employer market will therefore take some time and there are currently no plans to expand the program to all small employers in the

state. This necessary first step must be taken to determine whether an expansion makes economic sense or serves a public policy interest.

Our experience with the Connector is that it does indeed provide a service by helping to increase awareness of insurance products and eases the ability of an individual to compare products from different plans. The Connector has also been very successful in reaching and enrolling the subsidized population – for whom health care reform has been a resounding success.

Massachusetts Recognized the Importance of Quality and Cost.
Recognizing the need to ensure that evidence-based guidelines and best practice safety measures are key elements of high-quality heath care, Chapter 58:

- Established a Quality and Cost Council with the authority to establish and coordinate implementation of those health care quality improvement and cost containment goals aimed at promoting high quality, safe, effective, timely, efficient, equitable and patient-centered care;
- Created a Consumer Health Information Website to assist consumers in making more informed decisions about the quality and cost of care with information on specific services and procedures;
- Provided for Pay-for-Performance in Medicaid.

Where is Massachusetts health reform headed?

Fiscal Challenges
As mentioned at the outset of my testimony, while Massachusetts is certainly making unprecedented strides in terms of access, the state has become the victim of its own success and is currently experiencing a shortfall in paying for reform efforts. Much of the reason for the shortfall can be linked to higher than anticipated enrollment in the subsidized plan. In addition, because of the noteworthy increased enrollment of individuals in employer-sponsored insurance (159,000), Massachusetts has not raised as much revenue as anticipated

through employer assessments. Finally, the state's current Medicaid waiver has not yet been approved. With the pressures on the state budget and health care reform funding, Massachusetts may find it difficult to sustain its success.

Health Care Reform, Part II

Beyond the short term budget challenges, the current, underlying growth in medical trend poses an unsustainable burden on consumers, employers, and the government. Failure to develop enduring solutions to slowing the growth in health care costs will put our historic coverage expansions at risk. We view this as Health Care Reform, Part II.

Health Care cost growth must be slowed.

Laudably, our State Legislature passed a cost containment bill in July. With its focus on hospital acquired infections, serious reportable events, health information technology and primary care expansion, the law attempts to improve quality and decrease costs. We are particularly pleased that the law includes a commission on health payment reform.

The most promising route to slowing costs is by changing our payment system to reward high quality, efficient care.

We believe that by changing the way health care is purchased, and eliminating the incentives that are working against high-quality, affordable care, we can liberate physicians to select treatments based on effectiveness, efficiency, and patient preference. If we can change the way we pay for care, we can change the care itself, paving the way for a high quality, high value health care system.

At Blue Cross Blue Shield of Massachusetts we have developed an innovative payment model to do just that. It rewards providers for high quality, effective care and positive outcomes.

The plan combines two forms of payment: a global or fixed payment per patient adjusted for the health of patients, with annual increases in line with inflation, and

substantial performance incentives tied to nationally accepted measures of quality, effectiveness, and patient experience of care.

Developed by a team of physicians, finance experts and measurement scientists, this approach rewards providers for quality and appropriateness rather than volume and complexity. By freeing providers to make care decisions independent of reimbursement levels, the model encourages integration, prevention, and innovation, and discourages inefficient, redundant, or unproven care.

We are beginning to use this innovative payment model with some pioneering Massachusetts providers, and we believe it will have benefits for patients, providers, and payers alike. Patients will receive higher quality, more effective, more affordable care. Providers will gain a competitive advantage by delivering high quality care with demonstrated improvement in patient health. Employers will see more affordable premiums and a healthy, productive workforce. We believe this alternative payment model can – over several years – cut in half current medical cost trend, which has been rising at 12% per year.

We are optimistic about the results we will see in Massachusetts, and the potential for this model to be replicated in other communities. We believe, however, the lasting payment reform will require a significant role by the federal government, especially in Medicare. A consistent and comprehensive federal approach toward health care quality and cost will provide essential guidance to states, employers, and provider systems to redirect resources and make other needed changes.

Quality = Affordability

Payment reform, while likely to have the greatest impact on overuse, misuse and underuse, is just one aspect of our overall vision to transform the health care system into one that provides safe, timely, effective, affordable, patient-centered care for all.

We summarize our work on health system change with a simple equation – *Quality = Affordability*. If we improve the quality of health care – make it safer, more effective, and more efficient, we'll make care more affordable by slowing the rise in the cost of care.

There are four major elements to our Quality = Affordability plan. We need to:

1) Change the way we pay for care – as I have already outlined;
2) Improve the quality and effectiveness of care using measures that are nationally accepted;
3) Educate and inform patients – our members - so that they are more involved in their care, make healthier choices, and help change the system; and
4) Make investments in community based initiatives that lead to safer more effective care.

Working with providers we are:

- Sharing data with that will help them reduce the overuse, underuse and misuse of health care services;
- Asking that all hospitals make their Board of Trustees leaders in the campaign for safety and quality;
- Requiring all hospitals to use computerized systems for ordering drugs and tests by 2012 to participate in our incentive program. A recent study reveals that these systems could prevent 55,000 preventable medical errors and save $170-million a year here in Massachusetts alone; and
- Organizing our provider network around doctors and hospitals who provide the safest, most effective and efficient care.

Working with our members, we are:

- Developing easy-to-use web tools that provide information about the quality and effectiveness of the care provided by doctors and hospitals;

- Using the web to help our members and the public understand what's driving health care costs;
- Expanding the disease prevention, disease management, and wellness programs we offer our members - rewarding them for making better choices, following their doctor's advice, and sticking with treatment plans; and
- Encouraging both doctors and patients to use generic drugs – when appropriate. The result – the use of generics by our members has grown to more than 73 percent. It is worth noting that for every one percent increase in the use of generic drugs results in a one percent decrease in the cost of prescription drugs and saves our members co-pays of $10 to $35 per prescription.

