

**47 MILLION AND COUNTING: WHY THE HEALTH
CARE MARKETPLACE IS BROKEN**

HEARING
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED TENTH CONGRESS
SECOND SESSION

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JUNE 10, 2008
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47 MILLION AND COUNTING: WHY THE HEALTH CARE MARKETPLACE IS BROKEN

TUESDAY, JUNE 10, 2008

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

The hearing was convened, pursuant to notice, at 10:07 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Bingaman, Kerry, Lincoln, Wyden, Stabenow, Salazar, Grassley, Hatch, Snowe, and Smith.

Also present: Democratic staff: Russ Sullivan, Staff Director; Elizabeth Fowler, Senior Counsel to the Chairman and Chief Health Counsel; David Schwartz, Health Counsel; Billy Wynne, Health Counsel; Shawn Bishop, Professional Staff Member; Susan Hinck, Fellow; and Elise Stein, Detailee. Republican staff: Mark Hayes, Health Policy Director and Chief Health Counsel Advisor; Rodney Whitlock, Health Policy Advisor; and Lyndsey Arnold, Intern.

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

The CHAIRMAN. The committee will come to order.

About recovering from cancer, Happy Rockefeller, widow of the late Vice President Nelson Rockefeller, once said, "Once you have been confronted with a life-and-death situation, trivia no longer matters. Your perspective grows and you live at a deeper level. There's no time for pettiness."

Today we will talk about life-and-death situations. We'll look at problems in the health insurance market that are literally making the difference between living and dying. We will try to leave the trivia behind. We will try to gain perspective. We will try to understand at a deeper level.

More than 170 million Americans buy health insurance in some form through the private marketplace, but the insurance market is broken. Premiums are high, benefits shrinking, and 47 million Americans still lack health coverage altogether.

Today's hearing is the third in a series that the committee is holding to prepare for action on health care reform next year. The committee will spend this year studying the health system and reform options so that we can achieve what previous Congresses and presidents were unable to do. We must find a way for all Americans to have access to affordable, high-quality health care.

Next Monday, June 16, the Finance Committee will hold a day-long summit on health reform, and I thank Senator Grassley and other Senators of the committee for their involvement in next week's summit. It is open to all members of Congress and to invited guests from the health policy community, and its goal is to foster dialogue among members. Where we can, we want to start to delve into options for reform. Several Senators on the committee will co-chair panel discussions, and to those Senators who are, I say thank you.

Today we will hear about the major problems in the health insurance market. We need to know what does not work so we can craft the right reforms to yield the desired result: affordable high-quality health care for all Americans.

Private insurers are having difficulties offering affordable options. The average premium for family coverage is more than \$12,000 a year. Premiums can be even higher for families purchasing coverage on their own and not through their employer. Health coverage is even more expensive if you have an existing condition like diabetes or heart disease. Since the year 2000, health insurance premiums have been growing faster than the economy and faster than wages. These trends are unsustainable. The health insurance market is failing to keep premiums in check.

Employers are also having trouble purchasing coverage in the health insurance market. Large and small employers alike find it difficult to offer health insurance to their employees and retirees. Premium increases are forcing many employers to scale back benefits or shift costs to employees. Some employers have stopped offering health insurance altogether.

Since 2000, the share of non-elderly Americans with employer-sponsored coverage dropped from 69 percent to 60 percent. Among firms with 3 to 9 workers, coverage dropped from 58 percent to 45 percent. The health insurance market is losing ground with employers.

Individuals face hardships when they purchase health insurance on their own. People who are not covered through their employer or who do not qualify for programs like Medicare or Medicaid have to buy it through the individual health insurance market. But let us face it, the health insurance market for individuals is truly broken. Healthy people can forego coverage, while people with common health conditions are usually excluded. These days people are being denied insurance simply because they have allergies, or as we learned from a recent press story, because they had given birth through a C-section.

For many serious conditions like diabetes or heart disease, the inability to buy private coverage almost guarantees that their conditions will worsen, and that also means that their conditions will become even more costly to treat. Too often the coverage that individuals can afford has gaps and fails to protect against financial ruin if a person gets sick. These days, most personal bankruptcies are attributable to health care bills.

We have also heard troubling press reports that some insurers look for ways to rescind policies when individuals need expensive treatments. What is the point of health insurance if it does not cover serious illness? Having health insurance makes a difference.

People with health coverage get treated when they need it. They stay healthier longer and they lead more productive lives.

Today's market for health insurance leaves too many people without affordable coverage. The health insurance market needs reform. We must do it right. In order to do so, we must understand the problems.

Today we have a panel of witnesses to help us. Our witnesses can help us to understand the failings of the current market and where we need reform. The diverse perspectives will show us, hopefully, where to focus reform so that we reach our goal of having affordable high-quality health care for all Americans.

In a moment we will hear from Lisa Kelly. Mrs. Kelly will testify via video conference about how her health insurance, which had a \$37,000 benefit cap, did not insure her for the full cost of her cancer treatment. When she later applied for coverage under her State high-risk pool, they required a 12-month waiting period for her pre-existing condition and did not cover any of her cancer treatment during that year.

Problems like that in our health insurance market are not pleasant to think about. They are not easy to solve, but we cannot, and should not, ignore them. These are life-and-death issues. We need to leave the trivia behind. We need to gain perspective and to understand at a deeper level.

It was more than 30 years ago that Happy Rockefeller had cancer surgery. Let us try to apply some of her wisdom and her courage as we consider these issues today.

Senator Grassley?

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

Senator GRASSLEY. Thank you, Senator Baucus, for continuing to hold hearings on this very important subject of the uninsured, and health care delivery generally. The Health Care Summit next week is doing some good work, setting groundwork for what I hope we do next year on reform. I know a lot of people are critical of the way our health care system covers people.

The truth is that we do not really have a health care coverage system, at least not like other countries do. What we have is a patchwork of government incentives and government intervention. We have the military system for the military. Seniors have Medicare. Veterans have a program. For the rest, it is provided, for the most part, by employers. One hundred and fifty-eight million Americans benefit from incentives that the Federal Government delivers to encourage employers to provide health care coverage.

But approximately 47 million Americans do not have any coverage. The vast majority of the uninsured are also employed. If your employer does not provide coverage or if you are self-employed, you have to go out into the individual market to get health care coverage. Currently the individual market is simply not viable for millions of Americans. It does not mean that they could not get used to it if they were provided incentives to do it, but right now people seem to be satisfied with employer coverage.

Finally, we have the problems of coverage not being adequate for those who do have it. We all know the consequences of not having

enough, or any, insurance coverage. What is particularly alarming are the financial consequences for people with inadequate or no insurance when they seek treatment at a hospital for life-threatening diseases.

A recent *Health Affairs* study showed that self-paid patients, including the uninsured, are charged 2.5 times more for hospital care than the insured. That is just the beginning. Some hospitals even require payment up front from the uninsured or under-insured before they provide treatment.

I would like to put an article in our record from the *Wall Street Journal*, recently exposing this practice at a prominent institution, M.D. Anderson of Texas.

[The article appears in the appendix on p 42.]

Senator Grassley. You have already referred to the case of Lisa Kelly, so I will not go into that. We are going to hear more about that, but it seems to me that it is outrageous, the hospital's up-front collection policies.

The troubling thing about her story is that these were actions taken by a hospital that is funded through taxpayers' dollars and charitable gifts. I guess I shouldn't be shocked, given that my staff uncovered, through investigations, hospitals that purported to provide care for the neediest in society and that receive significant tax benefits for doing so not really providing that care that a charitable institution ought to.

In addition to not paying income taxes, nonprofit hospitals receive tax-deductible contributions, issue tax-exempt bonds, and receive exemptions from State and local property and sales taxes. In addition to not paying income taxes, nonprofit hospitals receive tax-deductible contributions, issue tax-exempt bonds, and receive exemptions from State and local property taxes. I said that twice because I think we ought to know what these benefits are of nonprofit status.

This committee heard testimony that these hospitals receive benefits of more than \$40 billion annually for the care that they are supposed to provide. These benefits were granted to hospitals back at the turn of the last century when hospitals were the only place where the poor could go when they were sick. The enactment of Medicare in 1965 and the explosion of the insurance market since then has resulted in incentives for hospitals to treat only paying patients.

The current environment is no different than where we were over 100 years ago. Back then, people with money had private physicians who made home visits, the poor received treatment at alms houses supported by philanthropy. The only difference now is that many of those former alms houses have become rich institutions that believe they no longer need to serve the poor to reap all the benefits of tax-exemption. I raise this issue again because, as we talk about tax incentives for health insurance, I want us to also consider the billions of dollars of tax benefits conferred to nonprofit hospitals.

Given that the majority of our country's hospitals are operating as charitable institutions, any discussion of health care reform should consider their role in the market. As we move forward on health reform, we need to look at all the incentives the Federal

Government has in place, particularly those in the tax code, to make sure they are serving people who need health care coverage.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Now I would like to welcome our witnesses. But, first, we will hear from Mrs. Lisa Kelly from Lake Jackson, TX. Mrs. Kelly purchased a limited benefit health plan. Approximately one million Americans have limited benefit plans. In 2006, Mrs. Kelly was diagnosed with acute leukemia and referred to a cancer hospital. She will share her experiences of being under-insured during her health crisis with us today.

I must say, though, Mrs. Kelly has a medical appointment later this morning, so she will not be able to stay for the entire hearing, so those of us who wish to ask questions will do so when she completes her statement. I would remind everybody that all written statements will be automatically entered. That is later on.

Anyway, Mrs. Kelly, it is yours. Tell us what you want to say. Let it all hang out. Tell us what you think. Do not pull any punches. Just be straight and tell us what you think we should hear.

STATEMENT OF LISA KELLY, LAKE JACKSON, TX

Mrs. KELLY. I am a little nervous.

The CHAIRMAN. Well, do not be.

Mrs. KELLY. Well, I bought a policy, thinking it would be good enough to at least help me get in the door. I never had any serious sicknesses. So I got a little policy through United Healthcare. It was, like, \$189 a month I paid. It got my allergy pills. And the hospital at home and my doctors there took the insurance. And then when I found out I had leukemia, they told me I needed to go to M.D. Anderson. So I thought, all right.

So I called, and I gave them all my information. They called me back and said they could not accept my insurance, that I would have to be self-paid and that I would have to bring a check for \$45,000 with me the very first day when they made my appointment.

I think our health care is really broken. But then I got to M.D. Anderson, and I also then went and tried to get on—since I found out my insurance was no good for them—I got signed up and got on the high-risk pool, and I have Blue Cross/Blue Shield. I got in it, and I had to pay for it for the whole year. But it would not cover my cancer until February of this year. So now it has kicked in. I was in remission, but now I am out of remission, so I am starting over again.

The CHAIRMAN. Could you tell us, I am just curious, based upon your experience, I take it that you believe—I certainly believe—that your condition is just unfair. It is almost unconscionable. But you bought coverage. You paid \$189, you said, a month for a plan and that did not cover your condition.

Mrs. KELLY. Yes.

The CHAIRMAN. And you then bought into a high-risk pool and that did not cover you for a long period of time. What do you want to tell our committee? We have a couple of people from the insurance industry here. Basically, what is the right thing to do? What

would the right approach be? What should Congress do, or what should insurance companies do? What just sounds kind of right to you?

Mrs. KELLY. I do not know what is right or what is wrong. I know health care is expensive. I know doctors, and their time, and the medicine is expensive. But I think some things are just totally over-charged. Now that my insurance has kicked in it is a little better, but when I was self-pay it was unbelievable, what they were charging for things, and things that I did not even have.

I just think that someone needs to monitor how they do that, or how the hospitals get by with charging the prices they charge. I just think it should be fair for everyone all the way around. Whether you have money or you do not have money, you should be able to go in and get health care and not be penalized or put to the side because you do not.

The CHAIRMAN. Well, thank you very much for taking the time to talk to us. Too often in this committee we have witnesses who talk about concepts and abstractions, but you are providing a face to the problem. You are showing us that this is real, that is, your condition and what you face. I just thank you very much for taking the time and having the courage to come and talk to us and tell us what you think we need to hear.

Thank you very, very much.

Mrs. KELLY. Thank you.

The CHAIRMAN. You bet. We have a couple of questions, Lisa, from other Senators.

Mrs. KELLY. All right.

Senator BINGAMAN. I was going to ask, Lisa—I'm Jeff Bingaman. I am from New Mexico. I was going to ask, when you got this limited benefit policy that you had that turned out not to cover the leukemia, what did you understand you were getting in the way of coverage at that time? Did you understand you were getting inadequate coverage? Because the problem, it seems to me, is you were insured, but you obviously were not insured for what you wound up having. So what was your understanding?

Mrs. KELLY. Well, I thought it covered it. I had to turn in—but M.D. Anderson would not accept it because it only paid 50 percent. It had to be 70 percent or above. That is the only reason M.D. Anderson would not use it.

Senator BINGAMAN. So you think perhaps some other medical institution would have accepted it? Is that your understanding?

Mrs. KELLY. I do not know.

Senator BINGAMAN. All right.

Mrs. KELLY. I mean, in between, after a while, just to save money I would get my levels checked at home and, if I needed blood or platelets, I would go to the hospital at home and they would turn it in to my insurance where it would not cost me as much, so I would not have to come up here and pay full price.

Senator BINGAMAN. All right. Thank you very much.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Mrs. Kelly, I am Ron Wyden, from Oregon. I am curious whether M.D. Anderson tried to help you get into this high-risk pool. Did they try to do anything to try to move things along and get you coverage in a quicker way?

Mrs. KELLY. No. They just told me I needed to check into it. So I went home, checked into it and signed up at home and got it started.

Senator WYDEN. But they did not do anything? They did not offer to try to help you? I gather it took you a fair while to get into that high-risk pool, did it not?

Mrs. KELLY. It took about 2 or 3 weeks. I had a friend of mine who contacted someone who did their insurance for them at work and he usually just did companies, but he took me in and gave me an application. We filled it out, and in probably 3 weeks I found out I was accepted, but that it would not cover me for a year on the cancer. I pay about \$1,900 a month for that. That covers for 3 months.

Senator WYDEN. And you basically found this friend. But M.D. Anderson, after that first contact you had with them, they did not say, we will try to set you up with these kinds of programs and get you through it?

Mrs. KELLY. No.

Senator WYDEN. All right. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Kerry?

Senator KERRY. Lisa, this is John Kerry from Massachusetts. I just wanted to ask you a couple of questions.

First of all, when did you first buy this insurance?

Mrs. KELLY. I had it for about 2, 3 years before I found out I had leukemia.

Senator KERRY. And were you working at the time?

Mrs. KELLY. No, I was self-employed.

Senator KERRY. Self-employed. Had you ever had insurance previously through an employer?

Mrs. KELLY. Yes.

Senator KERRY. How long before that?

Mrs. KELLY. Five or 6 years.

Senator KERRY. Before that. So you went 5 or 6 years without any insurance?

Mrs. KELLY. We went quite a while without insurance, yes.

Senator KERRY. Without any insurance.

And do you mind if I ask how old you are? You can avoid it if you want.

Mrs. KELLY. I am 53.

Senator KERRY. Fifty-three. All right.

How many years did you have insurance with an employer, or through your employer?

Mrs. KELLY. Well, for 10 years with the grocery store I worked for, and then probably 5 years with Hastings.

Senator KERRY. So, about 15 years you did have coverage through your employer?

Mrs. KELLY. Yes.

Senator KERRY. Now, once you bought into this limited program, did you know it was limited when you bought it?

Mrs. KELLY. I knew it was a little limited, yes.

Senator KERRY. All right. And when M.D. Anderson said you had to show up with \$45,000, did you have the \$45,000?

Mrs. KELLY. No. Well, my husband had to borrow it against a trust. His dad had passed away. So we just borrowed off the trust.

Senator KERRY. So you did borrow money and you did show up with a \$45,000 check?

Mrs. KELLY. Yes.

Senator KERRY. How much further, if at all, did you have to dig into your personal money in order to treat yourself?

Mrs. KELLY. I've paid in a little over \$82,000 right now.

Senator KERRY. Of your own money?

Mrs. KELLY. Yes.

Senator KERRY. And how much of a dent has that made in your retirement and savings?

Mrs. KELLY. Well, we are trying to stay away from our retirement. We do not want to have to cash anything in, because that is what we plan on living on. But so far we have not had to do that yet. We are negotiating with them on it, because I still owe \$137,000.

Senator KERRY. Whom do you owe the \$137,000 to?

Mrs. KELLY. M.D. Anderson.

Senator KERRY. All right. How do you expect to pay that?

Mrs. KELLY. We are going to have to cash in on some of our retirement, but we will use something where we will not be penalized.

Senator KERRY. All right. Thank you.

The CHAIRMAN. Thank you, Senator.

Any other Senators who wish to ask questions?

[No response.]

The CHAIRMAN. Lisa, thank you very, very much for taking the time. I know you have to leave for treatment. But I guess the main point here is that you spent over, what did I hear you say, \$137,000? How much?

Mrs. KELLY. That is what I owe.

The CHAIRMAN. That was on top of the \$80,000?

Mrs. KELLY. That is on top of what I have already paid.

The CHAIRMAN. That is right. So even though you are supposed to have health insurance, your health insurance did not cover those costs?

Mrs. KELLY. Yes.

The CHAIRMAN. Thank you very much for taking the time. Thank you, Lisa. We wish you well.

Mrs. KELLY. Thank you.

The CHAIRMAN. Now let us turn to the rest of our panel. Today we hear from Raymond Arth, president and CEO of Phoenix Faucets out of Avon Lake, OH. A third witness is Mr. Ron Williams, chairman and CEO of Aetna. Finally, Mr. Mark Hall, professor of law and public health at Wake Forest University in Winston-Salem, NC.

Thank you all for coming. We would ask each of you to give your statements. Speak for about 5 minutes, and your prepared statements will automatically be included in the record.

Mr. Arth?

**STATEMENT OF RAYMOND ARTH, PRESIDENT AND CEO,
PHOENIX FAUCETS, AVON LAKE, OH**

Mr. ARTH. Good morning. Thank you, Chairman Baucus and members of the committee. I appreciate the opportunity to participate in this discussion this morning. I am here actually in two capacities: one as a small business owner who is dealing with this issue of providing insurance for my employees as I have since day one, and also as a past chair of the National Small Business Association, the country's oldest small business advocacy group. So my testimony really has two pieces: some personal observations on my experience and a brief summary of NSBA's policy recommendations.

I will tell you that I am not an authority on health insurance or health care, but I do bring over 30 years of practical experience of maintaining group coverage for my employees. I served for several years as part of the group that ran a small business group purchasing program in Cleveland, OH, and I was also a participant with NSBA as we drafted our positions.

First, though, as you begin to look at solutions to this problem, I urge you to please remain conscious of, and sensitive to, the impact it will have on the small business segment. Small business is a powerful engine of growth in our economy. Over 70 million Americans, which is over half of the private sector workforce, are employed in small businesses.

Over the last 15 years, nearly 95 percent of all net new job creation emerged from small business enterprises. Because we are small, we have fewer resources, monetary and in terms of personnel, to deal with changes. So, please remain conscious of how any change will impact us because we are, as I said, a major engine of growth in this economy and we are straining to pull the load of the growing health care and health insurance costs.

When my brother and I started Phoenix Products over 30 years ago, he was a cancer survivor, so we understood from the very beginning how important it was to be able to offer a good-quality and affordable health insurance program for us and for all our employees. For 30 years, I have had to face that challenge almost every year. It has become sort of my rite of spring.

Over those 30 years we have probably, at one time or another, participated in every size, flavor, and style of health insurance program that has come along the way. By changing plans and plan designs, we have been able to control health care costs reasonably well. Up until as recently as 2003, we were able to offer very generous programs with modest monthly premiums that remained affordable.

Unfortunately, my group demographics have been working against me. The company is 31 years old. My average employee is now 52. They have about 16 years of service with the company. As people get older, they have more problems, they become higher risk.

So in 2007, we were confronted with a 22-percent premium increase that we managed to avoid, largely through a major increase in deductibles. We now have a \$3,590 deductible program, though the company self-insures part of that so the employee is not fully exposed. So, we pretty much avoided that 22 percent.

After our renewal last year, I learned that one of our covered participants has Gaucher's disease, a very rare condition. It is an enzyme deficiency, extremely expensive to treat. Our renewal figures for this year are up by 35 percent, which is pretty much the maximum allowed under State of Ohio insurance regulations.

I no longer have any design changes I can make, I do not have any new flavor-of-the-year to pull out in plan design that we can locate, so somehow my company and our employees have to figure a way to absorb almost \$40,000 in incremental insurance premiums to cover 22 active employees. This is, clearly, a quandary and a problem for me as well.

NSBA has been working on this issue for many years, and, in 2004 or thereabouts, we concluded over a full year of discussion on what we think we should do and have come out with a recommendation that really revolves around a key principle, which is universal coverage based on personal responsibility. We believe that everyone in this country should have access to health care, and we believe everybody should participate by having insurance.

This will require some major changes in the insurance market, in underwriting rules, and in rating. We encourage and support the notion of an established Federal basic benefits policy. We would like to see a basic level of coverage that would be more affordable and would cover especially catastrophic events like we have heard today.

There are issues with the tax treatment of premiums that are paid that are different for small businesses if they are not C corporations, and we would urge that some attention be given to that. If an owner of a business cannot benefit by creating and having a health insurance program, they are less likely to create one in the first place.

We are also in favor of changes in the health care area: better use of technology to help prevent errors and to make information more available, especially information regarding costs and quality. There is now no way to assess the performance of a physician or a hospital before you go, and I have asked doctors what a procedure would cost, and they will not even hazard a guess. The man who is going to do the procedure cannot tell me what the price will be.

We have moved from the medical model where a patient and a doctor confer about treatment and decide what to do, to the veterinarian model of medicine where the provider and the payer sit down and decide what they are going to do to the patient. We do believe we need to get the patient more involved, but that also means that individuals have to have a stake in having health insurance and in bearing the cost. Medical malpractice is also an important piece.

So that is a broad recommendation. Many points are covered. It is a very complex problem. For over 30 years I have worked to satisfy the primary goal of offering comprehensive and affordable health insurance to my employees, and unfortunately now, squeezed between my group plan demographics, one very serious and expensive condition, and medical inflation that is running out of control, I may have finally found the limit to my ability to do so.

With that, I will conclude. Thank you.

The CHAIRMAN. Thank you, Mr. Arth. That is very helpful.

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

The CHAIRMAN. Mr. Williams?

**STATEMENT OF RON WILLIAMS, CHAIRMAN AND CHIEF
EXECUTIVE OFFICER, AETNA, HARTFORD, CT**

Mr. WILLIAMS. Good morning, Chairman Baucus, Ranking Member Grassley, and members of the committee. Thank you for the opportunity to be here today.

My name is Ron Williams, and I am chairman and CEO of Aetna, a diversified health benefits company that provides products and services in all 50 States to more than 37 million Americans.

Mr. Chairman, we at Aetna are committed to being a key part of the solution. Like you, I believe our Nation must do a better job to ensure everyone can get high-quality and affordable health care. To achieve this, we need to take stock of what is and is not working in our system and address the interrelated challenges of access, quality, and cost. At Aetna, we are working to develop smart solutions to these challenges, and our approach is summarized in "To Your Health," our plan for health system transformation.