Working with the health care and business community, we are making investments to build a safer, more effective, more efficient system by:

- Creating a groundbreaking program with the Massachusetts Hospital Association that gives hospital trustees the knowledge they need to become effective advocates for quality and safety and have linked participation in this program to specific incentive payments to hospitals;
- Implementing, through the Massachusetts eHealth Collaborative ("MAeHC"), a cutting-edge electronic health records program in three Massachusetts communities that is proving technology can make care better and safer;
- Promoting electronic prescribing through our work with the e-Rx Collaborative where last year, some 4.8 million prescriptions were ordered through the eRx Collaborative. Nearly 104,000 or about 8,600 per month were changed as a result of drug-drug or drug-allergy alerts triggered by the Collaborative's technology; and
- Educating all of us about how to be better patients who are actively involved in the making sure we receive the highest quality, safest, and

most effective care through or funding and launch of The Partnership for Health Care Excellence.

On behalf of my colleagues at Blue Cross Blue Shield of Massachusetts, we look forward to working with the Finance Committee as it addresses the important issues of improving access to quality health care. Thank you again for the opportunity to testify. I look forward to any questions you may have.

TESTIMONY OF

Kim Holland
Commissioner of Insurance
State of Oklahoma

BEFORE THE

SENATE COMMITTEE ON FINANCE

on

Covering the Uninsured:

Making Health Insurance Markets Work

September 23, 2008

INTRODUCTION

Good morning, Mr. Chairman. My name is Kim Holland and I am the Insurance Commissioner for the State of Oklahoma. Thank you for the opportunity to testify today on a topic of great concern to me and the people of Oklahoma – reforming this nation's healthcare system. I applaud the Committee's continued efforts to wrestle with this very difficult task and offer any assistance I can provide to you, Mr. Chairman, and Members.

As Insurance Commissioner, my primary objectives are to protect consumers and ensure that the insurance marketplace remains strong and competitive. For the 3-1/2 years I have served in this position, I have worked diligently with the other stakeholders in the Oklahoma healthcare system to ensure that our citizens have access to affordable health insurance and high quality healthcare. Under our leadership, Oklahomans from all walks of life and all four corners of the state are participating in the creation of a plan for systemic change that will address everything from improving our public's health to greater accountability and transparency within our health delivery system to the development of a lower cost health insurance plan to expanding access to our innovative Insure Oklahoma premium assistance program.

The fact is, however, that the State of Oklahoma does not operate in a vacuum. This is a national issue, a regional issue, and a local issue. Outside forces can, and do, both hinder and help us as we struggle to improve healthcare in our State. True success will only be attained through coordination and cooperation between all stakeholders, both at the state

and federal level. This Committee has always been willing to work with States to resolve issues, and I am confident that spirit of collaboration will continue as work on healthcare reform proceeds.

STATE REFORMS

Over the past 20 years, States have acted aggressively to stabilize and improve the health insurance market for small employers – those that have fewer than 50 employees. States have required insurers to pool all of their small group risk by imposing rating bands or rating limitations, facilitating the fundamental premise of insurance – spreading individual risk across a large population. The National Association of Insurance Commissioners (NAIC) has developed two rating models that have been used, in one form or another, by most states to promote pooling and limit exposure to extraordinary rates due to high claims.

The first model places a cap on the extent to which health status can be used when pricing a new policy. Under this model, a business with a particularly unhealthy population cannot be charged a premium higher than 25% of the base or index rate and a small business that enjoys a healthy population cannot be charged a premium lower than 25% of that index rate. This "rating band" artificially caps the rates for unhealthy policyholders and raises them for healthy policyholders. This methodology has the important effect of spreading the risk to the entire pool. Upon the annual policy renewal, insurers may not increase premiums to a small group policyholder because of high claims or health status by more than 15%. Most States have enacted this model.

A second model has been established that provides for an adjusted community rate. Rates may vary based on age (limited to a ratio of 2:1), geography and family composition only. This is a much tighter rating scheme that makes coverage far more affordable to older and sicker small businesses, but much higher for others.

It is important to note that any artificial cap on rating will create "winners" and "losers"- rates will be artificially higher for some and lower for others. This not only impacts the small businesses involved, but also can significantly impact the risk makeup of the pool – impacting all rates. For instance, a pool with rate caps that make coverage more affordable at older ages would attract individuals/groups more likely to have chronic or serious health conditions. Rating reforms must be carefully considered and must take into account the risk populations and the overall marketplace. A single rating system will not benefit all markets.

There are a few States that have enacted reforms in the individual health insurance market. Some require guarantee issue of coverage and some apply adjusted or community rate requirements. However, due to the high probability of adverse selection in the voluntary individual market (the reality that those most likely to buy will be those most likely to need medical treatment), most States still allow insurers to deny or price coverage based on health status. High-risk pools have been created in many states to help address the issue of the medically "uninsurable", but they are often under-funded and can lock people into limited, but expensive, coverage choices. In Oklahoma, our high risk pool has facilitated insurers' ability to cherry-pick the very healthiest, shifting risk to the pool. Although funded in part by assessments to insurers, premiums to individuals are

150% of the average individual private health plan costs and unaffordable to most. And, while our individual insurance market is robust with many options and attractive pricing, only the very healthiest are approved for coverage.

States continue to experiment with other reform concepts as well, such as reinsurance, tax credits and subsidies, and programs to promote healthier lifestyles and manage diseases, as they pursue the twin goals of controlling costs and expanding access. These state-based reforms are, of necessity, very distinct – based on both the specific needs in the marketplace and the strengths and weaknesses of the marketplace. For example, the State of New York implemented its very successful "Health NY" program, a reinsurance-based scheme that addresses many of the problems identified in New York's individual and small group markets, and utilizing its strong HMO networks. Likewise, the Commonwealth of Massachusetts has implemented a comprehensive program built upon past reforms and their unique insurer, provider and business environment. However, Oklahoma's culture, demography and geography – our distinct market - causes a mirror of either of these reforms to be impossible and requires our own unique solution.