Today, 250 million people in America have coverage, and the great majority of them get their coverage through the employer-based system. Our health system is also extraordinarily advanced, with a competitive marketplace producing innovations that have revolutionized medicine and health care delivery. These are strengths to be built upon, not thrown away.

But make no mistake about it, the U.S. health care system has some severe problems, evidenced by the unacceptable fact that 47 million people lack health insurance. If we want to get everyone covered, we need to understand how insurance is supposed to work and make it work for everyone.

Insurance should not be something you wait to buy until you know you need expensive medical care. Instead, each one of us is supposed to pay into the system and take care of others today while we are healthy with the knowledge that tomorrow others may be taking care of us.

That is precisely why we support an individual coverage requirement, because universal coverage requires universal participation. But the uninsured, by choice or circumstance, are not participating in this system today, and it is a diverse group. Eleven million are eligible, but not enrolled in public programs. More than 30 million come from low- to moderate-income households, and about 19 million are between 19 and 34 years old. We need different approaches to pull each of these segments into the system, not only because it will be better for them, but because it will be better for all of us.

So as we contemplate the right mix of policies, I want to share my thoughts about some of the underlying reasons why so many people remain uninsured. First of all, the fact that 47 million people lack coverage is symptomatic of a different problem: the high and rising cost of health care. This translates into expensive health insurance, shown by the fact that premiums and health care costs

both increased about 7 percent annually over the period 1993 to 2003.

With this in mind, the right question is not, what can we do to lower the price of health insurance, but rather, what can we do to slow the growth of health care costs? Two of the most important steps are to reorient the system toward value and to refocus the system on promoting wellness rather than simply treating sickness. At Aetna, we are making progress on both fronts by providing preventive care free of co-pays and deductibles, creating incentives and tools for healthy living, and making it easier for members to know both the price of services in advance and the quality of services. With reduced costs, even the smallest employers will be able to offer coverage to their workers.

A second impediment lies in some State regulations. Though well-intentioned, they often end up making insurance unaffordable. Let us take, for example, guaranteed issue of insurance and community rating, which essentially say that insurers have to offer coverage to all comers for the same price, no matter when they decide to purchase it.

Not surprisingly, this results in really expensive health insurance, which not only frustrates efforts to get more people into the system, but also creates a situation in which I can always wait until I get really sick and then sign up for coverage on my way to the hospital. These regulations may promote equality, but regrettably, they make insurance equally unaffordable to everyone.

The third systemic problem is that the individual market is broken. Much of what makes the employer-based system function well—large and diverse risk pools and strong controls against adverse selection—is glaringly absent in the individual market.

While the practice of medical underwriting is often cast as a dirty word, policymakers must recognize that it is one of the only means insurers have to prevent adverse selection and remain competitive. But it does not have to be that way, and we want to work with you to create a true public-private partnership to offer viable options for the diverse set of individuals that make up this market.

I fundamentally believe we can cover the uninsured without pulling the rug out from under the 250 million people in America who currently possess coverage, but it is not good enough to simply identify problems. We need to develop solutions that respond directly to them, otherwise we will end up with a system where everyone can hypothetically get insurance, but few can actually afford to buy it.

I appreciate the committee's attention to this issue and hope you will continue to call on me and my industry colleagues to help shape solutions.

The CHAIRMAN. Thank you, Mr. Williams.

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

The CHAIRMAN. Next, Mr. Hall.

STATEMENT OF MARK HALL, PROFESSOR OF LAW AND PUBLIC HEALTH, SCHOOL OF LAW AND SCHOOL OF MEDICINE, WAKE FOREST UNIVERSITY, WINSTON-SALEM, NC

Mr. HALL. Chairman Baucus, esteemed Senators, it is a distinct honor to appear before this distinguished committee as it begins the monumental undertaking of reforming our health care system.

My testimony addresses the problems in the structure and functioning of the private health insurance market. I have studied these markets for almost 2 decades through extensive empirical research with health insurers, agents, employers, and regulators. Chairman Baucus presented the relevant statistics in his introductory remarks, and they are also contained in my written testimony.

In sum, the mounting cost of health insurance is driving more and more people out of the market. As the number of employers offering insurance steadily declines, there has not been any commensurate increase in the number of individuals purchasing their own coverage. And so, over the past decade or so, the percentage of non-elderly Americans covered by private insurance has declined from about three-quarters down to about two-thirds.

These declines, I want to stress, have occurred despite strenuous efforts to shore up the market's erosion. We have enacted most of the good ideas that are out there, and they have indeed helped quite a bit. Laws like the Health Insurance Portability and Accountability Act have been vitally important by providing for guarantee issue and portability within the group market and in between the group and individual market. Without laws like these, conditions would only have worsened much more than they have.

But things continue to worsen despite these good efforts because the basic market conditions that cause the problems are still very much in place. That is the main point I want to stress. The market's problems derive not from bad or inadequate policy, but more fundamentally from a basic fact of human nature or the human condition, that the need for medical care is highly skewed throughout the population.

The high concentration of medical costs in a relatively few number of people is the single most important fact for understanding how the private insurance market functions. To better make that point, let me refer to the graph on page 3 of my written testimony, which I have had enlarged here.

This shows the population arrayed in order of health spending within a given year. What you see is that the top 1 percent of the population, those like Mrs. Kelly who spend more than \$43,000 a year, account for 22.7 percent of total expenditures. So 1 percent of the population accounts for almost 25 percent of total expenditures.

On down the line, if we go all the way to the top 20 percent, those who spend more than about \$4,000 a year, that group as a whole accounts for 80 percent of total expenditures. The remaining 80 percent of people account for only 20 percent of expenditures, and half the people account for only 4 percent of expenditures. So I call this the 80/20 rule: 20 percent of people account for 80 percent of the costs, and 80 percent of the people account for only 20 percent of the costs.

Because of this basic phenomenon, insurers obviously stand to gain a great deal by identifying and either pricing out or avoiding high-risk people, and they also stand to lose a great deal if they do not attract a good number of the low-risks. Because so much money is at stake, competitive forces naturally and unavoidably focus on risk selection. Other ways to improve value, such as mentioned by Mr. Williams, are also part of the market, but they simply are not as profitable as the risk selection aspect.

That is why market regulation is so hard to do. The 80/20 rule cannot be avoided or simply wished away. It is a fundamental law of nature, as fundamental as gravity and as pervasive as the weather. It has been observed as early as the 1930s, and it will surely be with us for as long as anyone can foresee.

For instance, even if we entirely remove the top 50 percent of the market, we would still be left with a skewed distribution in which the remaining people at the top account for 10 times greater expenditures than the middle part of the distribution. So even removing the very high-risks, or half the risk of the market, would leave a highly skewed distribution in which there is money to be made by attracting fewer of the high-risk folks and more of the low-risk folks.

It is this basic dynamic that creates most of the problems that we have heard about, starting with medical underwriting. Now, as Mr. Williams said, medical underwriting is necessary because of adverse selection, the tendency of people to avoid the purchase of insurance unless they really expect to need it.

The health insurance market can never survive, or even form in the first place, if people could simply buy their insurance on the way to the hospital. Therefore, medical underwriting rewards people who purchase while they are still young and healthy and imposes pre-existing condition exclusions or charges higher rates for those who are not.

Even without medical underwriting, risk selection and segmentation still occur in the market because subscribers naturally sort themselves by risk classes, to some extent, according to the covered benefits and plan features that they find most attractive.

This gives insurers good reason to create new and attractively priced policies targeted to healthier people who are shopping for insurance, but focusing new policies on healthy people segments the existing subscribers into older policies whose prices increase much more than average. If employed aggressively, these sorting techniques become known as churning, but this kind of risk segmentation happens on its own to some extent even without any sort of manipulation.

I provided a glimpse of the market's more troubling dynamics. They are quite prevalent in the individual market, but the large group market still works quite well. Small groups are somewhere in between. Various insurance market reforms aim at keeping things from getting a whole lot worse, but they are not capable of eliminating these problems entirely because the problems, again, flow from the elemental nature of how competitive markets should, and must, respond to this concentration of health risks. Therefore, the problems will always be with us unless the market is fundamentally restructured.

If I could take just one moment to conclude: the basic requirement is to place people into large groups where membership is not tied to health risk. It is probably also necessary to limit the choice of plans to some extent within the groups. That is how large employer groups currently work, which is why they remain the best-functioning part of the market. It is also how things work with the Commonwealth Connector in Massachusetts and with Medicare Part D.

To meet those conditions, everyone who is eligible must agree to purchase insurance from their assigned group, and the insurers must not have too much of a stake in how healthy or sick each subscriber is. That may be easy enough to state in the abstract, but it is exceedingly difficult to achieve in practice. So, I wish this committee and the Senate Godspeed and wisdom in pursuing the formidable challenges that lie ahead.

Thank you.

The CHAIRMAN. Thank you, Mr. Hall.

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

The CHAIRMAN. Let me just follow up on your basic points. You are basically suggesting larger pools, and also some limitation of, I guess, choice, at least in the individual market. But then you said that is extremely difficult to do. Let me press you a little bit. If you were to go a little further in thinking this through, how would you define the pools? Some say sub-pools, some say larger pools.

How would you advise us or the insurance industry to limit choice so that the pool is large enough, but still pre-existing conditions are somewhat dealt with one way or the other? My gut sense is, the larger the pool the better. That takes away a little bit of the second problem of limiting choice.

Then second, I do think there should be some significant limits on choice. I think there are just too many plans out there. But your thoughts?

Mr. HALL. Well, great questions. The choice element is probably more important than the size element. A pool can be an adequate size if it is only—I do not know, I have to turn to my insurance experts—500 or 1,000. It does not have to be tens of millions to take advantage of the law of large numbers. Even in a group of 500 you are going to get a distribution similar to the one I showed.

It is important, though, that people stick to the pool that they belong to, so I am not suggesting that 500 is necessarily large enough. But it does not have to be millions and millions, it could be thousands and thousands. But the key is, if people are allowed to change pools, to pick pools, then you are going to have the sorting effect that tends to drive a portion of the people into an unaffordable zone.

So the main question in terms of pools is identifying membership according to some criteria other than health risk, so you belong to a pool because that is where you work, or you belong to a different pool because that is where you live, or you belong to a third pool because it provides subsidized coverage based on your income. So you can have pools formed in a variety of different ways, but the key is to limit the ability to move among pools based on individual health preferences.

The CHAIRMAN. Mr. Williams, your reaction to that? I sense that some in the insurance industry are a bit frustrated because people do change plans, are in and out of plans, and it makes it more difficult for insurers to plan. But the basic question is, what about pools? Define the size of pools. How helpful are pools? The second is limiting choice.

Mr. WILLIAMS. Yes. I would say that one of the things that does not carry over in insurance is, we all think about, more is better, larger is better. It really is not the size of the pool. If we were buying pencils or something, a carload, you can get a better deal than if you are buying a box.

In health insurance, if the concentration of the risk is at the extreme end, the left side of this chart, and it is all the top 1 percent, and it is an extremely large pool of the most expensive people, then you still end up with an unaffordable pool. The real key is to attract a pool that reflects a normal distribution of risk.

The CHAIRMAN. And how do you do that?

Mr. WILLIAMS. And you do that by having the basis of the pool be something other than your health condition—for example, employment. The reason that large employer groups work is people are in that pool not by virtue of their health status, but by virtue of their choice of where to work, or a pool that is put together on the basis of your occupation, or some other basis. So the basic notion is, pools are important. The fundamental size you really need is a thousand to a couple of thousand people. That is why insurance is more affordable for businesses that have 2,000 to 3,000 employees and above.

The CHAIRMAN. Assuming the membership is a normal distribution.

Mr. WILLIAMS. Yes. And the fact that they are there by virtue of their choice to work there is different than being there by virtue of being there solely for the purpose of getting insurance.

So I think the basic notion of pooling is fundamentally important to affordability, but it is not the size, it is mechanisms that give you a normal distribution of risk: some people who need it today, some who need it tomorrow, and some who will not need it at all.

The CHAIRMAN. What about limiting choice?

Mr. WILLIAMS. In terms of limiting choice, I think that is really more about the catastrophic component of choice, meaning that there is a set of decisions that we do want to limit choice on. That is regarding preventive care. Everyone should have access to the recommended—the clinically recommended—preventive benefits that are essential to be healthy.

Within that, people may have different choices about how they pay for an intermediate level of care that might represent a modest amount based on their income or their particular circumstances. The critical place to limit choice is to be certain that no one loses their home, suffers bankruptcy, and is able to maintain clinically cohesive care for catastrophic illness.

The CHAIRMAN. I thank you. My time has expired. But thank you very much.

Senator Grassley?

Senator GRASSLEY. Thank you, Mr. Chairman.

Mr. Williams, in regard to the 47 million people without health insurance, there are small business people like Mr. Arth and tens of thousands—maybe hundreds of thousands—of other people who want to provide health insurance for their employees. Can you tell us what the Federal Government and State governments do that makes it harder for Aetna to design, market, and sell products that people like Mr. Arth can afford? And while you are at it, are there any States where Aetna simply does not believe it is in their financial interests to operate?

Mr. WILLIAMS. I would say there are several things. I think one of those is a very difficult policy area for legislators and regulators, which is the whole area of benefit mandates. I think it is a difficult decision, because there are lots of very difficult cases that present themselves where it is very easy to add 1 percent or 2 percent to the premium.

When you have done that over a 20-year period, you end up with a significant impact. I think what we need are independent, objective clinical mechanisms to really answer the question of, what is the basic benefit package that enhances affordability and gets it to a price point? I think the other thing really is pooling. I think pooling is important. I think if we could pool Mr. Arth's firm with a company where the average age was 18 or the average age was 20, we would again restore a balanced risk pool and be able to make insurance more affordable to him.

The answer to States: there are States that we would prefer change some of their regulations and approaches. We tend to do business in all 50 States. Some are areas we choose to make significant investments in in promoting our small group business, and those are places where the market dynamics permit us to attract a balanced risk pool.

An example would be, New Jersey is a State where they have a guaranteed issue, where every individual can buy an individual health insurance policy. Unfortunately, that policy is twice as much as they would pay in the State of Pennsylvania. So you can buy it literally at the point of care, whereas, Pennsylvania has made a different trade-off, where there is medical underwriting permitted.

But I think the fundamental question that we have to address is, insurance is one mechanism. We have people in our society who do not have insurance, who need access to health care. How do we finance the fact that they need access to care and they did not purchase insurance or do not have insurance?

A lot of the solutions are the equivalent of taxing only the supermarkets to feed the hungry of the country. We have made a commitment that people should not go hungry, and so we mutualize over the whole society the cost of feeding the hungry, and we need to do the same thing for people who need health care and do not have insurance.

Senator GRASSLEY. Mr. Arth, insurance regulations differ from State to State. You being from Cleveland, what you pay for insurance is different from what somebody pays in Philadelphia or St. Louis, and that was just made clear by the difference between New Jersey and Pennsylvania. Do you think the Federal Government needs to act to limit the ability of States to drive up health insurance costs for small businesses? How big of a concern is it for you

and other small businesses that your State could push you out of the insurance market at any time?

Mr. ARTH. Well, I think Mr. Williams just mentioned how all of these State mandates add up over time and add to the cost of insurance. I know Ohio—I do not remember the number—has a large number of mandated coverages specific to our State. So one of the principles of NSBA's reform proposal, and something I personally support, is this notion of a bare-bones policy, something that will meet the basic requirements for health care, and especially protect against a catastrophic event.

It is not yet fair for me to say that competitors in Indiana have an advantage over me because they have fewer State mandates, but in my involvement with the group plan in Cleveland, State mandates were an issue very high on our priority list, and we were very concerned about the additional cost they created.

There is evidence out there—and I do not remember the numbers—that a 1-percent increase in the cost of health insurance translates into a 6-figure number of people who will lose their health insurance because employers will choose to drop it. So it is an important issue, and that is why we support this idea of a basic plan.

Senator GRASSLEY. All right.

Professor Hall, last week we had Ford Motor Company testifying where you are. I want Ford Motor Company to succeed and provide insurance, but I care about someone like Mr. Arth and his 31 employees who have it.

Do you think that the way the Federal Government regulates insurance through ERISA and the way States regulate smaller insurers, as they can also because of ERISA, create a bias against small business?

The CHAIRMAN. If you would answer briefly. We are going to have a vote at 11:30, and I want every Senator to have an opportunity to ask questions, so I am going to adhere to the 5 minutes quite strictly.

Mr. HALL. Very briefly. Yes, small employers are in a different market and a different regulatory field than large employers covered by ERISA. On the other hand, we have the difficult balance between federalism principles that respect States' autonomy to address issues the way they see versus the concerns that you just expressed, so it is a difficult and messy balance to strike.

The CHAIRMAN. Thank you, Senator.

Senator Bingaman?

Senator BINGAMAN. Thank you all for being here. Thanks for your testimony.

Professor Hall, let me ask you. You identified the central problem of our health care system being the need for companies to engage in risk segmentation, basically to deal with this adverse selection process.

Let me ask you about two specific areas that we have a lot of debate about around here. One is these health savings accounts. It has been my concern that every time a person buys a health savings account, or pretty much every time a person buys one, that is one more better-than-average healthy person who is excluding

themselves from the pool that might be otherwise insured, so that the problem of risk selection becomes worse.

Association health plans are another example. We are pushed to go ahead and approve association health plans. Again, my impression is that that has the effect of taking relatively healthy people out of what would otherwise be a larger pool and thereby running up the cost of health care for everybody else.

I would be interested in whether or not I am real confused on this, whether you agree with those points, whatever your thoughts are.

Mr. HALL. Thank you for the question. Yes, I agree. I share those concerns. Those concerns are very real and show the difficulty in making positive improvements in a complicated market like this.

That is not to say that association health plans or health savings accounts are necessarily a bad idea, but one has to be very careful about how they are implemented, to implement them with the awareness of the existing problems and with the awareness that we need to avoid making them vehicles for extreme risk selection. So I do not want to over-emphasize the problem in order to kill any attempt to make positive reforms, but those are two examples of things that could indeed aggravate risk selection.

Senator BINGAMAN. Is there some way to buffer against that? I mean, the way it is currently structured, the health savings accounts are a way to get healthy people out of the pool that is otherwise insured, are they not?

Mr. HALL. Yes. But there are several ways. One is risk adjustment, where you have reallocation between the two risk pools to offset that. A second is providing more help to people with chronic illnesses to purchase or to choose a health savings account. So one reason health savings accounts discourage sicker people is they are afraid they are going to run through their account more quickly.

So, if they were given larger accounts, then essentially you risk-adjust the size of the account, if you will, which currently is not permitted by the tax rules. So I think one small but positive change would be to allow employers to contribute more to the savings accounts of chronically ill people than to their healthy employees.

Senator BINGAMAN. But now, Mrs. Kelly, who was here on our screen a little while ago, if you have the circumstances she has, there is no way you can ever get coverage through a health savings account for that kind of illness. Am I right?

Mr. HALL. Right. In the ideal situation, the savings account would be approximately the same size as the deductible, so essentially you are paying your deductible out of a savings account that you have established for that purpose. Of course, you would have to be able to replenish that each year.

But the advantage of that is then, when you incur any medical expenses, you are getting the benefit of the negotiated discounts that the insurer has obtained for you, so, even though the ultimate coverage is only catastrophic, you are getting discounted care from dollar one rather than treating you as a self-pay patient, which is apparently what happened to her.

Senator BINGAMAN. So she, instead of having to pay the, what was it, \$130,000—

Mr. HALL. One hundred and thirty-seven thousand dollars. Yes. Senator BINGAMAN [continuing]. That she owes, plus the \$80,000 she has already paid.

Mr. HALL. Right.

Senator BINGAMAN. She would be able to pay something less.

Mr. HALL. She would be paying Blue Cross numbers rather than person-off-the-street numbers.

Senator BINGAMAN. All right. My time is up, Mr. Chairman. Thanks.

The CHAIRMAN. Thank you very much, Senator.

Next, Senator Kerry is not here. Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. This is a great panel.

Dr. Hall, I am going to leave you alone because I so strongly agree with your views about the insurance market. If you are going to restructure the market, you have to place people in large groups whose membership is simply not tied to health risk. We do that in our legislation, the Healthy Americans Act, and I think you are right on target.

Mr. Arth, you had nice things to say about the bill in your written remarks, so I probably ought to quit while I am ahead, but let me try a different way of getting into this with you for a minute. A large fraction of the uninsured today works at small businesses, and the fact is, these small businesses love to cover their people, but they cannot afford it. So, this is all about getting more affordability for both the worker and the employer.

Let me kind of kick off what I think the key elements are and see if you agree. I think we are in sync on this. First, we have to change the tax laws so as to eliminate the disadvantage for the small businessperson—change the incentives. We have been talking about pooling. That means that, instead of having four or five people at your small business, you are part of a big pool so you have more bargaining power. Then we have insurance reform so that, say, if one of your people has a pre-existing illness, they do not get clobbered because they are being discriminated against.

Next, you have to be able to find good, affordable providers. If you are going to have a marketplace, you have to have a lot more information in order to make the marketplace work. Fifth, you have to have relief from some of the mandates, particularly the ones that are less important, while still keeping personal responsibility so that the individual has some stake in the operation.

Does that strike you as kind of the check-off list of the key elements? That is what we tried to zero in on in the bipartisan Healthy Americans Act. But I would like your thoughts. Maybe some of these are more important than others to you. But take me through the list as it relates to the key concerns, because I think all of those go to affordability and being able to make the market work.

Mr. ARTH. Senator, I am glad I am able to agree with you. I would not want to get into some sparring match. But starting from the top of the list, changes in the tax treatment of how premiums are paid is important. I happen to be a C corporation, so it does not affect me personally, but any other business entity, the treatment of the owner is different from the employee, and that serves

as a disincentive to the owner to create programs. So, I think that is an important consideration.

The pooling issue is also important. I know there have been many proposals for association health plans or other pools, but they get into that problem of splitting up the risk pool into smaller fragments so that people can skim off the very healthiest and the very best. From what I understand of the Healthy Americans Act, you have taken steps to try to address that to make sure that risk pools are properly balanced, which will address that issue.

You have to get into insurance reform if you are going to change pool composition. I think you are talking now of community rating models and restrictions on pre-existing condition exclusions and those kinds of things.

In my own particular case, where I have one very expensive claim, I am not sure exactly where that fits into market reform, except for the comment that was made about taxing all the grocery stores to feed the hungry. We do things in this country because we can, with little consideration given to what it costs. I would not want to deprive this person of treatment.

I do hope that there is effective case management and that someone is looking over a shoulder to make sure that the treatment is being effective. I cannot ask those questions. I only know about it because I was told about it. So, I hope the market is doing its job in making sure that case management is in place and that the treatment is appropriate.

Information is so important. I can get more information if I want to buy a television than if I want to have my knee repaired, and that just does not make sense. That is a big problem. It works because most patients are willing to kind of let the system take care of them. We really need to get patients involved with their own health, with wellness initiatives and with selecting the care they get, but we have to have the information. We had an effort in Cleveland. It crashed and burned, unfortunately.

The mandates. I think we have already covered the fact that they drive up costs. They are very well-intentioned, but for small businesses they fall fully on us because we are the fully insured group. Ford Motor, across the street from me, has an ERISA plan. So all these well-sounding mandates end up being paid for by the small group and the fully insured sector.