As always, states are the laboratories for innovative ideas. In collaboration with healthcare providers, insurers and consumers, State policymakers are constructing and implementing unique reforms to improve healthcare quality and make health insurance more affordable for our citizens. But, ill conceived interventions – however well intentioned - will hamper our progress.

MULTI-STATE POOLING

One national reform concept that I know is of interest to this Committee is multi-state pooling. Small businesses in some states face limited choices when it comes to selecting a health insurance carrier. Some of this problem is due to a lack of insurer participation in the small group market (for a variety of reasons) and some is due to the simple fact that there are not enough small businesses in the state to support a multitude of carriers. The expectation of multi-state purchasing pools is that the combined purchasing power of large numbers of small businesses in multiple states will create the same economies of scale and negotiating power as that of large businesses.

While the multi-state pooling approach is to-date untested, the experience of single-state purchasing pools created in the mid- and late-1990s suggests that multi-state pooling initiatives will likely not fully address the challenges of the small group market. While these pooling arrangements did allow employers to provide more plan choices to their employees, they were not able to reduce costs or increase the number of small employers that offered coverage.[1] This was due to several factors, outlined below, which would similarly apply to multi-state pools.

First, grouping many small employers does not create the equivalent of a large employer any more than grouping three twelve-year-olds creates a thirty-six year old. One of the

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[1] Long, Stephen H. and Marquis, M. Susan, "Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?" *Health Affairs* 20:1 (January/February 2001), pp. 154-163;
Long, Stephen H. and Marquis, M. Susan, "Pooled Purchasing: Who Are the Players?" *Health Affairs* 18:4 (July/August 1999), pp. 105-111; and
Wicks, Elliot K., "Health Insurance Purchasing Cooperatives" Commonwealth Fund, November 2002.

major advantages that large employers have when purchasing coverage stems not only from their size, but from their cohesiveness. The employees of a large employer are highly unlikely to reject the employer's choice of plan and purchase coverage on their own as the employer's contribution to the cost of coverage significantly reduces the expense to the employee. There is no similar incentive keeping small employers from purchasing outside the pool, and they will go wherever they can get the lowest premium for comparable coverage. So long as there is an outside market to compete against, a purchasing pool will never offer insurers the large, cohesive group that would give them the incentive to negotiate aggressively. As rates rise and healthy groups are able to obtain coverage less expensively outside of the pool they will do so, leaving high risk, high cost groups behind. This adverse selection creates an inevitable death spiral of the pool as costs continue to rise and groups drop coverage for less costly options or go without. It is this inevitability that precipitated the NAIC rate band models which effectively induce pooling across insurers' markets within a state.

Second, the ability of pools to reduce administrative expenses through economies of scale has been less than expected. Early proponents of pooling initiatives expected these arrangements would facilitate enrollment in the pool and eliminate the need for extensive marketing by participating insurers. Actual experience has shown, however, that small businesses continued to rely upon agents and brokers to assist them in selecting health insurance coverage for their employees, and without commissions comparable to those in the outside market, agents were not inclined to participate in marketing the pools.[2] Furthermore, the reduction in administrative expenses that pools expected to realize by

[2] Wicks, p. 4.

facilitating enrollment did not materialize, and pools were unsuccessful in affecting the higher costs of processing claims, billing and underwriting inherent to the small group market.

This is not to suggest that there is no way to reduce administrative costs. Where possible, state regulators must compel insurers to eliminate unnecessary and burdensome red-tape, and without diminishing consumer protections, work together to ensure regulations are not unnecessarily adding to the cost of insurance.

The creation of a national, regional or multi-state pool poses numerous implications to existing markets. Following are specific issues of concern that must be considered:

- **Benefit Mandates** – For a plan to be effectively and efficiently marketed to the entire pool of small businesses, the package of benefits included in the policy cannot differ from state to state. This means state benefit and provider mandates would need to be preempted to a certain extent. Benefit mandates occur when citizens compel their legislatures to enact them. Each state jurisdiction has its own expectations and tolerance for expanding the scope of coverage required of a health plan. By requiring all plans to comply, States guarantee a level playing field within their market. A competing national plan with fewer mandates would disrupt this playing field by creating opportunity for adverse selection and ultimately raising costs within the local market. Conversely, in those states like Oklahoma where there are fewer than average mandated benefits, a national pool

could actually be more costly than local options and not serve the intended purpose of offering lower cost coverage.

- **Rating and Access Rules** – It is absolutely critical that the rating and access rules in force for each state's small group market continue to apply within the multi-state pool. If these rules differ, businesses will choose to purchase where the rules are most advantageous to them, again resulting in adverse selection that will ultimately undermine either the multi-state pool or the state small group market. Applying different rating and access rules to employers from different states will not prove to be a great obstacle to the creation of a multi-state pool, as geographic variations in the cost of health care services will necessitate different premiums for these employers, regardless of other rating and access provisions.

- **Eligibility** – Eligibility rules can greatly impact the outcomes of the pool. Including individuals and sole proprietors in the pool can provide additional options for these difficult-to-cover purchasers, but can also have implications for adverse selection, the stability of the pool, and the average cost of coverage. Requiring all small businesses' coverage to be purchased through the pool can help reduce some adverse selection problems and create a more cohesive group to more effectively reduce rates, but also reduces the choice of plans available to employers and could dramatically impact local markets depending on carrier participation.

- **Carrier Participation** – Like eligibility rules, the rules governing carrier participation can also have a profound impact on the success or failure of the pool. If all carriers are eligible to sell through the pool, participant choices will be maximized, but the pool's negotiating leverage will be greatly reduced. Conversely, limiting the number of carriers that sell through the pool can provide greater leverage to reduce premiums, but also reduces participant choice and creates disruption in local markets if non-participating plans are forced to compete unfavorably.