Senator WYDEN. Thank you, Mr. Chairman.

Mr. ARTH. Thank you, Senator.

The CHAIRMAN. Thank you, Senator, very much.

Senator Salazar?

Senator SALAZAR. Thank you very much, Mr. Chairman.

This is a question for Mr. Williams from Aetna, but I will use the information from Mr. Arth as preparatory comments to the questions. I understand very much what you said, Mr. Arth, coming from a small business with 22 employees. Your statement about the jobs created by small business is very accurate, and it is very important for us to make sure that we are trying to find a solution for these employers like yourself who want to provide health insurance to your employees.

But looking at your statistics for 2007, where you had a 22-percent rise in the increase of your premium, that is a shocker. Un-

fortunately, I think that is a shocker that we hear far too often across the board in the small business community. One of the recommendations that I heard from Mr. Arth is that we need to move forward with some kind of universal coverage program that establishes, I think your words were, a base coverage that would be provided to everyone.

My question to you, Mr. Williams, is, what do you think about that concept? How do we establish some kind of a base coverage that would be available to everyone that might cover some of these 80 percent of our health care costs essentially being consumed by 20 percent of the people?

Mr. WILLIAMS. I would start out by saying that I think the one issue that we have not really focused on is the fact that the cost of health insurance is an underlying reflection of the cost of the health care system itself. We are simply collecting the cost and passing it on, actually—and we heard from Mrs. Kelly—negotiating discounts and really advocating on behalf of the consumer to get them a better deal. So I think in terms of the—

Senator SALAZAR. Well, how do we bring health care costs down then?

Mr. WILLIAMS. I think how we bring health care costs down is to apply what we have applied to every facet of our business and industry, which is information technology to connect the system, to move the information around so that we avoid duplication, so that physicians and other health care professionals have the best, the most accurate and timely information in the system to create more value in that context.

Senator SALAZAR. How can we be assured that, if we move forward with some of those reforms and investments in information technology and recordkeeping, that we actually are going to see some constraint in the growth in health care costs? I mean, when you talk about a 7-percent increase a year from 1993 to 2003, how do we know that the IT or some of these other things we are talking about are going to bring down the costs, which you say are what is causing the rise in insurance rates?

Mr. WILLIAMS. One, there obviously is no guarantee. But two, I can look at what has happened. One of our subsidiaries just published a study in the *Journal of Health Economics*, an independent peer-reviewed publication, that demonstrated that, where you can bring the data of an individual patient together and use the best evidence-based medicine as published in the *New England Journal of Medicine* and the *Journal of the American Medical Association* and really use the lab data, the pharmacy data, the claim data from the individual physicians, you are able to produce savings of 6 percent simply by using what we know. I believe that, if we can truly connect the system, that the savings could be much more substantial.

Senator SALAZAR. These are complicated questions, and that is why I am so delighted that, through his leadership, Chairman Baucus has decided to hold this Health Care Summit next week, because I think these are the kinds of questions that we need to get into a much deeper discussion on.

One of the problems, I think, is the complexity of the system. I would think Mrs. Kelly was probably very fortunate in that she

had a trust fund that helped her get high-risk health insurance and she was able to pay for it, was able to get money from a trust fund to pay for her costs at M.D. Anderson.

But I would imagine for most of the people who are underinsured and who find themselves in those circumstances, they enter into this world of insurance with an expectation and simply not understanding that there are lots of limitations on what they are going to get coverage on.

So I guess my question to you is, do we just have a fundamentally broken system in that it is too complex or that the consumers simply do not understand it? If it is, how do we simplify this so that the American consuming public can understand what they are buying when they are buying health insurance?

Mr. WILLIAMS. I think it is fair to say the system is complex, that if we were designing a system from scratch we would not build a system that works the way this system works. However, it is 17 percent of the Gross National Product of the country, and we need to proceed with caution as we look at how we make changes.

I think that the member has not been asked, nor educated, to be engaged. What we find is, when you build the information support tools—for example, at Aetna, any of our members can go online through the Internet and find out the cost of a physician's top 30 procedures before they see the physician. That is revolutionary. In health care, you never knew what anything would cost until after the service was rendered.

Senator SALAZAR. I appreciate that.

Mr. WILLIAMS. So I think we have to create much more of a market.

Senator SALAZAR. My time is up, and I do very much appreciate all of your testimony this morning.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator.

Senator Stabenow?

Senator STABENOW. Thank you, Mr. Chairman. I, too, am very grateful for not only the hearings, but what we are doing with the Health Summit. Thank you for doing that.

The CHAIRMAN. And thank you for participating Monday.

Senator STABENOW. Thank you to everyone for coming. Mr. Arth, I think there is no question, from a small business perspective, you are hit right between the eyes on this and every other cost, and yet creating the majority of jobs in the country, and representing, I think, a very important national organization. So, thank you to all of you for being here, but particularly we need to have small businesses involved in the solution.

But I want Mr. Williams to speak to sort of where we go from here. There has been a lot of discussion about health reform efforts that should include a mandate on individuals to purchase insurance, and I am wondering, if there was a State or Federal individual mandate for individuals to purchase insurance, assuming help for low-income individuals and so on, could you then support the elimination of all pre-existing condition denials and exclusionary riders and waiting periods under that kind of a system?

Mr. WILLIAMS. If we create in this country an individual coverage mandate that works and is enforceable, I believe that we can elimi-

nate the pre-existing and medical underwriting activity in the industry and in the country, but we must have something in which everyone participates in the system so that we can achieve a balanced risk distribution and go to work on really helping those individuals who are ill get access to the highest quality care.

Senator STABENOW. Thank you.

Have you looked at our Healthy Americans Act that Senator Wyden has been such a champion on with all of us in terms of a universal policy using private health insurance delivery?

Mr. WILLIAMS. Yes, I am somewhat familiar with Senator Wyden's legislation. We talked about his program.

Senator STABENOW. We certainly would welcome your input on that.

Let me move to another topic and ask you, in terms of cost, you have indicated that your after-tax profit is about 6 cents per premium dollar. I am wondering how that breaks down between the individual market, the small group market, and the large group policies?

Mr. WILLIAMS. This is an excellent question. The answer is that the individual market is actually less profitable for us than the middle and the higher end. We tend to sell more fee income services, things where employers hire us to do condition management, disease management, health informatics work, where the margins are actually a little bit better than they are on the core insurance.

The individual, because there is no employer, there is no human resources, there is no billing department, the expense of working with the individual is a little bit more. So from our point of view it is not as profitable a business, but we view it as an important business and one that we are interested in growing.

Senator STABENOW. So from what you are saying then, can I assume the administrative costs then are the most for the individual market versus the group markets? Where are the administrative costs—

Mr. WILLIAMS. Yes. I would say that it is fair to say that the administrative expense associated—we think that our administrative expenses, when we look at pure general and administrative expenses roughly, are in the 10-percent range. When we adjust it for fee income where we do self-insured, our administrative expenses would be on what we call premium and equivalence, about 7 percent. So we worked very hard to be efficient.

I think the thing that is not well understood is how much we invest in information technology to predict which members, next year, will be the high-cost cases, help them get connected into a physician, into the health care system, so that they can have that episode of care in the most cost-effective way.

Senator STABENOW. On health information technology, I hope you will be working with us as we look for ways from a more systematic standpoint to be able to address the technology issues I think that are critical, not just for your company, but for all of us.

Mr. WILLIAMS. Yes.

Senator STABENOW. Thank you, Mr. Chairman.

Mr. WILLIAMS. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Kerry?

Senator KERRY. Thank you, Mr. Chairman.

Needless to say, as we are discussing here, we have a major overhaul staring us in the face, and the system is degrading daily. So this has to be, as the chairman has put it, at the top of our agenda next year.

Now, I believe that the best and most politically viable reform option is to maintain the parts of the system that are working and build new options to fill in the gaps. We have been through this in 1994, we have been through it in 1986, and at other times. To me that means stabilizing the employer-based market. You have 160, 170 million people in it who are currently getting insurance through their employers.

We also want to build around, I think, the public programs, Medicare, Medicaid, SCHIP, et cetera, because they do provide high-quality coverage and they provide it, frankly, more efficiently than the private market does.

Finally, we have to provide a new insurance option to the millions of Americans who do not get anything at all or who work for small businesses that do not have the purchasing power or the resources to be able to cover people.

But it seems to me that President Bush, and now Senator McCain, are promoting a policy that would effectively unravel the system, as I judge it, because they leave employees on their own to go out and purchase insurance in a deregulated market where you can discriminate against anybody who is sick or has a pre-existing condition, and those markets are particularly problematic for the disabled.

So, Mr. Hall, let me just query you a little bit along that line. You state that the large employer groups "remain the best functioning part of the market and that we need to get more people into groups like them where coverage decisions are based on a worker's choices, not on the health risks." That is what I heard you say, Mr. Williams, also when I was here earlier.

So if we unravel the system, if you just go out and give people "tax credits," are you not going to wind up with an incredible unevenness in the system, also with costly administrative waste increases as workers move away from a functioning group that is essentially community-rated and guaranteed-issue, and then they go into a market that favors costly current insurance practices?

Mr. HALL. That is the main concern. If you move from purchasing and providing health insurance on a wholesale basis, as employers do, to a retail basis, as tax credits or vouchers would, you certainly introduce a whole new set of problems.

Senator KERRY. Among them higher cost and discrimination, adverse selection, et cetera.

Mr. HALL. That is right. I assume that legislation would prevent overt discrimination, but there are more covert ways in which it tends to happen on its own even without trying.

Senator KERRY. Right.

Mr. HALL. But the other point, Senator Kerry, is also the point about administrative costs. Senator Stabenow was hitting at the point that the medical loss ratio for individual insurance is much lower than for group insurance, which reflects the residue of the premium that goes towards overhead.

Senator KERRY. Mr. Williams, you discussed the Kentucky experience with community rating. Let me throw another example out on the table. The State of New Hampshire repealed its adjusted community rating system for the small group market and it allowed significantly more premium variation.

As one would expect, premiums for smaller firms, firms with older and sicker workers, and firms in certain geographic areas all faced large premium increases, while larger firms with younger and healthier employees saw their premiums fall.

Among firms of 2 to 9 workers, 41 percent of employers faced premium increases of 30 percent or more. New Hampshire promptly repealed the law 2 years later and went back to the community-rated system that it had before. Are you familiar with that experience?

Mr. WILLIAMS. I am actually not. But based on what you are describing, it sounds quite consistent with what could happen.

Senator KERRY. So you say that the employer-based pool of coverage is really a strength to be built upon, correct?

Mr. WILLIAMS. Correct.

Senator KERRY. And despite being a proponent of employer-based coverage, you also suggest providing tax incentives for the purchase of health insurance in the individual market. A number of health and tax analysts, however, have pointed out that those incentives would lead some employers to no longer offer health insurance because there is a tax incentive out there, and those in poorer health would likely be unable to buy any insurance in that market and then they end up uninsured. Is there not a contradiction in sort of playing to the strength and expanding the pool, and then offering something that in fact pulls people away and might wind up adding to the uninsured pool?

Mr. WILLIAMS. I think you are fair to conclude it is a complicated set of issues. What I can tell you is, I spend an enormous amount of time with the benefits departments of the top 50 companies in this country. They are the most sophisticated purchasers, they are the most demanding, and they are doing, I think, a very positive job of having a positive impact on the quality of health care that is delivered in America.

I think as we look at how we expand coverage, there are interrelationships and I think there are policy decisions that legislators have to make about, how much do we neutralize the cost of health care, meaning, how much of that increase can the small business bear and how much do we shift to the individual market or to the large group market?

At the end of the day, if the insurance market is a voluntary market, it is not my opinion that matters, it is the opinion of the purchaser who decides that you have shifted too much to them and they simply cannot afford to offer the product.

Senator KERRY. Is that not exactly what we face today?

Mr. WILLIAMS. I think we face it as an issue. We still have over 250 million people who have coverage, and a big percentage of those people are in the commercial market. But it is an important issue, and I think that is why we are here.

The CHAIRMAN. Thank you. Thank you very much.

Senator Snowe?

Senator SNOWE. Thank you, Mr. Chairman. I know we have a vote pending.

I want to thank all of you for being here today. My focal point will be on small business, specifically as ranking member, and I know in joining with Senator Kerry who chairs the Small Business Committee. The single greatest problem facing small business, as you well know, Mr. Arth, is the cost of health insurance. It is simply a crisis long overdue to be addressed.

Senator Durbin, Senator Lincoln, Senator Coleman, and I have introduced legislation. Again, it is refashioning legislation that has previously been introduced by myself and others regarding pooling for small businesses nationally. This legislation gets at many of the issues that have been raised here today in my opinion, and I would like to have you comment on it.

I certainly want to share this legislation with you because we now have the support of a broad-based coalition across the spectrum, from the NIFB, the National Realtors, AARP announced its support yesterday, the Service Employees Union, and Families USA. It goes on and on because we have brought people together, disparate groups, to address each of the issues that have been raised. What we do is create a national pool for small businesses to join. We also begin the restructuring that many of you have identified, and Mr. Hall, you mentioned.

One of the issues is that we prohibit health status as a rating. And States can drop their pools, provided, of course, they agree to major restructuring through health status, prohibiting health status as a rating. They also get tax credits if they adopt these reforms as well for those who might have some issues with cost because, as we know, depending on which pool you are in, which employer you are working for, you might have a better plan than those who may be in a pool that has much sicker individuals. So, it would spread the risk. We also address the benefit mandates by allowing the National Academy of Science's Institute of Medicine to develop clinically and appropriate standards and practices.

So that is how we address the mandates question, which I know, Mr. Williams, you mentioned is one of the most vexing challenges and was here when we considered similar legislation on the floor last year.

Do you think that that is something that could address some of the issues? I know, Mr. Arth, your Council of Small Enterprises is a pool in northeast Ohio. I do not know how that compares to what we are doing, but we have to address this issue. We have a broad range of support, and it is really legislation that is long overdue. I think we can address it, given what we have put together, and I think responding to the problems of the past.

Mr. WILLIAMS. I think I would simply say, I think that anything that can create pooling is a very positive force in the marketplace. I would also just encourage that we pay attention to creating a level playing field so that there is not an opportunity for either individuals or others to move their place of insurance to one place, to the extent we attract more favorable risk, because they do not have to pay the mandates and lower costs, and then the rest of the insurance pool can be impacted. So there has to be a level playing

field, and I think many of the attributes you have in that bill sound very positive.

Senator SNOWE. I appreciate that.

Mr. Hall?

Mr. HALL. Yes. I think it sounds very innovative and has a lot of positive features.

Mr. ARTH. And Senator, much of what you described is the kind of thing we have been looking for. The one thing that struck me—and I am not clear how this works, so forgive me for not being fully up to speed—is that it sounds as though you could have a situation where you have two different sets of rules in a State, a Federal set of rules and a State set of rules, so it would be different. That raises some concern, based on my prior experience—this is my personal opinion—that you then create the opportunity for one pool to attract the healthy people and the other pool to be left with the ill and the harder to control.

Senator SNOWE. So they would be required to eliminate health status as a rating and vary the other ratings similar to what States do now so that you do not have that discrepancy and that there is not any adverse selection. I would like to share the legislation with you all because I think it is important, and I think it is something that could be done this year.

Senator Lincoln has joined us, and we have been working on it for a long time. So, I hope we can share that with you. I would appreciate your input on this, given what you have testified hereto today, and I thank you.

The CHAIRMAN. Thank you, Senator, very much.

Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman. I will try to be brief because I know we have a vote.

But Mr. Arth, your story is just way too familiar to me, and I think to many of us from small States where small businesses are our number-one source for jobs in Arkansas, and I know in many other States. Only 26 percent of those businesses with fewer than 50 employees offer health insurance coverage, and it is an enormous issue for us.

I have been extremely proud to work with Senator Snowe. She has been wonderful through the years as we have looked through and tried to find the common goals and figure out a way to really provide some solutions for small businesses and self-employed individuals, because they are the largest component of those 47 million who are uninsured. We want to do it in a responsible way that gives them a good product but lowers their cost, because, let us face it, I have yet to meet a small business that does not want to offer health insurance. It just needs to be affordable.

I guess one of the things, as Senator Snowe mentioned, in terms of being able to provide insurance in the pools that will make sense, both on a State level and then the national in ensuring that they do not have to use health status as a part of their rating, how important is stability in your plan premium from year to year for your company? In our bill we do ban those health status ratings, so companies like yours, your rates would not shoot up just because an employee gets sick. You would be able to maintain a balance there.

Mr. ARTH. Senator, it is absolutely critical for us in our planning. What we have seen now, and what I face going into the future, is probably the State maximum, in the range of 35 percent a year. I can plan on that, but it is not the kind of thing I can live with.

Senator LINCOLN. Well, for any business, I think the unknown, unfortunately, is the most dangerous. We also, as Senator Snowe mentioned, in providing incentives through the tax code, are able to really increase participation in the plans, in the pools, and therefore get to where we want to be quicker, we hope.

The last question to Mr. Williams. I just wanted to touch on the issue of guaranteed issue. It sounds to me that you are suggesting that, because guaranteed issue and other requirements are driving up the cost of premiums, that maybe perhaps we should do away with guaranteed issue and put the high-risk patients into some high-risk pool, in the States, maybe.

You mentioned that the existing high-risk pools are woefully inadequate. My concern, I guess, that we move to is, if we remove the sick people from your plan, put them in these high-risk pools, cover them by the States, who is going to pay for it? What are you going to do with all that extra money you get when you are just covering those well folks?

Mr. WILLIAMS. Well, I think, clearly, I was not clear, Senator. I think that the notion is that we invest a significant amount of effort and time in helping people who have severe health conditions manage those conditions. What we want is really a relationship with an individual or a company over a period of time, recognizing that, when you join today you may be young and healthy, but tomorrow something may happen through no fault of your own. We want to be there, and we want to provide that care.

The issue that I was trying to communicate is, if you have not been insured and today you need extensive care or expensive care and you join Aetna as an insurance plan, you really are not purchasing insurance, you really are purchasing the financing of your currently needed care.

We have certainly a strong expectation, and have invested a lot in things like managing cardiac conditions, asthma, diabetes, hypertension. We have over 30 different disease management programs to help people who have these conditions, but the object is to get into the health insurance pool, stay in the pool and, if you cannot afford it, then the question is, how do we as a society help you afford it?

Senator LINCOLN. Sure.

Mr. WILLIAMS. What I was saying was, to the extent that you have not been in the pool and you are not in the day you need health care and you need significant care, that perhaps a high-risk pool is an appropriate solution because it is not Aetna that pays the bill, it is how much of your cost shows up in the premium of Aetna members and how many of those are unable to then maintain their insurance.

The CHAIRMAN. We are going to have to conclude the hearing because we have a vote we are almost going to miss.

Thank you very, very much. This was very constructive, very helpful, and I deeply appreciate your attendance.
The hearing is adjourned.
[Whereupon, at 11:38 a.m., the hearing was concluded.]

A P P E N D I X

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD



Testimony from

Raymond Arth, Phoenix Products, Inc.

**On behalf of
THE NATIONAL SMALL BUSINESS ASSOCIATION**

For the hearing

**“47 Million & Counting: Why the Health Care Marketplace
is Broken”**

Senate Finance Committee

June 10, 2008

Good morning. I would like to thank Chairman Baucus, Ranking Member Grassley and the committee for inviting me here today. I am honored to testify before a committee recognized for its hard work and for its bipartisan cooperation. Each of us testifying today will provide you with a different story, a diverse perspective and I expect one, common conclusion—small businesses are being crushed by the burden of the increasing cost of health care.

I am here today in two capacities, as a small business owner and as a past Chair of the National Small Business Association and so have two parts to my testimony. The first is an overview of the challenges I have faced in providing affordable, quality health insurance to my employees; the second to briefly describe NSBA's position and policy recommendations for reform. I am not an authority on health insurance but I have had a lot of experience as a consumer, and participated in developing NSBA's policy recommendations.

Before I get into my health insurance adventures, it is important that we understand how broad this issue is, and why dealing with the problems facing small business are important. According to data from the U.S. Census and Small Business Administration Office of Advocacy, there are approximately 70 million people in the U.S. who work for or run a small business – that is more than half of the private U.S. workforce. For the past 15 years, small business has created on average 93.5 percent of all net new jobs—resulting in an average of 4,000 new jobs EVERY day. The small-business community's role in creating jobs and stimulating economic growth cannot be underestimated or made merely into a talking point. Neither can the extreme time and financial drain the current health care system poses for small-business owners.

In nationwide surveys, small-business owners consistently rank health care among their top concerns. According to the recently-released NSBA Survey of Small and Mid-Sized Business, only 38 percent of respondents—nearly 90 percent of whom employ less than 19 workers—offer their employees health insurance. That is down 3 percent from one year ago, down 11 percent from 2000, and down 29 percent from 1995. Despite the low-rate of offering health insurance, 69 percent of respondents rated health insurance as the top benefit they WANT to offer.

The cost of health care disproportionately hurts the smallest businesses, with only 25 percent of companies with fewer than 5 employees offering health insurance to their employees. Furthermore, the Kaiser Family Foundation estimates that 60 percent of small businesses shop for a new health insurance plan every year, but of those, less than half actually make any changes. These statistics tell us one very important, and far too bleak fact: small businesses have very few viable options. Unfortunately, that is where I find myself today.

Experience of Phoenix Products, Inc.

From the day we started our company, providing affordable, comprehensive health insurance has been a primary priority. My partner was a cancer survivor who had a variety of chronic health problems that were the result of the severity of his illness and the extreme measures taken to battle it. For over 30 years I have had to confront the challenge of finding suitable health insurance plans during which period the health insurance landscape has changed dramatically.

During that time we moved through a progression of coverage options; going from 100 percent, company paid indemnity plans with low deductibles through Preferred Provider Organizations (PPOs), to an HMO plan with a Point of Service option to high deductible coverage. In our discussion this morning I will focus on changes over the last few years.

My company also has gone through substantial changes, growing from a youthful start-up into a fairly large, small business with nearly 100 employees. Today, due to fundamental changes in the size of our core market and fierce foreign competition we are a much smaller and mature organization.

Phoenix Products is now 31 years old, and our employee group has gotten older with the company. Today our "average" employee is over 52 years old and has been with the company nearly 16 years. As the group has aged,

our health expenses have grown significantly and we have had to dramatically change the benefit structure of our plans to offset rising costs.

As recently as 2003 we still could afford to provide a plan with a \$250/\$500 deductible which included a \$15 co-pay for office visits and modest co-pays for prescription drugs. The monthly premium for this plan was \$218 for a single employee and ranged up to \$677 for full family coverage. But our group was shrinking, growing older and consuming more health care. At the same time, the cost of health care was increasingly rapidly, out of step with the rate of cost increases in other market segments. So my plan demographics and the dynamic increase in cost for health care were working against my group.

By moving away from what was a pre-paid health care plan that covered almost everything to an insurance plan that protects our employees from catastrophic events we have been able to control the premium increases which have grown by only about 10 percent from 2003 to 2007. Last year alone we avoided a 22 percent increase by moving to a very high deductible level. We were forced to pay a little more to cover much less.

Today we have a plan with a \$3,000 deductible for a single employee and \$5,900 for a family. The insurance company does not pay a thing until that deductible is met. Prescription drugs and office visits are treated like any other medical expense and are included in the same deductible limits. However, our company self-insures a part of the deductible so the actual exposure is limited to \$1,750/\$3,500 per employee.

Following our renewal last year I learned that we had a covered participant who had been diagnosed with Gaucher's disease, a very rare enzyme deficiency. While not immediately life threatening its long term effects can be devastating. Treatment consists of bi-weekly enzyme replacement therapy. Because the condition is so rare the cost of the drug is extremely high. As a result we have had extremely high utilization this last year and our renewal rates reflect that.

Our 2008 renewal rates are 35 percent above last year; the maximum allowed under Ohio insurance regulations. Quotes from other carriers were two to two-and-a-half times higher than our current rates. At this point we have exhausted all of the plan design options that could minimize our increase. Neither the company nor our employees are in a position to absorb an increase of almost \$40,000 in premiums.

The company pays a variable percentage of the premium based on the employee coverage, but in total we bear over 80 percent of the total cost. The increase in the cost of our health insurance has affected our employees over the last few years. The employee contributions have grown with the premiums. Wage rates have been frozen since 2001, though we do make occasional lump sum distributions of profits as conditions permit. The market is brutal so let me emphasize the word "occasional."

We have not yet figured out exactly what we are going to do about this renewal. We provide life insurance plus short-term and long-term disability coverage at the company's expense. Our average employee is now eligible for four weeks of paid vacation in addition to nine paid holidays. We are a family-run business and our employees are part of our family. As much as I do not want to resort to reducing some of these benefits, there are few other viable alternatives to offset the cost of health insurance.

Our situation has been aggravated because we have a single case that has such a dramatic effect on the total group. But last year, before this case emerged, we were confronted with a 22 percent increase that we averted by substantially increasing the deductible and self-insuring part of that risk. Despite countless hours working to redesign our plan to ensure its affordability, the rapid inflation in health care costs and our aging group are catching up with us.

As this committee rightly focuses on how to help small businesses afford health insurance, I urge you not to lose sight of the indirect costs our health care system imposes upon entrepreneurs. Often overlooked in the policy discussion is the time required to create and sustain a health insurance group plan. There are plan policies, procedures and documents that must be created and maintained, along with filing requirements for larger plans.

Annual shopping for new carriers or the evaluation of other plan design options also consume countless hours. In most small companies this means that the owner or other key employees are devoting their limited time to this effort. I can not begin to describe the exasperation and frustration that I experience trying to select the best plan option while lacking basic information about the actual utilization of the plan benefits; this information being "protected" under the HIPAA confidentiality shroud or otherwise unavailable. Each hour I spend struggling to find a way to continue offering health insurance to my employees is an hour NOT spent working to hire more employees.

Our group has experienced many challenges over the years and we have been fortunate to be able to find ways to continue providing our employees with a quality insurance plan that was affordable. But now we are squeezed between our group's demographics, the huge expense of a single case and the explosive increase in health care costs. After 31 years we may have finally found the limit of our ability to provide this benefit to our employees.

Broad Reform Proposal

My story is not unique. Small businesses are nearing a cliff, and we cannot continue down this path that creates such a significant competitive disadvantage globally and among larger businesses in our industry. When I was Chair of NSBA in 2004, the small-business community had been experiencing year-after-year double-digit increases in the cost of health insurance, and we decided it was time to come to the table with more than our horror-stories and criticisms. We spent a year working with myriad business owners, insurers and consumers, and crafted a proposal for reform that would fix not only our dilemma, but address the overall failures of the U.S. health care system.

While the need for reform is clearly urgent, and while there are a number of more short-term reforms that can improve on the system, what small businesses deserve is broad, comprehensive reform that will not only address the symptoms of a failing health care system, but cure the underlying illness plaguing the entire system.

The Realities of the Insurance Market

Implicit in the concept of insurance is that those who use it are subsidized by those who do not. In most arenas, voluntary insurance is most efficient since the actions of those outside the insurance pool do not directly affect those within it. If the home of someone without fire insurance burns down, those who are insured are not expected to finance a new house. But such is not the case in the health arena, where the costs of treating uninsured are split and shifted onto those with insurance in the form of increased costs. Moreover, individuals' ability to assess their own risk is somewhat unique regarding health insurance. People have a good sense of their own health, and healthier individuals are less likely to purchase insurance until they perceive they need it. As insurance becomes more expensive, this proclivity is further increased (which, of course, further decreases the likelihood of the healthy purchasing insurance).

Small businesses must function within the insurance markets created by their states. States have developed rules on rating and underwriting that attempt to establish the subsidies between the healthy and the sick. Most states require insurers operating in the small group market to take all comers and limit their ability to set rates based on health status and other factors. However, there is extensive variability among the states on these rules. Some states allow great latitude on rates, thereby limiting the cross-subsidies, but this makes insurance much more affordable for the relatively young and healthy. Other states severely limit rate variation, which often helps keep costs in check for many older, sicker workers, but drives up average premiums and puts insurance out of financial reach for many. These tight rating rules (known as "community rating" or "modified community rating") also can cause some insurers to leave certain markets they deem to be unprofitable. Problems in those states are then compounded by a lack of competitive pressures.

It is important to note the interplay between the small group and individual insurance markets, particularly in some states. In general, insurers in the individual market are not required to take all comers (at least not those not "continually insured") for all services and are allowed much greater discretion to underwrite and rate policies based on health history and a series of other factors. Individuals also can see their rates skyrocket if they get sick, usually to a much greater degree than in the small group market. In other words, there is far less of a cross subsidy in the

individual market than the small group market. That means that relatively young and healthy individuals can get much cheaper insurance in the individual market (at least initially) than they can get through an employer—particularly in states that have community rating in the small group market. In many of our smallest companies (under 10 employees but especially under five), it makes financial sense to increase wages to allow for the purchase of individual coverage. If the workforce becomes sicker, it may make sense to convert to the now-more-reasonably-priced small group market. This dynamic (and others) means that the “morbidity” of the under-ten market is much higher than the group market as a whole. Naturally, insurers often will seek ways to avoid serving an undue share of this market.

So long as we have in place a voluntary system of insurance, where individuals and businesses—at any given point in time—can choose whether or not to purchase insurance, this quest for the insurance rating “golden mean” will continue. While there has been endless debate about what the right set of rating rules should be, it is imperative that there be only one set of rules. Insurance markets where different players operate under different sets of rules are doomed to failure. Even in the interplay between the group and individual markets—which are different markets—we see the consequences of different rules. When two sets of rules operate within the same market, the self-interested gamesmanship that occurs among both insurers and consumers ultimately leads to dysfunction and paralysis.

Solution Principles

Any solution to the problem should abide by the following, most important principle - *primum non nocere*: first, do no harm. Often, legislation passed has hidden, unintended consequences that can create a larger problem than the bill initially sought to fix. Lawmakers must use a keen eye when considering any solution, no matter how incremental or sweeping, to ensure that the fix doesn't unearth an even bigger problem.

The second principle when discussing a health care fix for small business is to understand the real problems small businesses face. The biggest problem small businesses face is cost and competitiveness. Health insurance in the United States has transformed from a “fringe benefit” to a central component of compensation. The realities of the small group market make it much more difficult for a small firm to secure quality, affordable insurance than it is for a large business. The ebb and flow of workforce in a large company can be compensated for in their insurance pool simply due to the large number of workers. Whereas in a small business, that natural shift in workers can lead to extraordinary fluctuations in health premiums. Given these costs and general level of instability in the insurance market, the ability for a small business to effectively compete for good workers against large companies is exponentially more difficult.

There exists another competitiveness issue, and that is a global one. The U.S. boasts a unique entrepreneurial spirit and has been a leader in technological advances. A great deal of that innovation and creation comes from small businesses. According to the U.S. Small Business Administration's Office of Advocacy, small firms represented 40 percent of the highly-innovative firms in 2002, a 21 percent increase in just two years. Unfortunately, health insurance costs can serve as the deciding factor whether or not an individual will opt to continue with his or her business. A report released earlier this week by that same Office of Advocacy states that the presence of the health insurance deduction decreases the rate of exit from entrepreneurship for self-employed individuals by 10.8 percent for single filers, and 64.9 percent for married filers. What this tells us is that we are losing potential new advances and innovations due to the cost of health insurance, which holds serious implications to our overall global competitiveness.

The third principle is equity and common sense. While competitiveness does touch on fairness between large and small companies, equity in our mind is a different animal altogether. Any health care solution ought to provide the same benefits to a business owner as they do an employee. Tax benefits should be extended fairly to whichever party is paying for the health insurance, be it employers or individuals. Continually providing tax benefits to companies and employment and not individuals perpetuates the current system where employers are practically forced into providing insurance to their employees.

NSBA's Comprehensive Solution

In attempting to create positive health care reform for small businesses, one quickly bumps up against the reality that small business problems cannot be solved in isolation from the rest of the system. Since small businesses purchase insurance as part of a larger pool with shared costs, the decisions of others directly affect what a small business must pay and the terms on which insurance is available to them. It has become clear to NSBA that—to bring meaningful affordability, access, and equity in health care to small businesses and their employees—a broad reform of the health care system is necessary. This reform must reduce health care costs while improving quality, bring about a fair sharing of health care costs, and focus on the empowerment and responsibility of individual health care consumers.

There is no hope of correcting these inequities until the U.S. has something close to universal participation of all individuals in some form of health care coverage. NSBA's plan for ensuring that all Americans have health coverage can be simply summarized: 1) require everyone to have coverage; 2) reform the insurance system so no one can be denied coverage and so costs are fairly spread; and 3) institute a system of subsidies, based upon family income, so that everyone can afford coverage.

Individual Responsibility

Small employers who purchase insurance face significantly higher premiums from at least two sources that have nothing to do with the underlying cost of health care. The first is the cost of "uncompensated care." These are the expenses health care providers incur for providing care to individuals without coverage; these costs get divided-up and passed on as increased costs to those who have insurance.

Second is the fact that millions of relatively healthy Americans choose not to purchase insurance (at least until they get older or sicker). Almost four million individuals aged 18-34 making more than \$50,000 per year are uninsured. The absence of these relatively-healthy individuals from the insurance pool means that premiums are higher for the rest of the pool than they would be otherwise. Moving these two groups of individuals onto the insurance rolls would bring consequential premium reductions to current small business premiums.

Of course, the decision to require individuals to carry insurance coverage would mean that there must be some definition of the insurance package that would satisfy this requirement. Such a package must be truly basic. The required basic package should include only necessary benefits and should recognize the need for higher deductibles for those able to afford them. The shape of the package would help return a greater share of health insurance to its role as a financial backstop, rather than a reimbursement mechanism for all expenses. More robust consumer behavior will surely follow.

Incumbent on any requirement to obtain coverage is the need to ensure that appropriate coverage is available to all. A coverage requirement would make insurers less risk averse, making broader insurance reform possible. Insurance standards should limit the ability of insurance companies to charge radically different prices to different populations and should eliminate the ability of insurers to deny or price coverage based upon health conditions, in both the group and individual markets. Further, individuals and families would receive federal financial assistance for health premiums, based upon income. The subsidies would be borne by society-at-large, rather than in the arbitrary way that cost-shifting currently allocates these expenses for those without insurance.

Finally, it should be clear that coverage could come from any source. Employer-based insurance, individual insurance, or an existing public program all would be acceptable means of demonstrating coverage. More and more health care policy leaders are realizing the need for universal coverage through individual responsibility and a requirement on each person to have health insurance.

Reshaping Incentives

There currently is an open-ended tax exclusion for employer-provided health coverage for both the employer and employee. This tax status has made health insurance preferable to other forms of compensation, leading many Americans to be "over-insured." This over-insurance leads to a lack of consumer behavior, increased utilization of

the system, and significant increases in the aggregate cost of health care. Insurance now frequently covers (on a tax-free basis) non-medically necessary services, which would otherwise be highly responsive to market forces.

The health insurance tax exclusion also creates competitiveness concerns for small employers and their employees. Since larger firms have greater access to health insurance plans than their smaller counterparts, a greater share of their total employee compensation package is exempt from taxation. Further, more small-business employees are currently in the individual insurance market, where only those premiums that exceed 7.5 percent of income are deductible.

For these reasons, the individual tax exclusion for health insurance coverage should be limited to the value of the basic benefits package. But this exclusion (deduction) also should be extended to individuals purchasing insurance on their own. Moreover, the tax status of health insurance premiums and actual health care expenses should be comparable. These changes would bring equity to small employers and their employees, induce much greater consumer behavior, and reduce overall health care expenses.

Reducing Costs by Increasing Quality and Accountability

While the above steps alone would create a much more rational health insurance system, a more fair financing structure, and clear incentives for consumer-based accountability, more must be done to rein-in the greatest drivers of unnecessary health care costs: waste and inefficiency. Increased consumer behavior can help reduce utilization at the front end, but most health care costs are eaten up in hospitals and by chronic conditions whose individual costs far exceed any normal deductible level.

There is an enormous array of financial pressures and incentives that act upon the health-care provider community. Too often, the incentive for keeping patients healthy is not one of them. Our medical malpractice system is at least partly to blame. While some believe these laws improve health care quality by severely punishing those who make mistakes that harm patients, the reality is that they too often lead to those mistakes—and much more—being hidden.

Is it any wonder that it is practically impossible to obtain useful data on which to make a provider decision? Which physician has the best success-rates for angioplasty procedures? Which hospital has the lowest rate of staph infections? We just don't know, and that lack of knowledge makes consumer-directed improvements in health care quality almost impossible to achieve.

Health care quality is enormously important, not only for its own sake, but because lack of quality adds billions to our annual health care costs. Medical errors, hospital-acquired infections, and other forms of waste and inefficiency cause additional hospital re-admissions, longer recovery times, missed work and compensation, and even death.

What financial pressures are we bringing to bear on the provider community to improve quality and reduce waste? Almost none. In fact, we may be doing the opposite, since providers make yet more money from re-admissions and longer-term treatments. It is imperative to reduce costs through improved health care quality. Rather than continuing to pay billions for care that actually hurts people and leads to more costs, we should pay more for quality care and less (or nothing) when egregious mistakes occur.

Improved Consumerism:

Pay-for-Performance must be a policy goal for all providers. Insurers should reimburse providers based upon actual health outcomes and standards, rather than procedures. In some pilots, the Centers for Medicare and Medicaid Systems (CMS) already have begun this process. Evidence-based indicators and protocols should be developed to help insurers, employers, and individuals hold providers accountable. These protocols—if followed—also could provide a level of provider defense against malpractice claims.

Enhancing the use of electronic medical records and procedures should be a priority. From digital prescription writing to individual electronic medical records to universal physician identifications, technology can reduce unnecessary procedures, reduce medical errors, increase efficiency, and improve the quality of care. This data also

can form the basis for publicly available health information about each health care provider so patients can make informed choices.

NSBA's policy is broad, but doable. Five years ago the concept of requiring individuals to carry insurance was a non-starter, but that is no longer the case. With the Massachusetts legislature passing broad reform legislation that incorporates some of NSBA's key proposals, it is becoming clear that broad reform is really the only way to fix the problem. On the federal level, Sens. Ron Wyden (D-Ore.) and Robert Bennett (R-Utah) have introduced legislation, the Healthy Americans Act (S. 334) that also has some key pieces of the NSBA framework. Though NSBA may disagree with certain aspects of each of these proposals, they are to be applauded for moving the ball down the field and in doing so, changing the dialogue on this very important issue.

Targeted Solutions

While we argue that a comprehensive policy is truly the way to fix the health care market, we also realize that our plan is aggressive. In the mean-time, NSBA would support a series of more targeted solutions to provide some relief to small businesses and their employees.

Expansion of Health Savings Accounts

Health Savings Accounts (HSAs) are tax-free savings accounts that people can set up when they purchase a high-deductible policy to cover major medical expenses. Money from the HSA can be used to pay for routine medical expenses or saved for future health needs, while the major medical policy helps cover big expenses, like hospital stays. Unlike their predecessors, Medical Savings Accounts (MSAs), however, HSAs allow for both employer and employee annual contributions and unused funds to rollover. Individuals with an HSA can contribute up to 100 percent of the annual deductible of their health insurance program. HSAs also have lower minimum required deductible and out-of-pocket limits. Perhaps one of the most important changes from MSAs to HSAs is the fact that anyone can participate, and there are no longer restrictive limits on the program.

While HSAs have been available for nearly three years, there are still further actions Congress should take to expand the program. Individuals participating in an HSA should be allowed to deduct the premiums for the high-deductible health insurance policies from their taxable income in conjunction with an HSA. Increasing the tax benefit to these plans will increase affordability.

Pool Small Businesses Locally

There have been calls from various national small business groups to create Association Health Plans (AHPs). The push for AHPs are a reaction to the very dire circumstances small businesses currently face in the health insurance arena: huge premium increases, a lack of control and clout, the costly tangle of state and federal regulations, and fewer funding, carrier, and plan selection options than their larger counterparts.

Despite those good intentions, we are concerned that AHPs are not only a non-answer to the real issues driving cost, but will exacerbate the problems small businesses face. The primary focus and cost savings of AHPs is through circumventing state laws and rating rules. AHPs threaten to greatly worsen the market segmentation and risk-aversion that currently characterize the small group health insurance market, which are at the root of the health care crisis uniquely faced by smaller firms. AHPs might be good for small business associations (like NSBA) who want to run them, but NSBA believes that they will not be good for the small business community at-large, whose interests we are bound to represent.

One of the fundamental precepts that underpins the arguments of those advocating for AHPs is the idea that big pools will equal bargaining clout. In almost every market in the world, the larger the quantity you buy of something, the lower its per-unit price. In the health insurance market, however, the make-up and location of that pool are both far more important factors in establishing a price than size alone.

A pool of 1,000 people with an average age of 40 could demand (and receive) a much better rate than a pool of 50,000 people with an average age of 55. Moreover, when a plan is negotiating reimbursement with providers, a local hospital or physician will be driven by how many patients the plan will bring them. A local plan with a total

of 100,000 lives will be able to drive a much better deal than a big national plan with 5 million lives, only 15,000 of which are local.

NSBA encourages the development of local employer health care coalitions that would assist small employers in obtaining lower rates for coverage through group purchasing. Such coalitions also would assist small employers in learning about existing local health insurance plan options, how to be a wise health insurance purchaser, the issues of health care costs, health care quality and the availability of health care providers within their communities. Local employer health care coalitions would continue to be subject to their respective state laws. Therefore, there would continue to be a level playing field for all employers providing insurance in the small employer market. These coalitions already exist in many states, providing choice and savings for their members every day

Reform HRAs and FSAs

In 2002, President Bush and the Treasury Department highlighted Health Reimbursement Accounts (HRAs), which are similar to MSAs, but only can accept employer contributions, and employees cannot keep their excess funds. Though HSAs and HRAs are somewhat similar, HRA reform also would help those individuals seeking a low-deductible plan but also would like a savings account to help pay for medical costs. Reforming the HRA structure includes: allowing employees to contribute, allowing employees to roll excess funds into retirement plans, and, most importantly, allowing small-business owners to participate. Like so-called "cafeteria plans", HRAs specifically exclude owners of non-C Corporations from participating. This is a major obstacle that must be overcome if small companies are ever to take advantage of the potential of these plans.

On the subject of "cafeteria plans" (Section 125 plans), it should be noted that reforms of these plans also could be an important factor in increasing the ability of small-business employees to fund various kinds of non-reimbursed care. Two major roadblocks are in the way. First, small-business owners generally cannot participate in "cafeteria plans". Second, these plans have annual "use-it-or-lose-it" provisions, which cause some to spend money that did not need to be spent, but cause many more to never contribute to the plan in the first place. Fixing these two mistakes would be a real benefit to small-business employees struggling to meet their out-of-pocket medical bills.

Create Health Insurance Tax Equity

After 16 years of struggle and unfairness, small-business owners finally were able to deduct all of their health insurance expenses against their income taxes in 2003. Unfortunately, we are still only part-way to real health insurance tax equity for small business. Currently, workers are allowed to treat their contributions to health insurance premiums as "pre-tax," whereas business-owners are not. This distinction means that those premium payments for workers are subject neither to income taxes, nor to FICA taxes. While the self-employed owner of a non-C Corporation now can deduct the full premium against income taxes, that entire premium is paid after FICA taxes. Compounding matters, these business owners pay both halves of the FICA taxes as employer and employee on their own income for a total self-employment tax burden of 15.3 percent.

Right here in Washington, D.C., the cost of a Blue Cross/Blue Shield family policy in a small group plan has topped \$12,000 per year. A business owner who makes \$60,000 and purchases this plan for his or her family pays \$2,000 in taxes on that policy. An employee who makes \$60,000 and has the same plan pays nothing in taxes on that policy. By treating this business owner the same way that everyone else is treated in this country, we can give entrepreneurs an immediate 15-percent discount on health insurance premiums. Legislation has been introduced in the Senate by Sens. Jeff Bingaman (D-N.M) and Orrin Hatch (R-Utah) and in the House by Reps. Ron Kind (D-Wisc.) and Wally Herger (R-Calif.) that would bring this much-needed equity and tax relief to the nation's self-employed. I urge your support and co-sponsorship of the Equity for Our Nation's Self Employed Act of 2007 (S. 2239 and H.R. 3660).

Reform the Medical Liability System

The enormous costs of medical liability and the attending malpractice insurance premiums are significant factors pushing health care costs higher and restricting choice and competition for consumers of health care. Triple-digit increases in malpractice premiums over the last five years have been common in many states and specialties.

These costs have a distorting effect on the health care system by causing physicians to retire early, change their practices to serve lower-risk patients, move to states with reformed malpractice laws, and concentrate their practice in high-profit centers-making quality health care in rural areas and smaller towns increasingly difficult to access. All of these changes restrict competition and the ability of employers to negotiate lower reimbursement rates. But the most profound affect of the liability system is the "defensive medicine" that is practiced by many risk-averse providers. Unnecessary, purely defensive procedures, cost the health care system untold billions each year and drive up premiums for all of us.

Pay-for-Performance

NSBA is a strong advocate for pay-for-performance initiatives. One of the biggest usurpers of health care dollars is poor quality leading to further complications and cost. Quality health care is a major factor in reducing the cost of care, and providers must be compensated accordingly. The implementation of a third-party payer system has removed levels of accountability from all sectors of the current health care market where individuals, health providers and insurance companies have very different interests at heart. Individuals want ease and affordability, take very little responsibility in their care and do not generally make educated choices in terms of providers, procedures and costs.

NSBA strongly supports the CMS's new pay-for-performance policy change. CMS has taken the lead in implementing policy changes that will increase the importance of quality care. Through their reimbursements, CMS now will require hospitals to comply with certain quality standards. Those that do comply will see a small percentage of their reimbursements withheld. This kind of thorough evaluating and monitoring is necessary in providing patients with the highest quality care possible.

Improvements in Technology

Improved and standardized technology is necessary to gauge provider quality and ensure simple mistakes are not made as frequently. Individuals all should have a privately-owned, portable electronic health record. This would enable individuals and their doctors to access the record without having to wrangle a massive paper trail.