There are many other issues to consider such as how many states would constitute a pool, who would administer the pool, would there be risk adjustment among the participating carriers, and how would network adequacy be assured. However, the challenges outlined above must be overcome before these other matters are addressed.

KEYS TO REFORM

As Congress deliberates health care reform, I urge you to consider the following as means to the most successful outcome:

Address Healthcare Spending. Any effort to increase access to insurance will not be successful over time unless the overriding issue of rapidly rising healthcare costs is also addressed. While the health care challenge in this country is generally expressed in terms of the number of Americans without health insurance coverage, the root of the problem lies in the high cost of meeting our citizens' health care demands. According to the most recent National Health Expenditures data, health care spending reached $2.1 trillion in

2006, 16 percent of GDP and $7,026 for every man, woman and child in the United States.[3] This level is twice the average for other industrialized nations.

This level of healthcare spending has badly stressed our health care financing system. Health insurance is primarily a method of financing health care costs not the cause of health care costs. Roughly 85 cents out of every health insurance premium dollar is spent to pay for care to policyholders. The best estimates for gains produced by pooling and reducing administrative expenses would generate barely a ripple of savings in the sea of ever-increasing health care expenditures. Nevertheless, insurers do have a vital role to play in controlling costs by promoting and facilitating disease management, enhanced use of information technology, improved quality of care, wellness programs and prevention, and evidence-based medicine—all of which have shown promise in limiting the growth of health care spending and improving the quality of care provided. Effective insurance reform is merely one component of the healthcare and health system reforms necessary for a better society, but a vital tool in creating access, providing choice, controlling costs, and ensuring accountability.

Protect the Rights of Consumers. States already have the rigorous patient and policyholder protections, solvency standards, fraud prevention programs, and oversight mechanisms in place to protect consumers; these should not be preempted by the federal government. As the members of this committee know all too well, the preemption of state oversight of private Medicare plans has led to unethical and fraudulent marketing practices and considerable harm to thousands of seniors. In similar fashion, the

[3] Centers for Medicare and Medicaid Services, National Health Expenditures

Employee Retirement Income Security Act of 1974 (ERISA) severely restricts the rights of employees covered by a self-insured plan. I urge federal policymakers to assist state regulators in safeguarding our consumers by avoiding any further preemption of state oversight of health insurers and insurance, and to enact NAIC recommendations for the necessary overhaul of existing preemptions that impede our efforts.

Avoid Adverse Selection. Any program that grants consumer the choice between two pools with different rating, benefit, or access requirements will result in adverse selection for one of the pools. For example, if a national pool does not allow rating based on age or health status, while the state pool does allow rating based on those factors, then the national pool will attract an older, sicker population. Such a situation would be unworkable. While subsidies or incentives could ameliorate some of the selection issues, as costs continue to rise and premiums increase the effectiveness of such inducements could erode. If a national pool cannot create attractive savings through economies of scale alone, the potential for market disruption in the midst of states' robust reform efforts could have disastrous consequences.

Promote State Innovation. The NAIC urges Congress to review current federal laws and regulations that hinder State efforts to reform the healthcare system. As mentioned earlier, laws such as ERISA curtail consumer protections and supersede State laws, limiting the reform options available to states. In addition, inadequate and inequitable reimbursement payments in federal health programs have led to shifting of costs to the private sector. This has resulted in higher overall costs and decreased access for many consumers, and limits the ability of states to implement reforms. Cost shift has had

staggering consequences in my state, adding $954M annually to the cost of care and coverage and resulting in a growing population of uninsured.

To promote innovations and eliminate these barriers, the NAIC supports legislation like S. 325, the Health Partnership Act, that provides funding for state initiatives and establishes procedures for waiving federal requirements, such as certain ERISA provisions, that impede state innovation.

Just as important, Congress must carefully consider the impact of any new federal reforms on the states' ability to be effective partners in solving our health care crisis.

CONCLUSION

Years have been spent talking about broad healthcare reforms that will ensure that all Americans have access to affordable health insurance coverage and the peace of mind that goes with it. Action is long overdue.

I encourage Congress and the Members of this Committee to support – with resources and funding – State healthcare and health insurance reform efforts. Working together, we can attain our rightful place as the world leader in providing for the health and wellbeing of all our citizens.

GroupHealth

U.S. Senate Finance Committee
Hearing on Health Insurance Market Reform

Testimony of Pam MacEwan
Executive Vice President, Public Affairs and Governance
Group Health Cooperative
September 23, 2008
Washington, DC

Good morning, Chairman Baucus, Ranking Member Grassley, and members of the Finance Committee. I am Pam MacEwan, Executive Vice President for Public Affairs at Group Health Cooperative, an integrated health care coverage and delivery system based in Seattle, Washington.

Thank you for inviting me to be here this morning to discuss Group Health, the Washington state insurance market, and our ideas for improving the current system so that all people in this country have access to patient-centered, high-quality care. I particularly appreciate the leadership you have shown in convening the committee for hearings like this, and in looking ahead to bipartisan collaboration and progress in the coming year.

Group Health Cooperative is a nonprofit health system that provides both coverage and care. Directly and through our subsidiaries, we cover more than 580,000 residents of Washington State and Northern Idaho, about 70% of whom receive care in Group Health owned-and-operated medical facilities. About 900 physicians are part of the Group Health group practice, and we contract with more than 9,000 providers throughout the state. We offer health coverage through public programs and in the commercial market– in Medicare, Medicaid, the state Basic Health Plan, on the individual market, and to small, medium and large employer groups. We also support employers who have elected to self-fund their employee health coverage.