The system currently used for prescriptions also is outdated. NSBA urges the use of technological devices when issuing prescriptions in order to avoid costly and dangerous mistakes. The medical industry needs to establish a set of protocols by which doctors, hospitals and other care-givers can be evaluated. Improved technology will help providers report their compliance with these protocols. Such information should be made widely available to health care consumers.

Protect the Small Employer Health Market from Gamesmanship

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 ensured that small groups could not be denied coverage by any insurer offering small group coverage in their state. The federal law, however, does not ensure that this coverage would be affordable, though states generally have implemented "rate bands" that provide some upper limit on rate increases for particular groups.

The individual market, however, is generally free of the guaranteed issue requirements enacted by HIPAA. Only those who had other insurance within the previous six months would be free of exclusion. This difference in rules between the individual market and the small group market means that premiums for younger and healthier individuals almost are always lower in the individual market than in the small group market. The opposite is generally true for older and less-healthy individuals: their premiums are less in the small group market than in the individual market. This dynamic understandably leads some employers to purchase less expensive individual coverage on behalf of their employees, when they can qualify for low rates. When significant illness occurs, the individual premium escalates sharply, and the business will often switch to a small group plan, where they must be accepted and where the premiums will be much lower.

While this entire process is perfectly rational from the employer's perspective, it forces small group premiums to be higher than they otherwise would be under a different set of circumstances. Premiums would be lower and overall access to health insurance higher if this practice were discouraged, perhaps through a surcharge when the

business re-enters the small group market (much like the penalty for early withdrawal of Individual Retirement Accounts (IRAs)). Another way would be to clarify that employer-paid premiums in the individual market are taxable to the employee.

Help the Uninsured through Tax Credits and Current Programs

Much of the question of adequate health insurance coverage boils down to affordability. There is probably no more efficient way to provide public subsidies for health insurance than through a system of tax credits-scaled to income, and targeted at individuals, such as those proposals that the president has put on the table. Further expansions of Medicaid and SCHIP programs to serve uninsured populations should also be considered.

It is NSBA's philosophy that, while these piecemeal changes will have a very positive effect on small businesses, there ought to be a long-term health market reform movement. A health care system that embraces individual choice, consumerism, recognition for quality services and affordability is paramount.

Substantial cost containment is embodied in the NSBA Health Policy. Limits on the tax exclusion will drive individuals to become less-dependent upon third-party payers in their medical transactions. More of a consumer-based market will develop for routine medical care, thereby putting downward pressure on both prices and utilization. Through both increased consumer awareness and specific quality-control methods, costs can be reined-in and small businesses can get back to doing what they do best rather than searching for affordable health care: creating jobs.

I would like to applaud the members of this committee for their leadership and work toward broad reform. There have been several pieces of legislation introduced that aim to reform the small-group market, and even reform the entire U.S. health care system. While NSBA may not agree with every piece of every bill introduced, your efforts to truly address the problem are both admirable and appreciated.

I thank the committee for your time and welcome any questions you may have.

SUBMITTED BY SENATOR GRASSLEY

THE WALL STREET JOURNAL.

Cash Before Chemo: Hospitals Get Tough

Bad Debts Prompt Change in Billing; \$45,000 to Come In

By BARBARA MARTINEZ
April 28, 2008; Page A1

LAKE JACKSON, Texas -- When Lisa Kelly learned she had leukemia in late 2006, her doctor advised her to seek urgent care at M.D. Anderson Cancer Center in Houston. But the nonprofit hospital refused to accept Mrs. Kelly's limited insurance. It asked for \$105,000 in cash before it would admit her.

Sitting in the hospital's business office, Mrs. Kelly says she told M.D. Anderson's representatives that she had some money to pay for treatment, but couldn't get all the cash they asked for that day. "Are they going to send me home?" she recalls thinking. "Am I going to die?"

Hospitals are adopting a policy to improve their finances: making medical care contingent on upfront payments. Typically, hospitals have billed people after they receive care. But now, pointing to their burgeoning bad-debt and charity-care costs, hospitals are asking patients for money before they get treated.

Hospitals say they have turned to the practice because of a spike in patients who don't pay their bills. Uncompensated care cost the hospital industry \$31.2 billion in 2006, up 44% from \$21.6 billion in 2000, according to the American Hospital Association.

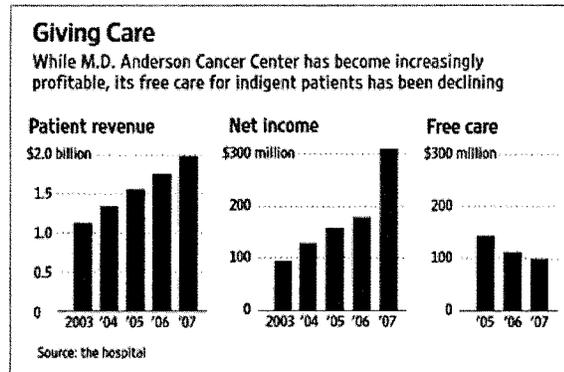
The bad debt is driven by a larger number of Americans who are uninsured or who don't have enough insurance to cover medical costs if catastrophe strikes. Even among those with adequate insurance, deductibles and co-payments are growing so big that insured patients also have trouble paying hospitals.

Letting bad debt balloon unchecked would threaten hospitals' finances and their ability to provide care, says Richard Umbdenstock, president of the American Hospital Association. Hospitals would rather discuss costs with patients upfront, he says. "After, when it's an ugly surprise or becomes contentious, it doesn't work for anybody."

M.D. Anderson says it went to a new upfront-collection system for initial visits in 2005 after its unpaid patient bills jumped by \$18 million to \$52 million that year. The hospital said its increasing bad-debt load threatened its mission to cure cancer, a goal on which it spends hundreds of millions of dollars a year.

The change had the desired effect: The hospital's bad debt fell to \$33 million the following year.

Asking patients to pay after they've received treatment is "like asking someone to pay for the car after they've driven off the lot," says John Tietjen, vice president for patient financial services at M.D. Anderson. "The time that the patient is most receptive is before the care is delivered."



M.D. Anderson says it provides assistance or free care to poor patients who can't afford treatment. It says it acted appropriately in Mrs. Kelly's case because she wasn't indigent, but underinsured. The hospital says it wouldn't accept her insurance because the payout, a maximum of \$37,000 a year, would be less than 30% of the estimated costs of her care.

Tenet Healthcare and HCA, two big, for-profit hospital chains, say they have also been asking patients for upfront payments before admitting them. While the practice has received little notice, some patient advocates and health-care experts find it harder to justify at nonprofit hospitals, given their benevolent mission and improving financial fortunes.

In the Black

An Ohio State University study found net income per bed nearly tripled at nonprofit hospitals to \$146,273 in 2005 from \$50,669 in 2000. According to the American Hospital Directory, 77% of nonprofit hospitals are in the black, compared with 61% of for-profit hospitals. Nonprofit hospitals are exempt from taxes and are supposed to channel the income they generate back into their operations. Many have used their growing surpluses to reward their executives with rich pay packages, build new wings and accumulate large cash reserves.

M.D. Anderson, which is part of the University of Texas, is a nonprofit institution exempt from taxes. In 2007, it recorded net income of \$310 million, bringing its cash, investments and endowment to nearly \$1.9 billion.

"When you have that much money in the till and that much profit, it's kind of hard to say no" to sick patients by asking for money upfront, says Uwe Reinhardt, a health-care economist at Princeton University, who thinks all hospitals should pay taxes. Nonprofit organizations "shouldn't behave this way," he says.

It isn't clear how many of the nation's 2,033 nonprofit hospitals require upfront payments. A voluntary 2006 survey by the Internal Revenue Service found 14% of 481 nonprofit hospitals required patients to pay or make an arrangement to pay before being admitted. It was the first time the agency asked that question.

Nataline Sarkisyan, a 17-year-old cancer patient who died in December waiting for a liver transplant, drew national attention when former presidential candidate John Edwards lambasted her health insurer for refusing to pay for the operation. But what went largely unnoticed is that Ms. Sarkisyan's hospital, UCLA Medical Center, a nonprofit hospital that is part of the University of California system, refused to do the procedure after the insurance denial unless the family paid it \$75,000 upfront, according to the family's lawyer, Tamar Arminak.

The family got that money together, but then the hospital demanded \$300,000 to cover costs of caring for Nataline after surgery, Ms. Arminak says.

UCLA says it can't comment on the case because the family hasn't given its consent. A spokeswoman says UCLA doesn't have a specific policy regarding upfront payments, but works with patients on a case-by-case basis.

Federal law requires hospitals to treat emergencies, such as heart attacks or injuries from accidents. But the law doesn't cover conditions that aren't immediately life-threatening.

At the American Cancer Society, which runs call centers to help patients navigate financial problems, more people are saying they're being asked for large upfront payments by hospitals that they can't afford. "My greatest concern is that there are substantial numbers of people who need cancer care" who don't get it, "usually for financial reasons," says Otis Brawley, chief medical officer.

Mrs. Kelly's ordeal began in 2006, when she started bruising easily and was often tired. Her husband, Sam, nagged her to see a doctor.

A specialist in Lake Jackson, a town 50 miles from Houston, diagnosed Mrs. Kelly with acute leukemia, a cancer of the blood that can quickly turn fatal. The small cancer center in Lake Jackson refers acute leukemia patients to M.D. Anderson.

When Mrs. Kelly called M.D. Anderson to make an appointment, the hospital told her it wouldn't accept her insurance, a type called limited-benefit.

"When an insurer is going to pay the small amounts, we don't feel financially able to assume the risk," says M.D. Anderson's Mr. Tietjen.

An estimated one million Americans have limited-benefit plans. Usually less expensive than traditional plans, such insurance is popular among people like Mrs. Kelly who don't have health insurance through an employer.

Mrs. Kelly, 52, signed up for AARP's Medical Advantage plan, underwritten by UnitedHealth Group Inc., three years ago after she quit her job as a school-bus driver to help care for her mother. Her husband was retired after a career as a heavy-equipment operator. She says that at the time, she hardly ever went to the doctor. "I just thought I needed some kind of insurance policy because you never know what's going to happen," says Mrs. Kelly. She paid premiums of \$185 a month.

A spokeswoman for UnitedHealth, one of the country's largest marketers of limited-benefit plans, says the plan is "meant to be a bridge or a gap filler." She says UnitedHealth has reimbursed Mrs. Kelly \$38,478.36 for her medical costs. Because the hospital wouldn't accept her insurance, Mrs. Kelly paid bills herself, and submitted them to her insurer to get reimbursed.

M.D. Anderson viewed Mrs. Kelly as uninsured and told her she could get an appointment only if she brought a certified check for \$45,000. The Kellys live comfortably, but didn't have that kind of cash on hand. They own an apartment building and a rental house that generate about \$11,000 a month before taxes and maintenance costs. They also earn interest income of about \$35,000 a year from two retirement accounts funded by inheritances left by Mrs. Kelly's mother and Mr. Kelly's father.

Mr. Kelly arranged to borrow the money from his father's trust, which was in probate proceedings. Mrs. Kelly says she told the hospital she had money for treatment, but didn't realize how high her medical costs would get.

The Kellys arrived at M.D. Anderson with a check for \$45,000 on Dec. 6, 2006. After having blood drawn and a bone-marrow biopsy, the hospital oncologist wanted to admit Mrs. Kelly right away.

But the hospital demanded an additional \$60,000 on the spot. It told her the \$45,000 had paid for the lab tests, and it needed the additional cash as a down payment for her actual treatment.

In the hospital business office, Mrs. Kelly says she was crying, exhausted and confused.

The hospital eventually lowered its demand to \$30,000. Mr. Kelly lost his cool. "What part don't you understand?" he recalls saying. "We don't have any more money today. Are you going to admit her or not?" The hospital says it was trying to work with Mrs. Kelly, to find an amount she could pay.

Mrs. Kelly was granted an "override" and admitted at 7 p.m.

Appointment 'Blocked'

After eight days, she emerged from the hospital. Chemotherapy would continue for more than a year, as would requests for upfront payments. At times, she arrived at the hospital

and learned her appointment was "blocked." That meant she needed to go to the business office first and make a payment.

One day, Mrs. Kelly says, nurses wouldn't change the chemotherapy bag in her pump until her husband made a new payment. She says she sat for an hour hooked up to a pump that beeped that it was out of medicine, until he returned with proof of payment.

A hospital spokesperson says "it is very difficult to imagine that a nursing staff would allow a patient to sit with a beeping pump until a receipt is presented." The hospital regrets if patients are inconvenienced by blocked appointments, she says, but it "is a necessary process to keep patients informed of their mounting bills and to continue dialog about financial obligations." She says appointments aren't blocked for patients who require urgent care.

Once, Mrs. Kelly says she was on an exam table awaiting her doctor, when he walked in with a representative from the business office. After arguing about money, she says the representative suggested moving her to another facility.

But the cancer center in Lake Jackson wouldn't take her back because it didn't have a blood bank or an infectious-disease specialist. "It risks a person's life by doing that [type of chemotherapy] at a small institution," says Emerardo Falcon Jr., of the Brazosport Cancer Center in Lake Jackson.

Ron Walters, an M.D. Anderson physician who gets involved in financial decisions about patients, says Mrs. Kelly's subsequent chemotherapy could have been handled locally. He says he is sorry if she was offended that the payment representative accompanied the doctor into the exam room, but it was an example of "a coordinated teamwork approach."

On TV one night, Mrs. Kelly saw a news segment about people who try to get patients' bills reduced. She contacted Holly Wallack, who is part of a group that works on contingency to reduce patients' bills; she keeps one-third of what she saves clients.

Ms. Wallack began firing off complaints to M.D. Anderson. She said Mrs. Kelly had been billed more than \$360 for blood tests that most insurers pay \$20 or less for, and up to \$120 for saline pouches that cost less than \$2 at retail.

On one bill, Mrs. Kelly was charged \$20 for a pair of latex gloves. On another itemized bill, Ms. Wallack found this: CTH SIL 2M 7FX 25CM CLAMP A4356, for \$314. It turned out to be a penis clamp, used to control incontinence.

M.D. Anderson's prices are reasonable compared with other hospitals, Mr. Tietjen says. The \$20 price for the latex gloves, for example, takes into account the costs of acquiring and storing gloves, ones that are ripped and not used and ones used for patients who don't pay at all, he says. The charge for the penis clamp was a "clerical error" he says; a different type of catheter was used, but the hospital waived the charge. The hospital didn't reduce or waive other charges on Mrs. Kelly's bills.

Continuing Treatment

Mrs. Kelly is continuing her treatment at M.D. Anderson. In February, a new, more comprehensive insurance plan from Blue Cross Blue Shield that she has switched to started paying most of her new M.D. Anderson bills. But she is still personally responsible for \$145,155.65 in bills incurred before February. She is paying \$2,000 a month toward those. Last week, she learned that after being in remission for more than a year, her leukemia has returned.

M.D. Anderson is giving Blue Cross Blue Shield a 25% discount on the new bills. This month, the hospital offered Mrs. Kelly a 10% discount on her balance, but only if she pays \$130,640.08 by this Wednesday, April 30. She is still hoping to get a bigger discount, though numerous requests have been denied. The hospital says it gives commercial insurers a bigger discount because they bring volume and they are less risky than people who pay on their own.

The hospital has urged Mrs. Kelly to sell assets. But she worries about losing her family's income and retirement savings. Mrs. Kelly says she wants to pay, but, suspicious of the charges she's seen, she says, "I want to pay what's fair."

Write to Barbara Martinez at Barbara.Martinez@wsj.com



Statement of Mark A. Hall, J.D.

Fred D. and Elizabeth L. Turnage Professor of Law and Public Health

**Wake Forest University
Winston-Salem NC**

**U.S. Senate Committee on Finance, Hearing on
“47 Million and Counting: Why the Health Care Marketplace is Broken”**

June 10, 2008

Chairman Baucus, Ranking Member Grassley, and esteemed Senators, it is a distinct honor to appear before this distinguished committee as it begins the monumental undertaking of reforming our health care system. My name is Mark A. Hall, and I am a Professor of Law and Public Health at Wake Forest University, where I specialize in health care finance and regulation.

My testimony addresses problems in the structure and functioning of private health insurance markets. I have studied these markets for almost two decades, starting with a Fellowship at the Health Insurance Association of America in 1991, and continuing through fifteen years of empirical studies with insurers, agents, employers, and regulators.

Health policy analysts are fond of invoking medical metaphors, and I too cannot resist. Some might say that the private health insurance market is crippled, severely wounded or on life support. I am not quite that gloomy, but no one can deny that the market is far from a picture of rosy health. Some parts are functional, other parts are in steady decline from chronic ailments, and yet others are fairly stable but show ominous precursors of acute illness. I will describe these critical indicators and diagnose the underlying conditions that afflict different parts of the market organism.

The Numbers

Since 2000, insurance premiums have doubled, increasing four times faster than earnings or general inflation (Figure 2). Today, the average cost of family coverage is over \$12,000 a year, which is about one-quarter of median household income. Single coverage averages about \$4500 a year, which is almost half the income of someone at the federal poverty line.

These averages reflect employer-based coverage. For individual insurance, the industry reports average rates that are about half these amounts (\$2600 single coverage and \$5800 family), but this is for coverage that tends to be much less generous and more difficult to obtain than employer-based insurance.

Premium increases are driving people out of the insurance market. Since 2000, both the percentage of employers offering coverage and the percentage of people covered by employers have dropped more than five points, to around 60 percent (Figure 3 and Exhibit 1). This decline in employer coverage has not been accompanied by any increase in individual coverage. Therefore, the portion of the non-Medicare population covered by private insurance has slipped from about 3/4 to about 2/3 in the past six years.

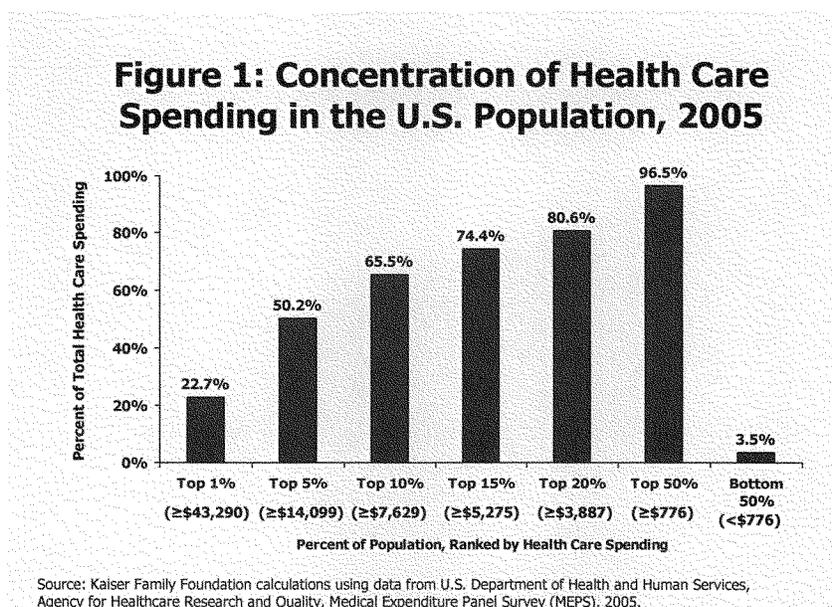
These disturbing declines have occurred despite strenuous efforts to shore up the market's erosion through legislation. For instance, federal reforms expand tax benefits for purchasing insurance (HSAs) and restrict insurers' from rejecting group applicants (HIPAA). These laws have been vitally important. Without them, conditions would only have worsened much more than they have. But, we must keep in mind that it will take

considerable additional effort simply to keep things from getting worse, let alone to substantially improve or to fix this market.

Things have gotten worse despite corrective efforts because the basic market conditions that cause the problems are still very much in place. Indeed, they are elemental. These market conditions will always plague us to some extent because they derive from a fundamental fact of the human condition – that the need for medical care is highly skewed throughout the population. This point is the main focus of my testimony.

The Highly Concentrated Burden of Medical Costs

The high concentration of most medical costs in a relative few people is the single most important fact for understanding the private insurance market. It is hard to find the right words to describe this foundational statistical phenomenon in terms that are sufficiently compelling, so I will start with a graphic depiction.



Arraying the population by health care spending in a year, this chart shows that

- the top 1% (those who spent more than \$43,000) accounted for almost one-fourth of total spending
- the top 5% (who spent more than \$14,000) accounted for half of all spending
- and the top 20% (who spent more than about \$4000) accounted for 80% of spending.

The bottom half of the population distribution (who spent less than \$800 that year) incurred less than 4% of total costs.

For convenience, I refer to this as “the 80/20 rule.” I call it a rule because the pattern is remarkably universal. This pattern has a fractal geometry that appears wherever one looks. It holds true both for the population at large and for just about any subpopulation of any size one might choose to examine (see Exhibit 3). Medicare spending is essentially just as concentrated as that for people in their 40s, or that in just about any larger employer group. The extreme concentration of health care costs is an economic law of nature that has been observed as early as the 1930s and that will be with us for as long as anyone can foresee – regardless of how we deliver and pay for health care.

There is no easy way to reduce or eliminate the effects of concentrated medical costs because the extremes are so great. Various techniques such as high-risk pools, reinsurance, and risk adjustment have been tried or proposed. These measures can certainly help somewhat, but the amount of money involved is too large to eliminate the basic underlying phenomenon. For instance, if even the top half of expenditures (which are concentrated in 5% of the population) were removed from the market, we would still have a market in which some people’s expenses were ten times greater than the *middle* of the distribution. Removing half the costs would cut the total costs in half, but this would not alter the basic dynamics created by the fact that the remaining costs would still be concentrated in a relatively small portion of people.

Market Dynamics: Risk Segmentation, Adverse Selection, and Medical Underwriting

I stress the 80/20 rule because it is the most elemental fact of health insurance. It is as fundamental as gravity, and as pervasive as the weather. It is the endemic First Cause that reaches everywhere and explains just about everything of importance in the market for insurance.

The high concentration of medical costs is why we need and have insurance in the first place. Pooling expenses across a population keeps them affordable for everyone, but the extreme costs at the high end also explain why insurance is so expensive, especially for those who anticipate no real need.

The extreme magnitude of differences in health risks also explains the private insurance market’s most perplexing dynamics. I will describe several troubling phenomena, each of which derives from the basic fact that insurers stand to gain a great deal by avoiding or appropriately pricing people with higher risks. They also stand to lose a great deal if they

do not attract a good number of lower risks. Therefore, competitive forces in health insurance markets inevitably focus on risk selection (or risk segmentation). Other points of competitive focus – such as product design, benefit coverage, sales vehicles, and care management – either have much less impact on profitability or are themselves surrogates for risk selection or segmentation.

The most visible form of risk selection is *medical underwriting*. This consists of evaluating the health risks specific to each subscriber in order to assign an actuarially fair price. According to industry figures, about 70% of people who apply for health insurance receive an offer of coverage at standard rates or better. The rest are either declined (12%), offered higher rates (6%), or offered coverage that excludes one or more particular pre-existing conditions (13%). In field studies, market testers found that conditions as common as asthma, ear infections, and high blood pressure can create problems obtaining coverage.

Medical underwriting is necessary because of *adverse selection* – the tendency of people to avoid the purchase of insurance unless they expect to need it, and for those with more need to buy more insurance. A health insurance market could never survive or even form if people could buy their insurance on the way to the hospital. Therefore, medical underwriting rewards people who purchase while they are still young and healthy, and imposes pre-existing condition exclusions or charges higher rates, for those who are not.

An especially aggressive form of risk screening is called “post-claims underwriting” – namely, waiting to assess pre-existing conditions until a paying subscriber submits large claims. If, after more scrutiny, insurers find that applicants were not completely forthcoming, they have been known to *rescind coverage retroactively*, even after people have paid premiums and received authorized treatment. State insurance regulators monitor such practices and determine when they are excessive or inappropriate, but it is a constant tension between public-minded regulators and competing insurers to determine the boundary of proper underwriting and claims adjudication.

The mirror image of *adverse selection* is *adverse retention*. A newly underwritten insurance pool will tend to deteriorate over time, meaning that the pool’s health costs will increase fairly steeply relative to marketwide averages. This *durational effect* is pronounced because people are free to shop around for cheaper or better insurance – but only if they are still healthy. To remain competitive, insurers target these shoppers by offering them their most attractive rates. To compensate, they must increase the rates of renewing subscribers – which is one reason people experience rate hikes that are much steeper than their increases in wages.

Existing subscribers who no longer can pass medical underwriting, or who would be subjected to new pre-existing condition exclusion periods, are stuck with the insurance they have. Although they are guaranteed to be able to keep this coverage forever, at some point mounting medical costs in the pool make it no longer economical for the insurer to sell that particular policy. And, once no new healthier subscribers are entering the pool, the costs skyrocket into what is called a “death spiral.” Some insurers exploit

this dynamic by *churning* risk pools. They frequently close off existing policies to any new subscribers and instead market new policies that are very similar but that are available only to freshly underwritten subscribers. This practice results in more hermetically separating lower versus higher risk subscribers into differently-priced policies.

Medical underwriting, plus constantly searching for a better price, adds additional costs to the system. These transaction costs account for a sizeable portion of the premiums people pay – on the order of roughly 20-25% for individual insurance and 10-15% for small groups. Constant turnover in coverage also undercuts the inherent efficiency of insurance markets. Insurers have little incentive to invest in life-long health prevention measures because the typical policyholder remains with a plan for an average of only about three years.

The natural dynamics of risk segmentation are so strong that risk selection occurs even without overt medical underwriting. Subscribers naturally sort themselves by risk to some extent, according to the covered benefits and plan features they find most attractive. Insurers and employers have learned that features such as deductibles, managed care, and particular benefits that are covered or excluded appeal differently to people with lesser versus greater health care needs. This is one reason many health policy analysts favor uniform benefits and why most employers limit their workers' choice of health plans.

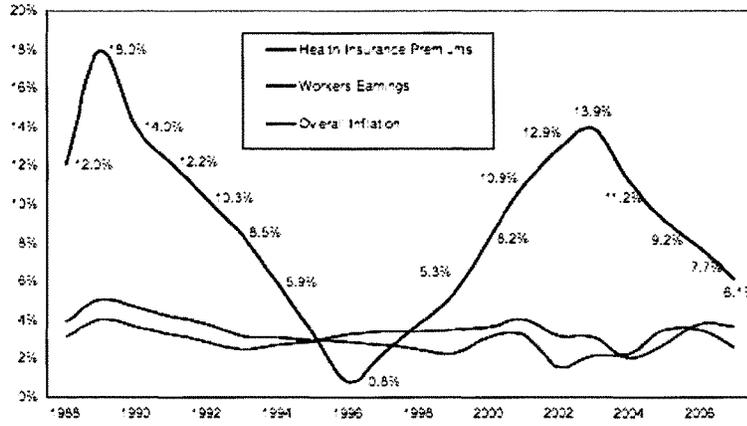
Necessary Reforms

Various insurance market reforms have worked well to mitigate the worst excesses of these market-driven competitive practices, but these counteractive measures are not capable of eliminating these effects. Risk selection practices flow directly from the very nature of how competitive markets should and must respond to highly concentrated health risks. Therefore, these effects will never be eliminated unless the market is fundamentally restructured.

The basic requirement is to place people into large groups whose membership is not tied to health risk, and to limit the choice of plans within the group. This is currently how large employer groups work, which is why they remain the best-functioning part of the market. These conditions also fit subsidized insurance pools such as the Massachusetts Connector. To meet these essential conditions, everyone (or almost everyone) who is eligible must agree to purchase insurance from their assigned group, and the insurers must not have a great deal to lose or gain according to how healthy or sick each subscriber is. This is easy enough to state in the abstract, but exceedingly difficult to achieve in practice.

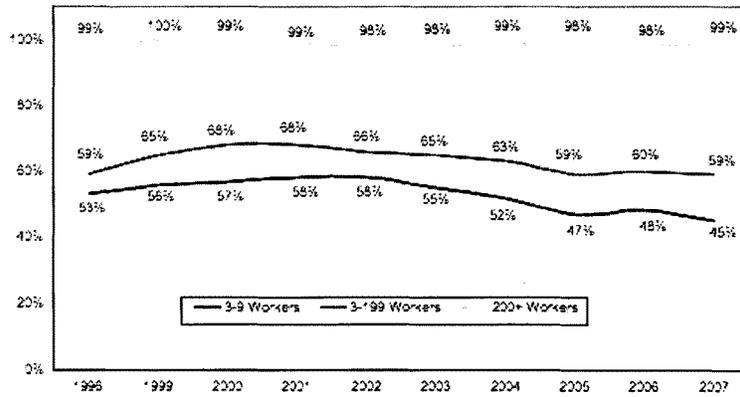
I wish this Committee and the Senate Godspeed and wisdom in pursuing this formidable challenge.

Figure 2: Annual Growth Rates for Health Insurance Premiums, Workers Earnings, and Overall Inflation, 1988-2007



Source: Kaiser Family Foundation/Health Research and Educational Trust.

Figure 3: Percentage of Employers Offering Health Benefits by Firm Size, 1996-2007



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits.

EXHIBIT 1
Health Insurance Coverage Among Nonelderly Americans, By Age And Source Of Coverage, 2000–2004 And 2004–2006

	All nonelderly			Adults			Children		
	Coverage distribution		Change (millions of people)	Coverage distribution		Change (millions of people)	Coverage distribution		Change (millions of people)
2000–2004	2000	2004	2000–04	2000	2004	2000–04	2000	2004	2000–04
All incomes (millions of people)	245.1	255.1	10.0 ^c	168.8	177.3	8.5 ^c	76.3	77.8	1.5 ^c
Employer	67.8%	63.3% ^b	-4.9 ^c	68.9%	64.4% ^b	-4.5 ^c	65.4%	60.7% ^b	-4.7 ^c
Medicaid/state	8.8	11.2 ^a	2.4 ^c	5.3	6.5 ^a	1.2 ^c	16.7	21.9 ^a	5.2 ^c
TRICARE/Medicare	2.1	2.3 ^a	0.2 ^c	2.3	2.7 ^a	0.4 ^c	1.7	1.3 ^a	-0.4 ^c
Private nongroup	5.1	5.4 ^a	0.3 ^c	5.6	5.8 ^a	0.2 ^c	3.9	4.4 ^a	0.5 ^c
Uninsured	16.1	17.8 ^a	1.7 ^c	17.9	20.6 ^a	2.7 ^c	12.3	11.6 ^a	-0.7 ^c
2004–2006	2004	2006	2004–06	2004	2006	2004–06	2004	2006	2004–06
All incomes (millions of people)	255.1	260.0	4.9 ^c	177.3	181.8	4.5 ^c	77.8	78.2	0.4
Employer	64.0%	63.0% ^b	-1.0 ^c	65.2%	64.4% ^b	-0.8 ^c	61.4%	59.7% ^b	-1.7 ^c
Medicaid/state	11.2	11.3	0.1 ^c	6.8	6.6	-0.2 ^c	21.9	22.4	0.5 ^c
TRICARE/Medicare	2.3	2.3	0.0	2.7	2.8	0.1 ^c	1.4	1.4	0.0
Private nongroup	5.6	5.5	-0.1 ^c	6.0	5.9	-0.1 ^c	4.5	4.5	0.0
Uninsured	16.9	17.9 ^a	1.0 ^c	19.5	20.4 ^a	0.9 ^c	10.9	12.1 ^a	1.2 ^c

SOURCE: Urban Institute, 2007, based on data from the 2001, 2005, and 2007 March Supplements of the Current Population Survey.

NOTE: Excludes those age sixty-five and older and those in the Armed Forces.

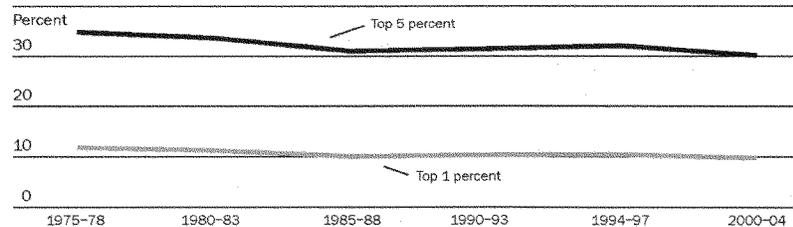
^a Change in percentage of people is statistically significant (at the 95% confidence level).

^b Change in percentage of people is statistically significant (at the 90% confidence level).

^c Change in numbers of people is statistically significant (at the 95% confidence level).

^d Change in numbers of people is statistically significant (at the 90% confidence level).

EXHIBIT 4
Percentage Of Medicare Spending Attributable To The Most Expensive 5 Percent And 1 Percent Of Beneficiaries, Aggregated Over Four-Year Periods, 1975–2004



SOURCE: Claims and enrollment data from the Continuous Medicare History Sample, various years.

NOTES: Data are for beneficiaries entitled to Part A and Part B and in fee-for-service in each year they were alive. Data have been inflation adjusted to the last year in the period using the Consumer Price Index–All Urban Consumers.



**U.S. Senate Committee on Finance, Hearing on
“47 Million and Counting: Why the Health Care Marketplace is Broken”**

Additional Information for the Record, July 1, 2008

**Mark A. Hall, J.D.
Fred D. and Elizabeth L. Turnage Professor of Law and Public Health**

**Wake Forest University
Winston-Salem NC**

Questions from Senator Bingaman

Question for the Panel: What effect on [the] insurance market will there be if free and discounted care requirements are mandated? Would it create disincentives for people to purchase insurance?

Response: This question requires economic analysis that I am not qualified to conduct, and also requires better specification of what the particular mandates would be. Therefore, I am not able to respond.

Question 1: Could you explain why high-deductible health insurance plans attached to Health Savings Accounts (HSA's) are likely to be most attractive to the healthy, in comparison to more traditional low-deductible, more comprehensive plans?

Response: High-deductible insurance is likely to attract disproportionately healthier subscribers for two reasons: 1) higher deductibles are less appealing to people who expect greater medical expenses. 2) HSA insurance is new, and unhealthy people in general are less inclined to change insurance, regardless of what kind of insurance it is.

Question 2: Despite many claims to the contrary citing various flawed industry-supported studies, there is little firm evidence that people who otherwise would have been uninsured now

have health insurance just because of the availability of HSAs. While no doubt some people with HSAs were previously insured when they enrolled in them, many of those people would likely have purchased similarly priced high-deductible insurance plans that have on the market for years anyways. Do you wish to comment?

Response: I agree that, standing alone, statistics about whether new subscribers were previously uninsured are not a good measure of how much the particular insurance in question reduces the number of uninsured. Whatever the type of insurance, it's always the case that a good number of new purchasers will be previously uninsured.

Questions from Senator Rockefeller

Question 1. You seem to be suggesting that the best way to reform the health insurance market is to ensure that every American has access to a large group product that spreads risk across all enrollees. Is that what you are suggesting? If so, is it also your opinion that it is virtually impossible to enact the type of reforms that would be necessary to make health coverage in the individual market adequate, accessible and affordable for all people – particularly those with chronic conditions?

Response: It would be very difficult to reform the individual market in a way that avoids the major problems I discussed. To do so would require, essentially, converting the individual market into a different form of a group market. By endorsing group purchase over individual purchase, however, I do not want to foreclose the possibilities of structuring groups in ways other than only around employers.

Question 2: You recommend large groups as a way of avoiding adverse selection. Would large group coverage for everyone also address the problems of pre-existing condition exclusions and post-claims underwriting?

Response: Adverse selection is the only good justification for pre-existing condition exclusions. Therefore, anything (including group coverage) that reduces adverse selection also reduces the need for these exclusions. It is difficult to say whether group coverage would entirely eliminate the need for these exclusions without knowing more about whether and how people have choice among different groups.

STATEMENT OF SENATOR GORDON H. SMITH

**U.S. Senate Committee on Finance
“47 Million & Counting: Why the Health Care Marketplace is Broken”
June 10, 2008**

Good morning and thank you all for being here today.

I also would like to thank Senators Baucus and Grassley for continuing the Committee’s examination of reforming the health care system to address the issue of the uninsured. Your efforts reflect the tremendous need for this important issue to be a top priority of this Congress, and the next.

Every American deserves access to quality, affordable health care coverage. This begins with strengthening and protecting federal programs like Medicare, as well as vital safety-net programs like Medicaid and the State Children’s Health Insurance Program (CHIP). This committee has done a great deal of work to improve these programs and reduce the number of uninsured, including ramping up outreach and enrollment of those eligible individuals in public health programs. Yet, as the title of today’s hearing suggests, it also is important that we focus our attention toward crafting new solutions that will support those who lack health care coverage in the private market.

Nearly 47 million people in the United States do not have health care coverage. They come from every age group and every income level. More than 80 percent of the uninsured are in working families. It should be noted that 60 percent of these, or more than 27 million, are small business owners, their employees and their families.

This disparity is due to the fact that small business owners and their employees are disproportionately burdened by the current structure of our health care system and health care costs.

Under current law, they do not enjoy the same tax breaks, coverage or pooling options as large businesses and corporations, and on average, they pay 18 percent more for the same healthcare benefits.

Before becoming a Senator, I managed a small company called Smith Frozen Foods. I was fortunate to be able to provide health care to my employees. I do, however, understand the difficulties small business owners face in offering quality health care coverage to their employees without bankrupting the business. The majority of small business owners want to provide health care, they just need an affordable way to do it.

Over the last year and a half, I have been working on a proposal that I hope will shape the debate of this issue in the Senate. It provides national direction to the problem of small group market reform, but relies upon existing infrastructure forged by states and the private market to provide new coverage options to small employers. The proposal also includes provisions to offer insurance coverage through the program to sole proprietors and individuals who wish to join.

Simply by focusing on small businesses, we can cut the ranks of the uninsured in America by more than half.

One of the key principles of my plan is regional cooperation. Congress needs to provide both the framework and incentives for states to work together to more consistently regulate insurance products sold to small employers. The result: the overall market becomes more stable and efficient in the long-run.

While many proposals have been introduced in this Congress that would overhaul how health care currently is delivered, it's important to point out that America's health insurance system was established in stages.

It has been over 15 years since the last time Congress tried to tackle broad health care reform. In 1994, one party held the White House and had comfortable majorities in both houses of Congress, yet health reform never came to a floor vote in neither the Senate nor the House.

You would think this would have been the perfect formula for change, yet, it did not happen. I believe that is because Congress tried to do too much, too quickly.

Reflecting on that history, it seems to me that to make improvements we may need to do so incrementally. Providing coverage for small businesses is the appropriate place to start.

Again, I am committed to the goal of providing quality health care in this country that is accessible and affordable for all Americans. And, I understand that finding real solutions requires the cooperation of diverse, bipartisan groups willing to work together for change.

I look forward to learning more from our panelists about these issues and to discuss what options we, as a government, have in order to improve upon our health care delivery system and reduce the number of the uninsured.

I hope this Committee can focus on important, achievable reforms that will help those in need.

I thank the witnesses for coming today, and I look forward to a productive discussion. With that, I'll turn it back to Chairman Baucus.

Testimony of

Ronald A. Williams

Chairman and Chief Executive Officer, Aetna Inc.

before the

United States Senate Committee on Finance

Tuesday, June 10, 2008

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

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

Aetna's Involvement in Public Policy

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

The U.S. Health Care System at a Crossroads

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

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

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

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

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

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

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

¹ Cowen, Tyler, "Poor U.S. scores in health care don't measure Nobels and innovation," *New York Times*, October 5, 2006.

² Turner, Grace Marie, "Look at the data, not propaganda," *Baltimore Sun*, June 29, 2007.

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

Systemwide Challenges to Expanding Access

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

Recognizing the Inextricable Link between Access and Cost

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

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

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

High Health Care Cost Yields Expensive Health Insurance

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

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

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

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

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

Focusing on Value to Increase Affordability

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

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

⁴ Raskin, J.R., et al. Health Insurance and Consumerism, Lehman Brothers, May 22, 2006.

⁵ PricewaterhouseCoopers, “The Factors Fueling Rising Healthcare Costs, 2006.” Prepared for America's Health Insurance Plans. Available at www.pwc.com.

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

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

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

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

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

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

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

I am pleased to report that Aetna has a number of positive outcomes on this front to share with you. Our *Health Connections Disease Management* program, for example, averages a 2.5 to 1 return on investment, and the program has made a remarkable difference in reducing expensive emergency room visits (e.g., reduced by 7 percent for asthma patients) and inpatient admits (e.g., reduced by 13 percent for those with coronary heart disease).⁷ Our *Healthy Lifestyles* program, which provides Aetna employees working 20 or more hours with an opportunity to earn up to \$600 by making healthy food choices and engaging in physical exercise, has also shown impressive results. Over 50 percent of participants have shown an improvement in their body mass index; the return on investment for the program's physical fitness component is 3.4 to 1.⁸

⁶ DeVol, R. et al., "An Unhealthy America: The Economic Burden of Chronic Disease – Charting a New Course to Save Lives and Increase Productivity," October 2007.

⁷ AHC Disease Management Performance Survey – Aetna Health Analytics Survey, March 2008.

⁸ 2006 Aetna, Inc. study, published in 2007; National Business Group on Health, "Healthy Lifestyles: A Best Practices Case Study," February 2007.

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

(2) State regulations often exacerbate affordability challenges

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

Negative Consequences of Guaranteed Issue, Community Rating and Benefit Mandates

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

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

A Comparison of Neighboring States

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

⁹ Wachenheim, Leigh, and Hans Leida, "The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets," Milliman/America's Health Insurance Plans, July 10, 2007.

¹⁰ Cubanski, Juliette, and Helen H. Schauffler, "Mandated Health Insurance Benefits: Tradeoffs Among Benefits, Coverage, and Costs?" Center for Health and Public Policy Studies, University of California, Berkeley, July 2002.

Let us take, for example, New Jersey and Pennsylvania. New Jersey's individual health insurance market is more heavily regulated than Pennsylvania's. New Jersey requires guaranteed issue of health insurance policies in the individual market, as well as community rating of those policies with no rate bands allowed for health status. In sharp contrast, Pennsylvania neither requires guaranteed issue nor imposes rating restrictions on insurers. New Jersey has 26 mandated benefits, while Pennsylvania has 17.¹¹ Now there is no doubt in my mind that legislators implemented these market rules with an eye toward consumer protection, but these good intentions have had a marked negative impact on the affordability of insurance. In Pennsylvania, an HMO plan with a relatively rich benefit package (i.e., no deductible or coinsurance and office visits priced at \$10 to \$20) costs \$196 a month (or \$2,352 annually) for a 35 year-old male.¹² After allowing for potential rate-ups of up to 50 percent based on health status, the cost of this plan in Pennsylvania would be \$294 a month (or \$3,528 annually). A comparable plan in New Jersey costs \$674 per month (or \$8,088 annually). An Aetna high-deductible plan in Pennsylvania costs the same person \$118 a month (and up to \$177 with possible rate-ups), while a comparable high-deductible plan offered by a different carrier in New Jersey costs \$460 a month.

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

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

Ensuring Pathways to Coverage for High-Risk Individuals

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

¹¹ Bunce, Victoria C., J.P. Wieske, and Vlasta Prikazsky. "Health Insurance Mandates in the States 2007," Council for Affordable Health Insurance, 2007.

¹² www.ehealthinsurance.com; Rates accessed for a 35 year-old male on May 2, 2008.

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

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

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

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

The Critical Role of Employer-Sponsored Insurance

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

¹³ U.S. Census, “Income, Poverty, and Health Insurance Coverage in the United States: 2006,” Issued August 2007.

¹⁴ Kaiser/HRET Survey, 2007.

¹⁵ U.S. Census.

¹⁶ U.S. Census.

Expanding Access to Insurance by Increasing Employer Benefit Provision

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

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

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

Exporting Key Benefits of Employer-Sponsored Insurance to Other Markets

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

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

¹⁷ Kaiser/HRET Survey, 2007.

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

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

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

Current Performance of the Individual Market

As we discuss these shortcomings, it is also important to maintain perspective on the functioning of the individual and small group markets, as there are many false impressions about them. In the individual market, 89 percent of applicants undergoing medical underwriting were offered coverage in 2006 and 2007, with offer rates ranging from 96 percent among those under 18 years old to 71 percent for those aged 60-64.¹⁸ Average annual premiums were \$2,613 for single coverage and \$5,799 for family coverage during the 2006-2007 period.¹⁹

¹⁸ America’s Health Insurance Plans, “Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits,” December 2007.

¹⁹ America’s Health Insurance Plans, “Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits,” December 2007.

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

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

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

Individuals Who are Eligible for Public Coverage but Not Enrolled

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

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

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

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

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

Enhancing Access and Expanding Involvement for Young Adults

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

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

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

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

Ensuring the Participating of Higher-Income Individuals

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

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

Conclusion

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

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

Responses to Questions Submitted for the Record
United States Senate Committee on Finance

“47 Million and Counting: Why the Health Care Market Is Broken”
Tuesday, June 10, 2008

Ronald A. Williams
Chairman and Chief Executive Officer, Aetna Inc.

Question 1

In the May 2007 issue of *Health Affairs*, it was reported that for the nation as a whole, uninsured patients were charged an average of 2.5 times more for hospital services than those with insurance. What effect on the insurance market will there be if free and discounted care requirements are mandated? Would it create disincentives for people to purchase insurance?

Mandating free and discounted care requirements may provide some financial relief to the uninsured, but it is an inadequate approach for addressing a much larger problem. While few would disagree that it is unfair that the uninsured are charged the highest prices for the health care they receive, it is essential to recognize that health care is expensive, and even if we were to offer free or discounted care to the uninsured, someone would have to pay for it. This would most likely come in the form of higher negotiated rates for privately insured individuals and additional cost-shifting in a system already rife with cross-subsidization (e.g., public payers such as Medicare and Medicaid pay physicians at rates that are, on average 83% of private rates¹). Employers, working families and individuals *with* health insurance would be exposed to even higher burdens because of the redistribution of these costs.

Another flaw with mandating free or discounted services is that many of the uninsured would have a hard time affording *any* negotiated rate. About 25% of the uninsured come from households with annual incomes below \$25,000,² which means that even sizeable discounts would fail to put many services and treatments within their financial reach. Finally, this approach would likely result in providers trying to avoid serving this set of patients – as is currently the case with Medicaid patients – as more and more people seek discounts that are not sustainable for providers without the benefit of the volume provided by insurers.