We are fairly unique in the health care market given that we also provide healthcare directly to the majority of our members. We are a regional plan, serving Washington State. This means several things. First, for most of our beneficiaries we operate under the rules governing Washington state insurance market, which are different from many other states. Secondly, we know that while rating rules and insurance market regulations are necessary for an efficient and affordable marketplace, rules are not enough to solve the problems of access to affordable health insurance, and the uninsured.

Our system at Group Health is built on a mission of providing health care. The best regulations are those that will allow us to provide high-quality, patient-centered care to our patients. **We know that insurance market reform – likely through a combination**

of state and federal activity – is needed to ensure that everyone can get access to health care coverage. And we know that *both* insurance market and delivery system reform will be necessary to ensure that everyone's coverage provides them access to high quality patient-centered care.

Let me begin by describing the Washington state insurance market. On the whole, Washington's insurance market provides affordable, high-quality insurance products to the consumer, through the use of premium rating protections and the availability of a high-risk pool. In Washington, insurance cannot be denied to any applicants for coverage if they are part of a small group (defined as between 2 and 50 employees) or other kind of group coverage – this is called guaranteed issue. However, exclusions and waiting periods are allowable for pre-existing conditions, to prevent people from waiting until they get sick to enroll in coverage.

Washington has struck an interesting balance for the individual market. Everyone has access to coverage, either through the individual market, or through the state's high risk pool. Washington employs a state-mandated health status questionnaire. Those without previous continuous coverage who score higher may be denied coverage on the individual market but will be automatically offered enrollment in the state high-risk pool. Generally, people who have complex medical conditions such as AIDS or Lou Gehrig's disease, or a combination of conditions such as diabetes and hepatitis A, would score high enough on the questionnaire to be screened out into the high risk pool. The high-risk pool currently covers about 3,300 individuals, who have access to a variety of different benefit designs through that pool. It is funded principally by an assessment on the insurance carriers. The proportion of individual market applicants that can be denied by each carrier and offered coverage in the high-risk pool is capped at 8% of applicants, significantly less than the typical underwriting practices in other states.

For both the small group and individual markets in Washington, monthly premiums are guided by what is called adjusted community rating, which means that carriers can only adjust premiums by demographic factors such as age, geography, family size, or by enrollees' participation in certain wellness activities. This system of rating constrains the amount of variability between the premiums different individuals or small groups can pay, thereby spreading the risk of the population's health status among more people.

For a brief time, our market was even more regulated than is it today. In the 1990s, I was a member of the Washington State Health Services Commission, working to implement a sweeping health reform bill. The comprehensive reforms were passed in 1993, with most taking effect in 1995. Under those reforms, everyone would have been required to have coverage through an employer or individual mandate. Unfortunately, things did not play out as the original reform bill intended.

First, the law allowed the insurance commissioner to proceed in implementing prescribed insurance regulation changes before the full reforms (including the individual mandate) took effect. This meant that while the pre-existing condition exclusion was reduced to three months, there was a three month open enrollment period where people were

allowed to sign up with no waiting periods or limitations whatsoever, and guaranteed issue was put into effect, these changes were made without any of the other underpinnings designed to help make the system sustainable. There was no requirement that people enroll before they got sick – no individual mandate to purchase coverage – and no risk adjustment mechanism in place.

Soon afterwards, a change in political climate resulted in the repeal of the individual mandate. But the changes in insurance regulation described above were allowed to stand. As a result, many individuals with serious health care needs signed up for coverage. This rapidly led to a classic adverse risk spiral in the marketplace. In short order, claims costs for many health insurers were exceeding their premium collections. Community rating in this context meant that everyone's premiums went up significantly. More individuals decided not to take coverage. The individual market collapsed when the two major carriers, Blue Cross and Blue Shield, closed enrollment in that individual market. Group Health followed suit because of adverse selection.

We learned four things from this experience. First, that rules governing the insurance market must protect the consumer, but must also make such allowances that massive adverse selection does not drive insurers out of the market. Second, that guaranteed issue, community rating, and limits on pre-existing condition exclusions and waiting periods will only be successful if there is an individual mandate to balance the risk in the insured population. Third, that as long as you have an individual mandate, some people will need financial subsidies – to be provided by the government – in order to purchase insurance. Finally, we have learned that in reforming the insurance marketplace, both individuals and small business prefer some degree of flexibility and choice when purchasing health insurance, and that successful insurance reform will allow for value-based benefit design, support high-quality patient-centered care, and therefore be coordinated with delivery system reform.

Regulation that mandates that insurance products have the same benefits and cost sharing – a "one size fits all" approach – will not succeed. We at Group Health provide a number of integrated delivery products that provide flexibility for consumers in how they access their health care, from the physician's office to the telephone, to home visits and web-based secure messaging with the care team. Many of our products focus on primary and preventive care, provide incentives for engaging in healthy behaviors, and offer care management tools to engage patients in their health care in a way that works best for them. Successful health reform will support such innovation in value-based benefit design and foster patient-centered care.

One of the challenges this country faces in achieving successful reform nationally, and ensuring that all people have access to health care coverage, is that states today are playing by different sets of rules. In Washington, for example, I mentioned that only 8% of applicants for coverage in the individual market can be denied coverage, while some states screen out a significantly higher fraction. Moreover, some states do not even have high-risk pools to provide them with a safety net. In Washington, our adjusted community rating system keeps variation between premiums fairly low; while in some

states, a person with a severe medical profile will pay many times more than a healthy individual for the same coverage, contributing to an already high health care cost burden for that person or family.

I am not saying that Washington is perfect – in fact, we are working hard to achieve further reforms so that everyone in Washington can get access to affordable care and coverage. But I do believe that one important role the federal government can play is to look at the different results achieved by various states' insurance regulations, and to determine which rating rules strike the right balance. Another important role will be to support the unique nature of regional insurance and healthcare markets, which are today so very different. This will be critical if the federal government considers implementing a nationally-managed marketplace mechanism – like the Massachusetts' "Connector" – on a national stage. Absent sensitivity to regional markets, such an entity risks squashing regional innovation.