In short, mandating discounted rates is not the right solution for the uninsured. The better – and more sustainable – solution is one that brings the currently uninsured into the ranks of the insured, either through enrollment in a public program or through the private marketplace. For

¹ Direct Research, LLC for the Medicare Payment Advisory Commission, “Medicare Physician Payment Rates Compared to Rates Paid by the Average Private Insurer, 1999-2001,” August 27, 2003.

² U.S. Census Bureau, “Income, Poverty, and Health Insurance Coverage in the United States: 2006,” August 2007.

policy makers, a good place to begin is to target the approximately 11 million children and adults who are currently eligible for but not enrolled in a public program (e.g., Medicaid and SCHIP). Another important starting point is an individual coverage requirement. Aetna was the first national health insurer to call for an individual coverage requirement, which would not only result in all Americans possessing health insurance, but also would address the problem of uncompensated care that contributes to rising health care costs for everyone. An individual coverage requirement is increasingly viewed among health policy experts as the only viable approach for dramatically reducing uninsurance levels without dismantling and undermining the positive effects associated with the employer-based system and the competitive marketplace.

Question 2

A) Is it not true that your firm's administrative costs as a percentage of the premium (as compared to the portion devoted to benefits) is substantially higher for your products in the individual market and the small group market, than it is in the large group market?

General and administrative costs (G&A) as a percentage of premiums are, in fact, higher for Aetna products in the individual market than they are in Aetna's national accounts and government business (i.e., 3,000-plus employees). G&A costs as a percentage of premiums for Aetna's small group (i.e., 2-49 employees) business are also higher, but they are more closely aligned with our national accounts and government business. This is true for Aetna and more broadly across the industry.

There are several reasons for these differences in G&A across business lines. First, in the individual market, insurers must interact with their consumers on a one-to-one basis – from initial pre-sale contact to enrollment, and from underwriting to claims processing. This highly individualized mode of operation differs significantly from operations in the large group market (i.e., Aetna's national accounts and government business), in which the principal "customer" is a large corporation or governmental entity that possesses a robust infrastructure for managing employee health benefits. Second, the individual market is primarily a residual market, meaning that most consumers purchase individual coverage when they are in-between periods of employer-sponsored coverage. This makes the individual market more transitory than employer-sponsored coverage, with individuals entering and leaving the market frequently.³ This too places upward pressure on an insurer's administrative costs.

When considering G&A, it is also important to recognize that it is problematic to judge administrative costs solely on a percentage basis, because a "high" G&A on an affordable insurance product can be lower in real dollar terms than a "low" G&A on a more expensive product. At the same time, it is critical to understand that administrative costs are themselves real costs borne by someone. Whether these costs are paid for principally by an employer (as is the case in the large group market), an individual or a third-party, administrative costs such as billing and collecting cannot simply go away.

³ Over half the policies sold in the individual market are held for less than two years. See Kaiser Family Foundation and eHealthInsurance, "Update on Individual Health Insurance," August 2004; America's Health Insurance Plans, "Individually Purchased Health Insurance: An Overview of the Current Market," March 2006.

I also want to take this opportunity to highlight what G&A consists of, as it is often misunderstood. Contrary to the widespread notion that G&A represents “waste” in the system, or that it is something that should be minimized to single-digit figures in order to improve efficiency, G&A consists of a wide range of critical expenses, many of which serve to improve quality and reduce costs. These include *customer services and information technology* (e.g., nurse help lines and other clinically oriented customer services; personal or electronic health records; internet-based clinical or consumer choice information provided to customers); *care management and networks* (e.g., wellness programs; non-benefit costs associated with disease management, utilization review and quality assurance; provider network credentialing); and *product development, claims, compliance and administrative costs* (e.g., enrollment; billing; claim adjudication; privacy compliance; financial reporting; marketing and sales; anti-fraud activities). This range of expenses and activities captured in G&A suggests that private sector administrative costs fulfill a vital function and should not be targeted as a means for slowing the rising cost of health insurance. Given the extensive attention Medicare Advantage has garnered in recent months, I also want to point out that it is problematic to compare administrative costs in the private insurance marketplace with administrative costs in Medicare. Unlike private health insurance plans, Medicare’s “capital costs” are not included in administrative spending calculations, nor are key administrative functions such as the collection of Part B premiums. Another key difference is that Medicare does not provide the care coordination or disease management services offered in the private sector.

This is not to suggest that we should not be concerned about waste or inefficiency in the U.S. health care system. But it does suggest that we will not get very far by imposing measures such as minimum medical cost ratios to constrain the way private health insurers do business, as doing so could lead to unintended consequences that reduce quality, lessen affordability and make access even more difficult.

B) What is the average administrative cost on your individual market policies? What percentage of that is medical underwriting costs? What is the average administrative cost on your small group policies? What is the average administrative cost on your large group policies?

While it is also helpful to understand absolute costs and costs per member per month, I need to avoid disclosing proprietary business practices and detailed financial metrics for competitive reasons. With that caveat, which I am sure the Committee can appreciate fully, I can tell you that the G&A costs for Aetna’s individual market book of business generally fall within a range of \$25 to \$30 on a per member per month (PMPM) basis. The G&A costs on a PMPM basis are indeed lower for Aetna’s small group and large group markets, though the differential is relatively modest – which tends to be true across the industry. While there are some economies of scale for our larger customers, many of the G&A costs are related to supporting individual members, regardless of case size.

Underwriting and actuarial costs – which include evaluating experience data in order to set prices, rate filings and rating methodologies, supporting the sales and renewal process, and tracking and explaining underwriting and pricing results – account for less than 15% of G&A for Aetna’s individual market business. Given that G&A comprises a small proportion of premium

on a percentage basis in the first place, underwriting and actuarial costs represent only a fraction (less than 2%) of the average premium for Aetna policies sold in the individual market. Even more, it is vital to understand that medical underwriting to determine whether to cover specific individuals and/or to set rates represents an even smaller fraction within the category of underwriting and actuarial costs.

Question 3

You state that your after-tax profit is only six cents per premium dollar. How does that break down across your lines of business: individual market, small group, and large group policies?

I am pleased to provide you with additional detail about how Aetna spends each premium dollar, as this is another area in which there are significant misperceptions. While these numbers may fluctuate quarter by quarter, the premium dollar is spent in the following ways:

How Aetna Spends Each Health Care Premium Dollar	
79-80 cents	Directly reimburses doctors, hospitals and other providers for medical services that Aetna members use. In 2006, Aetna paid \$50 billion in health services on behalf of customers, including \$15 billion for insured customers.
11 cents	Covers costs associated with serving more than 35 million members, such as customer service support, medical management technology, product development, patient and provider education, and salaries and benefits (e.g., in 2006, Aetna spent \$2.3 billion on compensation and benefits for approximately 30,000 employees).
4 cents	Goes to pay required federal and state taxes.
6 cents	Is profit that Aetna returns to shareholders through dividends and share repurchases, uses for charitable giving (\$22 million in 2006), and reinvests in the business to benefit customers.

For all of Aetna's medical risk business, the after-income tax and interest expense (AFIT) profit was 5.6 cents on the premium dollar in 2007, with a range of 4.4 cents to 6.5 cents for different lines of business. Aetna's after-tax profit margin is lower in our individual and small group lines of business than it is in our large group business.

Since there has been considerable debate about Medicare Advantage recently, I also want to provide you with a breakdown of how Aetna spends each Medicare Advantage premium dollar.

How Aetna Spends Each Medicare Advantage Premium Dollar	
88 cents	Directly reimburses doctors, hospitals and other providers for medical services that Aetna members use.
7 cents	Covers operating expenses, which include employee salaries and benefits, and other administrative costs that support our nurses and staff who deal directly with members; investments in information technology to benefit members, employers and providers; investments in medical management programs for members; and member education to ensure awareness of the broad array of services available to them.
2 cents	Goes to pay required federal and state taxes.
3 cents	Is profit that Aetna returns to shareholders through dividends and share repurchases, uses for charitable giving, and reinvests in the business to benefit customers.

Question 4

You spend a lot of time discussing the risks of adverse selection from the perspective of the insurer and you also talk about the merits of Association Health Plans. Numerous health analysts, however, have explained how AHPs could provoke adverse selection, where those enrolling through AHPs would tend to be healthier, on average, than those enrolling in the traditional small group market, thus making coverage in the small group market more costly and increasingly unaffordable.

There is a clear need for the nation to find new ways to cover workers in small firms, as well as independent or self-employed workers. To put this problem into perspective, in 2006, 5.8 million workers (35%) in firms with fewer than 10 workers were uninsured, and 4 million workers (30%) in firms with 10-24 workers were uninsured. Among self employed workers, 3.8 million (27%) were uninsured.⁴ New pooling arrangements, such as Affordable Health Groups, have the potential to significantly reduce the number of uninsured in our country.

Over the past several years, Association Health Plans (AHPs) have been proposed as a means of providing more affordable coverage to small employer groups. Under the AHP model, trade associations representing employers would be permitted to aggregate members' employee groups into a single plan (i.e., an AHP), which would be exempt from state benefits mandates and most state insurance regulation. This, in turn, would allow for more affordable benefit designs, greater risk spreading and increased competition – all of which should lead to lower costs. As critics of AHP correctly point out, however, it is possible that a law authorizing AHPs could create a limited number of “winners” (i.e., those inside the AHP pool) and “losers” (i.e., those outside the pool). Such adverse selection could, over time, lead to a “death spiral.” The challenge, therefore, is to create a mechanism for taking advantage of the benefits of AHPs – namely, reducing benefit and regulatory costs – while avoiding a structure that creates winners and losers.

A viable alternative to AHPs are Affordable Health Groups (AHGs), which would expand the concept of pooling to many more employees (see Appendix A and B for a summary comparison of AHPs and AHGs, along with recommendations for implementing AHGs). Under the AHG model, insurers would be authorized to form small group pools analogous to AHPs, wherein such pools would be *open to any small group* that wished to participate. By allowing health insurers to form their own association groups, many more small employers could participate in an AHP-type pool with more choices and more competition, but with little additional administrative burden. Virtually all small employers would have access to at least one AHG, creating a significant impact on the uninsured population and providing healthy competition among AHGs.

AHG could enjoy the same or similar preemption as AHPs with respect to state benefit mandates and state insurance regulation. Given this preemption, it remains possible that some of the highest-risk individuals would be unable to access coverage that sufficiently responds to their needs. These high-cost or high-risk individuals may be best served through a well-funded safety net (e.g., a state high-risk pool or reinsurance mechanism), which would allow the majority of

⁴ Employee Benefit Research Institute, “Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey,” Issue Brief No. 310, October 2007.

the population to access insurance coverage that is affordable to them. Finally, I believe we must also work to develop new pooling arrangements for people who currently lack access to group insurance through a large or small firm. New pools of this type would enhance the ability of the market to respond to a larger number of those who are currently uninsured.

Question 5

You support providing tax incentives for the purchase of health insurance in the individual market. Numerous health and tax policy analysts, however, have pointed out that such incentives would lead some employers to no longer offer health insurance to their workers. Those in poorer health would likely be unable to obtain health insurance in the individual market and may end up uninsured. While analysts may disagree about the magnitude of such effects, likely any incremental gain in coverage will be offset, in part, by these coverage losses. It seems to me a far better approach would be to expand the employer-based system than further erode it. Do you disagree?

I am an ardent proponent of the employer-based system of insurance, through which 177 million Americans today access their insurance coverage.⁵ This system offers numerous advantages over the individual market, which come in the form of diverse risk pools, administrative savings and lower premium costs for employees.⁶ In light of these attributes, I believe health care reform efforts should seek to expand – not erode – the employer-based system. At the same time, there are some groups for whom the individual market will remain the primary, if not the only, option – namely the unemployed, self-employed, and workers (and their dependents) who are not offered coverage through the workplace. Exporting some of the benefits of the employer-based system to the individual market will help these groups find affordable, quality coverage.

Yet, there is a fundamental inequity in the tax treatment of health insurance in our current system. For the more than 18 million non-elderly U.S. residents who possess coverage in the individual market, there are few incentives designed to give them tax relief or to encourage the many uninsured who could potentially purchase insurance in this market to do so.⁷ This not only unfairly disadvantages those who buy individual insurance, but also yields a market that is much smaller than it could be.

I believe we need to equalize the tax treatment of health insurance for those who obtain coverage through their employer and those who purchase it directly in the individual market by extending favorable tax treatment to both sets of individuals, *without* changing the favorable tax treatment employers currently receive for offering benefits. The question is, of course, would extending

⁵ U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2006," August 2007.

⁶ Employers subsidize three-quarters or more of the employee premium on average, and administrative overhead for group coverage at 10% is significantly lower than for the individual market. (See Gary Claxton, Samantha Hawkins, Jeremy Pickreign, et al., "Employer Health Benefits: 2007 Annual Survey," Kaiser Family Foundation and Health Research and Education Trust, September 2007; Jon Gabel, Kelley Dhont and Jeremy Pickreign, "Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets," Commonwealth Fund, May 2002; Mark Hall, "The Geography of Health Insurance Regulation," *Health Affairs*, March/April 2000, 19(2):173-84.)

⁷ U.S. Census Bureau, August 2007; President's Advisory Panel on Federal Tax Reform. "Simple, Fair, and Pro-Growth: Proposals to Fix America's Tax System," November 2005.

this favorable and equitable tax treatment to individuals serve to erode the employer-based system? I believe that, overall, it would not. Numerous researchers have addressed this question, reaching a variety of conclusions.⁸ As you point out, one frequently voiced concern is that offering tax incentives in the individual market could cause employers to stop offering health insurance to their employees. Some believe that if federal policy makers were to remove all, or just some, of the difference in the tax treatment of health insurance between the individual and group markets, employers would begin dropping their coverage.⁹

In evaluating the possible effects of changes to the tax treatment of health insurance, however, it is critical to recognize the distinctions between the many different proposals that have surfaced, as the likely impact of each on employee and employer incentives varies. For example, existing proposals differ with regard to who is offered tax incentives, how they approach the current tax status of employer-sponsored benefits, the size of the proposed tax credit or deduction, and the relationship of the tax credit/deduction to an individual's premium costs and income. Another key factor to consider in analyzing various tax reform proposals is the employer subsidy of the health insurance premium, which in 2007 was 85% of premiums for singles and 73% of premiums for families.¹⁰ Finally, the degree to which we believe employers will actually replace the value of any discontinued health benefits with increased wages will also make a significant difference in how we might expect individuals to respond to changes in the tax code.

For two key reasons, I question the belief that changing the tax treatment of health insurance for people purchasing coverage in the individual market would erode the employer-based system. First, employers typically offer a heavy subsidy of the employee premium, as well as access to insurance free of individual medical underwriting, both of which make the purchase of health insurance through the workplace an attractive option for employees. If an employee foregoes coverage through the workplace he or she loses both the guarantee of coverage and, typically, the opportunity to access a significant employer subsidy. While some contend that this employer subsidy would be "cashed-out" in the form of higher wages, it is noteworthy that most employers do not currently "cash-out" an employee's benefits when, for example, that employee chooses to be covered through a spouse's employer. Moreover, there are few scenarios in which an individual would do better by buying their health insurance in the individual market rather than through an employer offering coverage. One possible instance might be that of a young, healthy individual whose employer subsidizes almost none of the premium. If the tax savings from employer-sponsored insurance are lower than the savings attained by buying in the individual market, this person would have an incentive to drop his or her employer coverage. This scenario is highly unlikely, however.

⁸ See Paul Fronstin and Dallas Salisbury, "Health Insurance and Taxes: Can Changing the Tax Treatment of Health Insurance Fix Our Health Care System?" EBRI Issue Brief No. 309, September 2007; Leonard Burman and Jonathan Gruber, "Tax Credits For Health Insurance," Tax Policy Issues and Options, June 2005; Thomas M. Selden and Bradley M. Gray, "Tax Subsidies For Employment-Related Health Insurance: Estimates for 2006," *Health Affairs* Nov/Dec 2006; 25(6): 1568-1579; Paul Fronstin, "The Tax Treatment of Health Insurance and Employment-Based Health Benefits." EBRI Issue Brief No. 294, June 2006.

⁹ For example, Fronstin and Salisbury (2007, pp.11-14) discuss this in relation to capping the tax exclusion for employee benefits or removing the exclusion altogether. Burman and Gruber (2005, pp.4-6) discuss this being a strong possibility in regard to non-group-only tax credits, though they note any erosion would be minimal if a tax credit is available to all insured.

¹⁰ Gary Claxton, et.al.

Second, employers have strong incentives to continue offering coverage to their employees, despite potential changes to the tax treatment of health insurance. Employers offer coverage voluntarily today because it allows them to keep their employees healthy and, thereby, maximize productivity.¹¹ Further, employers offer health benefits as a way to attract and retain a quality workforce. These motivations will not change even if tax incentives are made available in the individual market. Some economists point out that these motivations may be less powerful for some small employers, particularly those with a low-skilled labor force or those who currently contribute little toward employee premiums.¹² Their contention is that for small firms already making the decision on the margin, the fact that tax incentives toward the purchase of health insurance are extended to the individual market may weaken the motivation to offer insurance or give them a reason to drop employer coverage.

While it is possible to imagine scenarios in which some employers might discontinue their involvement in offering health benefits to their employees, these firms will be the exception and not the rule. The magnitude of any erosion is unknown, but I believe it will be minimal and most pronounced among small employers. Critically, there are policy solutions to mitigate this behavior, such as offering tax incentives (e.g., tax credits) to small employers that continue or begin offering coverage to their workers.

In sum, the concrete benefits of extending favorable tax treatment of health insurance to the individual market – namely, making coverage more affordable for those excluded from the employer-based system, bringing some of the currently uninsured into the system, and addressing a fundamental inequity – far outweigh the *potential* for modest declines in employer offer rates.

Question 6

In your written testimony on page 9 you stated, “While the main forces in keeping the employer-based system affordable are diverse risk pools and the employer subsidy, the main factor that drives affordability in the individual and small group markets is the ability of health insurers to put in place tools for preventing adverse selection. Mr. Williams, my first question is “affordable for whom” – the insurance company or the beneficiary? You heard the testimony of Mrs. Kelly who has been through a horrifying experience trying to get the cancer treatment she needs while battling her hospital and her insurer to cover the cost of her care. Despite being covered by an individual market plan, Mrs. Kelly is personally responsible for over \$145,000 in medical bills and has to pay \$2,000 a month toward those. How is that affordable?”

Tools for preventing adverse selection, such as medical underwriting, unequivocally make insurance more affordable *for the beneficiary*. When adverse selection exists in any insurance market, it means that some individuals wait to purchase insurance until after they already know

¹¹ Fronstin, 2006.

¹² *Ibid*; Stuart Butler and David B. Kendall, “Expanding Access and Choice For Health Care Consumers Through Tax Reform.” *Health Affairs* Nov/Dec 1999; 18(6): 45-57.

they need to seek expensive medical care. This behavior has strong implications for affordability, particularly in markets where regulatory rules require insurers to offer coverage at community-rated premiums, regardless of when that coverage is sought. Everyone ends up paying for this adverse selection in the form of more expensive insurance premiums. When this kind of behavior is controlled, insurance becomes more affordable for the vast majority of the population.

States tend to take two different approaches regarding affordability of coverage. Some have tried to create a regulatory and legislative environment in which affordable insurance is available to the majority of the population, while putting in place safety nets for those who may be excluded. Others have chosen to make insurance accessible to all people at any point in time – through guaranteed issue and community rating – an approach that has been shown to make insurance unaffordable for a large number of people.

The differences in premiums in states like Pennsylvania, which takes the former, *affordability*-centric approach, and New Jersey, which takes the latter, *accessibility*-centric approach, are telling. For example, rates for a standard HMO plan for a 35 year-old male are currently 159% to 288% higher in New Jersey than in Pennsylvania. The following charts, which compare premiums for different types of coverage in Pennsylvania and California, where medical underwriting is permitted, to Massachusetts and New Jersey, which have community rating and guaranteed issue, highlights the implications of these regulatory rules.

Monthly Premiums of Comparable Health Plans in Four States for a 35-Year Old Male ¹³ (Massachusetts and New Jersey require community rating and guaranteed issue.)				
	Pennsylvania	California	Massachusetts	New Jersey
HMO	\$196 - \$294 (Independence Blue Cross)	\$367.39 - \$551.09 (United Health Care Pacificare)	\$501.40 (Blue Cross Blue Shield of MA)	\$759.94 (Oxford Health Plans)
High-Deductible	\$118 - \$177 (Aetna)	\$142 - \$213 (Aetna)	\$218 (Fallon Community Health Plan)	\$474.91 (Oxford Health Plans)
Least Expensive	\$53.40 - \$80.10 (United Health Care)	\$79 - \$118.50 (Blue Shield of California)	\$193.19 (Neighborhood Health Plan)	\$182.36 (Oxford Health Plans)
Most Expensive	\$291.38 - \$437.07 (Celtic)	\$582 - \$873 (Blue Shield of California)	\$551.49 (Harvard Pilgrim)	\$1,491 (AmeriHealth New Jersey)

Looking at a similar chart that lists premiums for a 55-year old in the same states, it is clear that Massachusetts and New Jersey are more oriented toward ensuring accessibility for older and higher-risk individuals. This orientation, however, yields higher premiums in the private marketplace for younger and healthier individuals. Thus, in a state like New Jersey, where there

¹³ www.ehealthinsurance.com; www.mahealthconnector.org; quotes accessed on July 2, 2008 for 35 year-old male with annual income of \$32,000.

is no individual coverage requirement, the emphasis on accessibility over affordability comes at the expense of younger and healthier individuals, who may be discouraged from participating or priced out of the marketplace.

Monthly Premiums of Comparable Health Plans in Four States for a 55 Year-Old Male ¹⁴ (Massachusetts and New Jersey require community rating and guaranteed issue.)				
	Pennsylvania	California	Massachusetts	New Jersey
HMO	\$472 - \$708 (Independence Blue Cross)	\$903.79 - \$1,355.69 (United Health Care Pacificare)	\$919.76 (Blue Cross Blue Shield of MA)	\$759.94 (Oxford Health Plans)
High-Deductible	\$318 - \$477 (Aetna)	\$368 - \$552 (Aetna)	\$406 (Fallon Community Health Plan)	\$474.91 (Oxford Health Plans)
Least Expensive	\$147.11 - \$220.67 (United Health Care)	\$210 - \$315 (Kaiser Permanente)	\$382.72 (Neighborhood Health Plan)	\$353.91 (Oxford Health Plans)
Most Expensive	\$794.39 - \$1,191.59 (Celtic)	\$1,530.07 - \$2,295.11 (Celtic)	\$919.76 (Blue Cross Blue Shield of MA)	\$1,491 (AmeriHealth New Jersey)

Given our system's current configuration, we should ask not only "for whom is insurance affordable," but also, "for how many is insurance affordable?" I believe our aim should be to let the marketplace function, while activating – and improving upon – a safety net that ensures that unhealthy people have access to the medical care they need. The alternative would be to drastically increase the number of uninsured in our nation by making insurance easily accessible, yet still unaffordable to many.

Today, affordability is more attainable within the employer-based system, where employees and their dependents can access group insurance that is not medically underwritten on an individual basis. I believe we need to find ways to export the elements that make insurance more affordable for employees (e.g., large and diverse risk pools) to all health care consumers. This being said, in the absence of such tools within the individual market, medical underwriting does, in fact, make insurance more affordable for the majority of people.