As the federal government approaches insurance market reform, it will be important to protect states like Washington that have developed markets that are more generous to the consumer, and that work. Proposals allowing insurance to be sold across state lines, based on the regulatory framework of the state of domicile of the carrier, would severely destabilize our markets. As a general rule, our goal should be to lift all boats, and this will require some careful policy development.

Before I close and welcome your questions, I want to tell a story that illustrates Group Health's unique perspective as a provider of health care as well as coverage.

Back in March, a man named Fred Watley, from Spokane, Washington, needed a liver transplant. But when the time came for him to get his new liver, he found out that since his employer – a small group – had transferred over to Group Health at the beginning of that year, he had entered into the standard 6-month waiting period for a transplant. Even through Mr. Watley had been continuously covered with health insurance for years; he would be required to serve a new waiting period. Group Health doctors wanted him to receive the transplant. But legally, that would mean he was on the hook for the cost, and we knew that was unfair; in fact, it would have been a death sentence. So we decided to change our policies – breaking ranks with the rest of the Washington insurers – and approve Mr. Watley's transplant. Our doctors got right back on the case, Mr. Watley got his new liver, and over the following days we proactively worked with our insurance commissioner and with the other health carriers in the state and agreed to work on changing the rules going forward. This next legislative session, we will be working to assure that others in Mr. Watley's situation will be able to get the care they need.

A solution in Mr. Watley's case was relatively simple when we were willing to think differently, and thankfully it was also possible without waiting for statutory change. But as I hope I've illustrated, most problems in the insurance system are not so quickly solved by the private sector, and regulatory strategies will require delicate balancing between state and federal government. We urgently need coordinated action to improve both the insurance market and our nation's system of care.

Your topic today is a broad one, and I have touched on a number of points. First, the need for insurance reform to assure that more people in all states can get access to coverage and have the right incentives to get coverage before they are sick. Second, the need to pay attention to states like Washington where some form of community rating is in place and working, and where the rules are more generous toward the consumer. And finally, the need to do insurance reform and delivery system reform in concert so that we can ensure not only access to coverage for all people, but access to high-quality, patient-centered care.

Thank you for your attention, and I will welcome your questions.

COMMUNICATION

United States Senate

Committee on Finance

September 23, 2008

"Covering the Uninsured: Making Health Insurance Markets Work"

Written Statement for the Record
Submitted by

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The National Association of Health Underwriters (NAHU) is a professional trade association representing more than 20,000 health insurance agents, brokers and employee benefit specialists all across America. Our members work on a daily basis to help individuals and employers of all sizes purchase health insurance coverage. They also help their clients use their coverage effectively and make sure they get the right coverage at the most affordable price.

All of this experience gives our membership a unique perspective on the health insurance market place. Our members are intimately familiar with the needs and challenges of health insurance consumers, and they also have a clear understanding of the economic realities of the health insurance business, including both consumer and employer behavioral responses to public policy changes. They have had the chance to observe the health insurance market reform experiments that have been tried by the states and private enterprise, and are in a unique position to report on which of these efforts have worked the best.

The members of NAHU believe all Americans deserve a health care system that delivers both world-class medical care and financial security. Americans deserve a system that is responsible, accessible and affordable. This system should boost the health of our people and our country's economy. That being said, the system must also be realistic.

We believe the time is right for a solution that controls medical spending and guarantees access to affordable coverage for all Americans. We believe this can be accomplished without limiting individuals' ability to choose the health plan that best fits their needs and ensures them continued access to the services of independent state-licensed counselors and advocates. We also believe that the federal government could adopt several key reform measures that would go a long way toward making health insurance coverage more affordable and more accessible to millions of Americans.

NAHU must stress that by far, the greatest access barrier to health insurance coverage in America today, particularly in the individual health insurance market, is cost. NAHU believes that any successful comprehensive health reform plan will need to address the true underlying problem with our existing system—the cost of medical care. Constraining skyrocketing medical costs is the most critical and vexing aspect of health care reform. The cost of health care delivery is the key driver in rising health insurance premiums and it is putting the cost of health insurance coverage beyond the reach of many Americans.

As such, NAHU urges the Committee to consider cost with every single health insurance market reform proposal you entertain. Not just whether or not the market reform idea includes cost containment elements, but also whether or not the market reform idea itself would cause health insurance premiums to increase. Great care needs to be taken when implementing market reforms on a national level to not inadvertently induce cost increases in the existing private market system. No matter how "fair" a market reform idea might seem on its surface, it's not at all "fair" if it also prices people out of the marketplace.

A greater focus on medical cost containment will help lower health insurance premiums nationwide, since premium costs are directly related to medical care expenditures. But we also need to make sure that all Americans have access to affordable health care coverage. As important as affordability, is choice. There needs to be choice of providers, choice of payers and choice of benefits, with many price and coverage options. The reality is that we are a diverse nation with diverse needs. One size does not fit all when it comes to health care.

Our states are excellent laboratories for democracy, and some state health insurance markets have greater stability and competition, and lower costs and fewer uninsured than others. State governments have tried all kinds of health insurance market reform measures—both large-scale and small. NAHU encourages the Committee to look at things like how implementing guarantee issue coupled with community rating and a high number of mandated benefit requirements have priced thousands out of the individual market in New Jersey. Whereas allowing for the assessment of insurable risk in the individual and small-group health insurance markets for effective risk-management have yielded substantially lower premium and higher coverage rates in the adjoining state of Pennsylvania.

Look at how creating a public coverage option to compete with the private market in Maine has been a costly experiment that hasn't yielded a significant dent in the uninsured population. Think about the soaring costs associated with the Massachusetts Connector experiment, and how the program has resulted in a huge number of people who are eligible for subsidized coverage to enroll (which is a positive, albeit expensive result). But also consider how the Connector has attracted very few private paying customers, which was not at all what the Commonwealth thought would happen. Then look at states like Oregon and Oklahoma, which have both addressed the issue of subsidizing employer-provided health insurance premiums for lower-income individuals and small business in very different, but equally market-friendly, ways. Or look at the legislation Georgia just passed to provide an innovative state tax incentive for the purchasers of private consumer-directed coverage.

Some states have also been highly successful in crafting measures to fill gaps in federal coverage protections. For example, the issue of preexisting conditions and individual market coverage portability has been repeatedly identified as a problem with our nation's individual market coverage system. People who have obtained individual coverage when healthy and then acquired a medical condition can be limited in their options for switching coverage plans, due to preexisting condition and medical underwriting requirements. However, these very requirements are what helps prevent individual market adverse selection and keeps individual market prices down for the entire insured population. Texas addressed this issue a number of years ago in a way that ensures people access to coverage while still preserving affordability in the private market. The state offers individuals who have been responsible and maintained individual market health insurance coverage over time credit for their prior coverage with just a one-month waiting period.

Utah and Idaho have both managed to provide guaranteed access to private individual market coverage, using a unique twist on a high-risk pool in Utah and a reinsurance mechanism in Idaho. States such as Florida have implemented innovative price transparency requirements helping those without health insurance and those with consumer-directed health insurance coverage to be much more aware of both the true cost and the quality of the medical care they are purchasing at the point of purchase.

NAHU believes that Congress would be wise to look at our existing system for holes, and see what the states have done to fill those coverage gaps successfully. A few simple reform measures enacted at the federal level of government would go a long way toward extending health insurance coverage to millions of Americans.

One of the first national access issues Congress should address is making sure that people with serious medical conditions no access to employer-sponsored health insurance can buy a private health insurance product. Right now, in a number of states there are people who cannot buy individual health insurance at any price. Most states, but not all, have independently established

at least one mandatory guaranteed purchasing option, the most common and effective of which is a high-risk health insurance pool. The federal government should require that all states have at least one private guaranteed purchasing option for all individual health insurance market consumers.

In addition, to support state high-risk pools, who serve this population in 34 states, the federal government should continue to provide financial support to keep risk-pool premiums stable and allow states to provide risk-pool premium subsidies to low-income citizens and older beneficiaries (who tend to be charged the highest rates) to help ensure continued coverage for early retirees.

Congress should also actively encourage the states to create regulatory climates that ensure the availability of many affordable coverage options, and should offer premium subsidies to targeted populations in need of such support. The federal government should make block grants available to states to encourage and reward health insurance innovations that utilize the strengths of the existing private marketplace. Examples of positive actions states can take to positively reform their health insurance markets include:

- Create broadly funded high-risk pools to serve individuals with serious medical conditions purchasing coverage in the individual health insurance marketplace.
- Allow for the assessment of insurable risk in the individual and small-group health insurance markets for effective risk-management. Limit the cost-impact of unnecessary health insurance mandated benefit requirements through the creation of effective independent state mandated benefit review commissions and/or allowing the availability of limited mandates health benefit plan options.
- Enact statewide medical liability reforms that limit non-economic damage awards, allocate damages in proportion to degree of fault, and place reasonable limits on punitive damages and attorney fees with a statute of limitations on claims.
- Create state-level subsidies of private health insurance premiums. Subsidies could target individual purchasers or employers offering coverage to employees, or both. Subsidies could also be indirect through a private and voluntary reinsurance mechanism.
- Modify their state Medicaid and/or State Children's Health Insurance Programs to allow for the subsidization of private health insurance coverage for eligible beneficiaries. Such subsidies could be created for use in either the employer-sponsored health insurance market (if such coverage was available to the beneficiary) or through the individual health insurance market. For individual market purchasers, Medicaid dollars could be used to fund individually controlled health care accounts, which could be used to purchase health care coverage in the private market, as well as to pay any health care related expenses that might not be covered by the private market plan due to deductibles or other cost-sharing arrangements.
- Provide state-level income and payroll tax incentives for the purchase of health insurance coverage. This could include refundable tax credits for the purchase of private market health insurance coverage, allowing for the deduction of health insurance premiums for individual and group health insurance purchasers, exclusion of Health Savings Account contributions from state income tax liability and/or other means determined by the states.

Another market reform idea that has received a great deal of attention at the federal level and has been tried in numerous different ways with varying degrees of success in states is pooling individuals and or small businesses together to purchase coverage. Whether called a "purchasing pool," "connector" or "exchange," the fundamental idea is similar: If a significant amount of small businesses and/or individuals can be grouped together, enough risk can be spread around

and the same savings and economies of scale can be achieved as coverage through a single large employer.

Pools are not new. They have been tried in numerous states and with varying degrees of success in lowering costs (California's HIPC experience achieved some initial positive results, but recently disbanded). They have all had to deal with the very real and very negative consequences of adverse selection, or the tendency for people with greater needs to be more likely to sign up for insurance, or to enroll in one plan instead of another. We all know disproportionate enrollment in a health plan by less healthy people leads to higher premiums for all, which tends to drive healthier people out of that plan, further increasing costs. The same holds true for health plans that are grouped together in a pool.

Cost containment can be achieved in group purchasing under the right setting. Two of the unique characteristics that make large-group employer coverage work so well are controlled entry into and exit from the plan (mitigating adverse selection), and employer premium contributions to all eligible employees regardless of their need for coverage. These mechanisms help ensure a good mix of insurable risks.

Success of any pooling arrangement also depends on who is being insured. From a risk-management, or administrative perspective, a pool with 1,000 five-employee groups is very different (more risk, higher cost) from one employer with 5,000 employees. And although political temptations are strong to combine individuals seeking insurance with small employers in hopes of creating a large purchasing pool, careful consideration must be given to preserve health insurers' ability to assess risk and price products accurately, and to avoid the creation of an unbalanced playing field in the health insurance marketplace.

One of the most important lessons we have learned from state-level pooling experiments is that care must be taken to ensure that the same market reform measures apply to coverage purchased both inside and outside the pool. Otherwise, an unlevel playing field can destroy both the pool and also the conventional private market. If, by government dictate, the true value or cost of insurance is markedly different than the value/cost that people inside a special pool are being promised, conventional markets will likely erode over time. We have seen this happen in a number of states, and the end result typically has been less choice and increased costs.

The real world experiences from pooling arrangements illustrate that the most stable and competitive marketplaces have been those that maintain as level a playing field as possible for all players in the health care equation—consumers, insurers, employers and providers.

It is possible that purchasing pools could evolve into a better cost-saving vehicle than they have proven to be in the past if the right regulatory environment and financial incentives are in place. However, care must be taken to ensure that competitive prices both inside the pool and in the outside market can be maintained over time in order for any savings to be meaningful.

Another one of the proposed universal-coverage solutions often discussed is an individual mandate for insurance coverage. An individual mandate requires each citizen to have some type of health insurance coverage or face a penalty. Massachusetts became the first state to enact individual-mandate legislation in 2006, and the idea is currently receiving bipartisan attention in many other states and at the federal level.

NAHU feels that imposing an individual mandate that utilizes the private market is certainly an outside-of-the-box approach to reducing the number of uninsured Americans. This idea assumes

people will take personal responsibility for their health care utilization and would help reduce the amount of "charity care" provided for the uninsured in this country through emergency rooms and other means, the cost of which is ultimately shifted to the private health insurance market. Often individual-mandate proposals are associated with a move away from employer-sponsored coverage, but they need not take that direction. A mandate to require individuals to carry coverage could allow coverage to be obtained in a variety of settings, including through an employer-sponsored plan.

However, the idea of an individual mandate does raise many questions and concerns that will need to be addressed, particularly in states where the health insurance regulatory environment is much different than the regulatory climate in Massachusetts. For example, will imposing an individual mandate do anything to reduce the rising costs of providing health care, and thereby the costs of providing insurance? Massachusetts still has some of the highest health insurance premiums in the nation, largely because the new program was put in place without addressing inappropriate regulations that were already in effect at the time its mandate was enacted.

In order for an individual health insurance mandate to work, all people in the jurisdiction with the mandate must have equal access to health insurance coverage, including those purchasing coverage in the individual market. In Massachusetts, access to coverage is not an issue because state law already mandated that all health insurance coverage be issued on a guaranteed basis, which means that no individual can be denied coverage based on any type of preexisting medical condition. Federal law mandates that health insurance coverage be issued on a guaranteed basis to small-employer groups, but there is no such federal individual or large-group mandate. In the majority of states, traditional individual health insurance is not issued on a guaranteed basis, so people can be turned down for coverage due to a preexisting medical condition to prevent adverse selection.

Although this sounds unfair, the ability to ask health questions of individual market applicants keeps the cost of coverage down for most people who purchase coverage. And even though they are not required to do so, most states have developed some way to provide uninsurable people with access to individual health insurance coverage. However, the way the majority of states provide for coverage for people with catastrophic medical conditions seeking individual market health insurance coverage is very different than in Massachusetts, and this way is not as easily aligned with an individual mandate. Thirty-three states provide coverage to medically uninsurable people through high-risk pools, which allow the costs for less healthy purchasers to be handled in a way that does not impact the cost of coverage for the majority of people who buy coverage in the individual market, and six others use a similar private mechanism known as a "carrier of last resort." The reason these states have gone a different route than Massachusetts is that the "guaranteed-issue" route has been found time and time again to raise individual health insurance rates, as it provides individuals with little incentive to purchase coverage unless they anticipate that they will need the benefit.

Therefore, in most states an individual mandate would require some study as it relates to current laws and regulations. Additionally, high-risk pools would have to reassess their financing mechanism to allow for increased enrollment, perhaps through increased federal funding. Also, it is important to note that five states currently have no means at all of providing individual health insurance access to people with catastrophic medical conditions, and so the means of providing access to coverage in these states would have to be addressed on an immediate basis. Imposing an individual mandate in these states would be next to impossible without significant individual market restructuring.

Some may say that a simple way to address the issue posed by not having a guaranteed-issue and or community-rated individual market would be to change each state's individual health insurance regulatory structure so these measures exist. However, NAHU has observed that, in all states with guaranteed issue and the community-rating or modified-community-rating mechanisms, younger, healthier individuals and workers are penalized because insurance carriers cannot account accurately for these healthy risks. This causes much higher overall health insurance rates than in the states that allow for the use of underwriting based on insurable risk. In addition, since these laws make it much more difficult for health insurers to rate their products accurately, doing business in states with these requirements is much more costly. As such, fewer health insurers may offer plan options in these states, which limits consumer choice, reduces competition and leads to overall higher prices. An important goal of an individual mandate is to improve access and expand coverage in a state. Care would need to be taken to ensure that the market reforms needed to implement the mandate did not inadvertently create cost increases.

NAHU commends the Finance Committee for taking up this important topic. Our association believes that if serious steps are taken both to reduce overall medical care costs and increase consumer access to private insurance, the result will be will be greater degrees of health plan competition, more consumer plan choices, lower health insurance rates and a lower number of uninsured Americans. NAHU urges the Committee to carefully consider the cost and market impact of all potential reforms to America's health insurance marketplace. Our private health insurance plans are innovative, flexible and efficient, and our marketplace is up to the task of responding to well-structured reforms. We look forward to working with you to both fill the gaps in our nation's coverage system and also to make private health insurance more affordable and accessible for all Americans.