With regard to Mrs. Kelly, who has certainly undergone a difficult ordeal, her story exemplifies some of the challenges inherent in today's individual market. Had Mrs. Kelly been able to continue under some form of group coverage (e.g., an Affordable Health Group), her insurer would have likely covered the costs of her treatment. However, she faced one of the primary challenges that exists within our current system – a dearth of affordable portable health insurance

¹⁴ www.ehealthinsurance.com; www.mahealthconnector.org; quotes accessed for a start date of August 1, 2008 for a 55 year-old male with an annual income of \$32,000. Plans were chosen based on their comparability to each other and to the quotes derived for a 35 year-old male. In several cases, the quoted plan is not the least expensive comparable plan available, but was chosen because it is identical to the plan quoted in the 35 year-old male model.

options. Having left her job and her employer-sponsored coverage, Mrs. Kelly sought individual insurance coverage. In Mrs. Kelly's case, her insurance was affordable; but by purchasing a limited benefit product, she took on the risk that her coverage would be insufficient if she required extensive, and expensive, medical care – a risk that, unfortunately, became reality. Mrs. Kelly's predicament raises several important points. First, people need to recognize the importance of purchasing coverage that will serve them well, just in case they need it. This is, after all, the purpose of insurance – to protect against unknown harms. Second, the expansion of new pooling mechanisms, such as Affordable Health Groups, could help people like Mrs. Kelly – who may choose to retire before they are eligible for Medicare – secure access to health insurance coverage that is affordable and of value to them. Finally, private commercial health insurance companies should not be the only private players held responsible for making and keeping health care affordable. Private, non-profit institutions must also be expected to uphold their missions by providing care to those who are otherwise unable to afford it. The nonprofit Blue Cross Blue Shield entities, which were established to serve as charitable and benevolent organizations, are well-known to maintain much higher surpluses than publicly traded for-profit entities. According to a recent report published by J.P. Morgan, the risk-based capital ratio for the nonprofit Blues is over 800%, which is considerably higher than it is for commercial for-profit health insurers. In short, as we contemplate ways to serve the nation's most vulnerable, we must embrace the notion that health care reform is a shared responsibility in which all stakeholders must participate.

Appendices:

- (A) Comparison Chart: AHPs versus AHGs
- (B) Recommendations for Implementing AHGs

Appendix A**Comparison Chart: AHPs versus AHGs****Site of Authority**

	AHPs (insured)	AHPs (self-insured)	AHGs (insured)	AHGs (self-insured)
Benefit mandates	Full Preemption. No Federal replacement*	Full Preemption. No Federal replacement*	Full Preemption. No Federal replacement*	Full Preemption. No Federal replacement*
Solvency/ operations (e.g., prompt pay, claims) of insurer	State of employer domicile	DOL control (no insured benefits)***	State of employer domicile	DOL control (no insured benefits)***
Agent Licensing	State of employer domicile	State of employer domicile IF insured benefits are also offered	State of employer domicile	State of employer domicile IF insured benefits are also offered
Small Group Rating Methodology**	State of employer domicile****	DOL Control	State of AHG (e.g., trust or incorporation) domicile	DOL Control
Stop Loss	N/A	Governed by domicile of AHP (subject to preemption)	N/A	Governed by domicile of AHG (subject to preemption)

*Full pre-emption except for a state law to the extent that such law (1) prohibits an exclusion of a specific disease or (2) is not pre-empted under section 731(a)(1) with respect to matters governed by section 711 and 712.

**Individual state rules (e.g., state Community Rating law or small group reform law) would apply. Thus, state by state variations could be imposed on insured AHPs/AHGs. Each AHP/AHG could apply a given states' rating law to the plan as a whole or to discrete employer groups within the plan, to the extent permitted under applicable state law.

*** DOL control over solvency is fairly well spelled out in various AHP proposals; remaining items could benefit from more detail in legislation.

**** AHPs might prefer AHG treatment, i.e., "domicile" of AHP rather than domicile of employer

Appendix B**Recommendations for Implementing Affordable Health Groups**

Congress could use any of the existing AHP proposals to:

- Add a new definition of an Affordable Health Group, as a trust or similar vehicle established by a health insurer to which the insurer issues one or more policies of health insurance.
- Small employers would be allowed to join this trust on behalf of their employees and obtain coverage under the relevant policy(ies).
- It would *not* be necessary to extend the administrative/governance rules to AHGs, other than perhaps a general requirement that the trust be maintained for the benefit of participants. Again, these sorts of arrangements have existed for many years with no difficulties and employers are free to “vote with their feet” if they are not comfortable with the benefits offered or any other aspect of the plan's administration.
- If there is provision to permit self-funded AHPs, then AHGs should get the same level of benefit mandate and insurance regulation preemption and the opportunity to elect DOL as its regulatory authority.

In the final analysis, these changes will have the following results *as to AHGs*:

- The state of domicile of the AHG (trust, corporation) will control and regulate the insurer and its products with respect to insurance matters (such as rating) except with respect to licensing (company/agent, solvency and insurer operations (e.g., prompt pay, claims).
- For licensing, solvency and insurer operation matters, each and every state of residence of an employer member of a trust will control and regulate the insurer.
- All state *benefit* mandates will be preempted with no federal replacement.
- Multiple HMOs under common control can operate as a mega-HMO as long as one of the individual HMOs is domiciled in the state of the trust and one is licensed in the employee's state of residence.

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June 10, 2008

Senate Committee on Finance
Attn Editorial and "Document Section
Rm. SD 219
Dirkson Senate Office Bldg
Washington, D.C.
20510-6200b

Re: Hearing June 10, 2008
47 Million & Counting:
Why The Health Care
Marketplace is Broken

Dear Committee,

The problem with healthcare is the cost.

The problem with the cost is that no one is looking at the bills.

70% of all hospital bills contain gross errors.

Do you know that insurance companies do not look at the bills that they pay? **They pay by summary.** Would you pay a \$10,000.00 credit card if the bill had three line items: Food, clothing and incidentals? That is what insurance companies do every day.

Enclosed is an itemized bill [page 1] which has many errors. Insurance companies never see an itemized bill. Let's look at the one [marked by #4] showing erroneous charges for the recovery room. The hospital charged for 2 first hours of a recovery room. There is only one first hour.

Page 2

On page 2 you will see how the bill is presented to the insurance company. Look at the line item: Recovery room, [marked by #4] \$1001.62.

There is an overcharge of \$511.55.

This is one operating room, for one hour, of one day.

If you extrapolate these abuses hour by hour and day by day, it amounts to billions.

Insurance companies do not care what they pay. If their expenses get to high, they just ask you and me for more money each month. Then the cost goes up again and so does the number of uninsured Americans.

Insurance companies and hospitals keep increasing profits at the expense of patient care and physician reimbursement.

That is why the healthcare system is broken.

Sincerely,

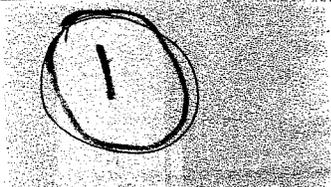


Holly S. Wallack
Administrative Solutions Plus, L.L.C

P.S. this bill is for a 40 minute outpatient breast biopsy from 2005.
How egregious is that!!

ABY224 L/ 07/30/ MEDICAL CENTER AS OF 07/29

PHONE ()
 A FOR-PROFIT HOSPITAL LICENSED BY THE STATE OF FLORIDA



F/C: N P/T: O A/C: 4788749 DSC CODE:

ADMISSION: 04/04/05 DISCHARGE: 04/04/05

GROUP POLICY ID:
 GROUP POLICY ID:
 GROUP POLICY ID:

DATE	DEPT	REV	BA#	HCPC	CRCD	DESCRIPTION	QTY	AMOUNT
04/04/05	401	360	1041	10225		LEVEL 2 MAJOR 1ST HR	1	4,399.04
04/04/05	401	360	1041	10226		LEVEL 2 MAJOR ADD 15MIN	1	882.75
04/04/05	404	940	1041	90784	10057	INJECTION IV 940	1	271.11
04/04/05	404	940	1041	90784	10057	INJECTION IV 940	1	271.11
04/04/05	404	940	1041	90784	10057	INJECTION IV 940	1	271.11
04/04/05	404	940	1041	90784	10057	INJECTION IV 940	1	271.11
04/04/05	404	710	1041	21522		RECOVERY 1ST HOUR	1	511.55
04/04/05	405	510	1047	06073		DAY SURGERY ERROP	1	107.00
04/04/05	405	710	1047	10094		SDS RECOVERY 1ST HR	1	271.09
04/04/05	405	710	1539	10095		SDS RECOVERY ADD 15 MIN	2	83.40
04/04/05	405	710	1047	10095		SDS RECOVERY ADD 15 MIN	1	67.79
04/04/05	405	710	1047	10095		SDS RECOVERY ADD 15 MIN	1	67.79
04/04/05	405	940	1047	90784	12346	INJECTION INTRAVENOUS	1	42.73
04/04/05	412	250	5200	04190		BUPIVACAINE 0.5% 10ML INJ	1	26.08
04/04/05	412	250	5200	04290		BUPIVACAINE/EPI 0.5% 10ML	2	57.16
04/04/05	412	250	5200	10166		LEVOFLOXACIN 500MG/DSW 100ML	1	198.39
04/04/05	412	250	1539	11810		DROPERIDOL 2.5MG/ML 2ML INJ	1	78.52
04/04/05	412	250	5200	13530		FAMOTIDINE 10MG/ML 2ML INJ	1	34.94
04/04/05	412	250	5200	13720		FENTANYL CITRATE 0.05MG/ML 2ML	1	34.79
04/04/05	412	250	5200	20810		LIDOCAINE HCL 2% 10ML INJ	1	78.83
04/04/05	412	250	5200	22620		MEPERIDINE 25MG/ML INJ	1	12.79
04/04/05	412	250	5200	J2765	24030	METOCLOPRAMIDE 5MG/ML 10ML	1	71.42
04/04/05	412	250	5200	24430		MIDAZOLAM 1MG/ML 2ML INJ	1	33.54
04/04/05	412	250	5200	32450		PROMETHAZINE HCL 25MG/ML 1ML	1	12.79
04/04/05	412	250	5200	32580		PROPOFOL 10MG/ML 20ML	1	108.30
04/04/05	412	250	5200	38100		TRIAMCINOLONE ACET 40MG/ML 1ML	1	39.30
04/04/05	412	250	5200	46680		MORPHINE SULFATE 5MG/ML	4	51.16
04/04/05	416	258	5200	02650		RINGERS SOLUTION 1000ML	1	83.40
04/04/05	416	258	1539	02650		RINGERS SOLUTION 1000ML	1	83.40
04/04/05	418	272	1041	00059		SUTURE	1	27.02
04/04/05	418	272	1041	00059		SUTURE	1	27.02
04/04/05	418	272	1041	00059		SUTURE	1	27.02
04/04/05	418	272	1041	02014		DRESSING GAUZE 4X4, 2S	1	30.46
04/04/05	418	270	1041	02087		MONITOR CARDIAC	1	91.85
04/04/05	418	272	1047	03430		KIT IV START	1	12.79
04/04/05	418	270	1041	04064		TRAY ERBP	1	40.27
04/04/05	418	270	1041	04194		TUBE SUCTION	1	6.87
04/04/05	418	250	1041	08706		WATER FOR IER STERILE 1500ML	1	7.85
04/04/05	418	270	1047	09575		SET IV UNIVERSAL PUMP	1	189.77
04/04/05	418	270	1047	10134		CUFF BP W/ADAPT 2-T DISP ADULT	1	23.57

CONTINUED..

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FRAUD
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2

Extrapolate
1 OR
1 hour
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1 day

50 PHARMACY		18	774.44
50 PHARMACY	J2765	1	71.42
58 IV SOLUTIONS		2	166.80
70 MED-SUR SUPPLIES		19	1185.62
72 STERILE SUPPLY		8	165.76
12 PATHOL/HYSTOL	88307	1	396.83
12 PATHOL/HYSTOL	88314	2	84.48
12 PATHOL/HYSTOL	88331	1	255.39
12 PATHOL/HYSTOL	88332	1	98.24
20 DX X-RAY	71020	1	149.50
60 OR SERVICES	19120LT	1	5281.79
70 ANESTHESIA		3	1654.87
10 CLINIC		1	107.00
36 DRUGS OTHER	J1260	1	76.08
36 DRUGS OTHER	J2405	4	113.66
10 RECOVERY ROOM		6	1001.62
40 OTHER EX SVS	90784	5	1127.17
01 TOTAL CHARGES			12710.67

4

5

PAGE 1 OF 1

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18

9! SELF EMPLOYED

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		FLMB0051573
8521	040405	E67520 LARRAURI J
		FLMB0051573
		E67520 LARRAURI J

Testimony for the

**United State Senate
Committee on Finance**

Regarding

***47 Million & Counting: Why the Health Care
Marketplace Is Broken***

Submitted by



**Janet Stokes Trautwein
Executive Vice President and CEO
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National Association of Health Underwriters

America's Benefits Specialists

June 10, 2008

The National Association of Health Underwriters (NAHU) is the leading professional trade association for health insurance agents and brokers, representing more than 20,000 health insurance producers and employee benefit specialists nationally. Our members service the health insurance policies of millions of Americans and work on a daily basis to help individuals and employers purchase health insurance coverage. They also help their clients use their coverage effectively and make sure they get the most out of the benefits they have purchased. As such, NAHU is extremely concerned about the problem of the uninsured and how rising health care costs are impacting health insurance coverage in this country.

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. Americans also deserve a system that is 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 the people's 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 a few simple reform measures enacted at the federal level of government would go a long way toward making health insurance coverage more affordable and more accessible to millions of Americans.

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. It is the key driver in rising health insurance premiums and it is putting the cost of health care coverage beyond the reach of many Americans. The reality is that consumers pay for all health care costs through one of three ways: taxes, health insurance premiums or out-of-pocket expenses. If the cost of health care becomes too great, the method of payment no longer matters – the country and its people are bankrupt or unable to access care.

There is no one magic answer to health care cost containment and there are many reasons health care costs are skyrocketing. Addressing this massive societal problem requires a multitude of comprehensive actions by individual citizens and elected officials. Many of the topics that need to be addressed to truly lower health care costs in the country, like physical education for children or wiser nutritional choices, are not ones in which NAHU members as a whole have any particular expertise. However, as health insurance producers and employee benefit specialists, we do have extensive knowledge of health insurance markets and the factors that are directly driving up health insurance claims costs and, consequently, health insurance premium rates. We

National Association of Health Underwriters
2000 N. 14th Street, Suite 450 · Arlington, VA 22201 · (703) 276-0220 · www.nahu.org

feel that the following recommendations would make important improvements to the U.S. health care system to lower costs, improve quality and create greater efficiency:

- Require federal and state governments to incorporate wellness and disease-management programs into medical programs for employees and government-subsidized health coverage.
- Provide employers with legal protections and tax and premium incentives for wellness programs.
- Provide incentives for doctors and medical facilities to improve system efficiencies and eliminate errors with pay for performance, best-practice guidelines and support for evidence-based medicine.
- Create federal standards for interoperable electronic medical record technology to help unify the health care system, reduce errors and improve patient satisfaction.
- Enact comprehensive medical malpractice reform that limits non-economic damage awards, allocates damages in proportion to degree of fault, places reasonable limits on punitive damages and attorney fees, and imposes reasonable statutes of limitations on claims. Encourage state authorities to increase the effectiveness of discipline imposed on incompetent doctors.
- Reimburse providers participating in all federal health care coverage programs, including Medicaid, Medicare and SCHIP, at the same level paid to providers serving federal employees through the Federal Employees Health Benefit Plan.
- Encourage states to streamline the application processes for public health insurance programs like Medicaid and SCHIP, and allow for presumptive eligibility so that all eligible participants are enrolled and their providers are paid instead of incurring uncompensated care expenses.
- Encourage expansion of consumer-directed health insurance products.
- Make consumers fully aware of the cost of the health care that they are purchasing by enabling and encouraging health plans and providers to overcome policy concerns (e.g., prohibiting gag provisions in provider contracts) and bring complete price information to the public as soon as possible.

In addition to containing health care costs, a successful national health care reform effort must ensure Americans access to a variety of health care coverage choices. 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. There are a number of steps Congress could take to improve American access to affordable private health insurance options.

In a number of states there are people with serious medical conditions and no access to employer-sponsored health insurance; they cannot buy health insurance at any price. Federal access protections in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) ensure that small-group health insurance customers and individuals leaving group health insurance coverage must always have at least one guaranteed purchasing option, but they do not apply to everyone. People purchasing coverage in the traditional private individual health insurance market who are not transitioning from an employer's plan do not have federal guaranteed-issue rights. Most states, but not all, have independently established at least one mandatory guaranteed purchasing option, with the vast majority of state choosing a high-risk health insurance pool to serve this important purpose. While the mechanism for access to health care coverage may vary from state, access should not be denied any American.

To solve this problem quickly and efficiently, the federal government should require that all states have at least one private guaranteed purchasing option for all individual health insurance market consumers. Congress should also provide seed grants to states creating high-risk pools

and states that 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.

Another area where Congress should consider effecting change is the subsidization of reinsurance. A small number of insured within any insurance pool incur the bulk of claims. This makes spreading risk difficult in every market segment. To deal with this challenge, many health plans obtain private reinsurance coverage. These arrangements allow insurance companies to protect themselves against unanticipated, large losses. Self-funded employers typically purchase coverage in a similar manner and project losses based on expected claims from their employee group. The premium paid to reinsurers is factored into the overall premiums paid by employers and insureds. Making it easier and more affordable for carriers to reinsure expenses related to extraordinary claims could prove to be an effective way to lower insurance premiums. Making coverage more affordable might result in significant savings for American families. The concept of reinsurance is not new. What is missing, however, is a definitive understanding of its overall impact on health insurance costs and the proper role of government in these programs.

Since the business of insurance is primarily regulated at the state level of government, state-level health insurance reforms have enormous potential to impact access and affordability. In some states, over-regulation of the health insurance market has decreased competition and placed complex burdens on private health plans, increasing premium costs. Conversely, states implementing market-friendly measures have greater competition among more carriers, provide consumers with greater choice, and have lower premiums and lower numbers of uninsured.

NAHU believe states should be encouraged to create regulatory climates that ensure the availability of many affordable coverage options. We further believe states should be encouraged to 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 state health insurance innovations that utilize the strengths of the existing private health insurance marketplace. Examples of state reform measures that should be rewarded include:

- Creating broadly funded high-risk pools to serve individuals with serious medical conditions purchasing coverage in the individual health insurance marketplace.
- Allowing for the assessment of insurable risk in the individual and small-group health insurance markets for effective risk-management.
- Limiting the cost impact of unnecessary mandated-benefit requirements through the creation of effective independent state-mandated benefit review commissions and/or allowing the availability of limited mandated health benefit plan options.
- Enacting 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.
- Creating 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.
- Modifying state Medicaid and/or 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.

- Providing 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.

A final access issue that the federal government should address is tax equity for health insurance purchasers. The vast majority of privately insured Americans receive their health insurance coverage through their employer or the employer of their spouse or parent. To help encourage the provision and acceptance of employer-sponsored health insurance, there is a current federal tax exclusion in which amount of an individual's group health insurance coverage premium paid by an employer is excluded from the employee's gross income for income and payroll tax purposes. NAHU strongly supports employers contributing toward the cost of their employees' health insurance coverage and we believe the preservation of the federal employer deduction and employee exclusion is critical.

However, the employer-sponsored health insurance system does not work for everyone. The availability of employer-based coverage has declined in recent years as costs have increased. Employer-based coverage is also not always an option for early retirees or the self-employed. As such, NAHU supports equity in the tax treatment for individuals and families purchasing health insurance coverage on their own and equal tax treatment for the self-employed. NAHU believes federal tax laws should be updated to provide the same federal tax deductions to individuals and the self-employed that corporations have for providing health insurance coverage for their employees.

Specifically, Congress should take action to:

- Remove the 7.5 percent of adjusted gross limit of medical expenses on tax filers' itemized deduction Schedule A form.
- Allow the deduction of individual insurance premiums as a medical expense in itemized deductions.
- Equalize the self-employed health insurance deduction to the level corporations deduct by changing it from a deduction to adjusted gross income to a full deductible business expense on Schedule C.
- Clarify that individual health insurance policies purchased by employees with no premium paid by the employer are not the same as group health insurance policies and are not subject to the group insurance requirements specified in HIPAA. Employees own these policies and they stay in force when workers leave their job. In particular, the federal requirements regarding individual policies sold on a list-bill basis – whereby the employer agrees to payroll-withhold individual health insurance premiums on behalf of its employees and send the premium payments to the insurance carrier but does not contribute to the cost of the premiums – need to be clarified. Furthermore, insurers should recognize the individual insurance plan as a valid coverage option for the accounting of participation guidelines of the insurer.
- Clarify that employers implementing list-billing arrangements for their employees may also establish Section 125 premium-only plans for their workers. This would enable employees to pay for their individual policies on a tax-favored basis. If an individual participated in a Section 125 plan for a list-billed policy, those premiums would not be eligible for deduction as a medical expense under Schedule A.

- Establish that all individual health insurance policies sold under a list-billed arrangement are subject to all state insurance regulations governing the issuance of traditional individual insurance policies in the state in which the policy was sold, including rating requirements, issuing requirements and the requirement that such products only be sold by licensed health insurance producers.

NAHU believes that the final component in any successful health care reform effort is responsible financing. While many of the cost-containment measures we recommend will yield substantial savings, it is also likely that other measures to ensure access to affordable private health insurance will likely result in the need for increased public funds. NAHU feels such funds should generally be derived from assessments (fees, taxes and the like) on activities that drive health costs higher. Assessments that generally encourage healthy and cost-effective behaviors while discouraging unhealthy and cost-ineffective ones will result in both additional funds and healthier citizens.

We look forward to working with the Committee on Finance as you endeavor to improve our nation's health care delivery system. If you have any questions, or if our association could be of any further assistance, please do not hesitate to contact me at (703) 276-3806 or jtrautwein@nahu.org, or our vice president of policy and state affairs, Jessica Waltman, at (610) 972-2404 or jwaltman@nahu.org.

Respectfully submitted,



Janet Trautwein
Executive Vice President and CEO

**United States Senate Committee on Finance
Public Hearing
47 Million & Counting: Why the Health Care Marketplace is Broken
June 10, 2008**

**Statement for Committee Record
The University of Texas M. D. Anderson Cancer Center
John Mendelsohn, M.D.
President
1515 Holcombe Boulevard
Houston, Texas 77030**

I appreciate the opportunity to provide written testimony for the public hearing on the challenges facing more than 47 million Americans who are without insurance. I also would like to clarify the significant role The University of Texas M. D. Anderson Cancer Center plays in addressing the cancer problem that confronts the nation and the world, including the help we give to many medically indigent patients.

The testimony of Lisa Kelly, one of the 85,000 patients seen at M. D. Anderson last year, and the opinions expressed in the April 28, 2008, *Wall Street Journal* article "Cash Before Chemo: Hospitals Get Tough," that highlighted her experience, do not present full and accurate descriptions of the care we provide. The testimony and newspaper account also do not fully describe our patient billing policies. These policies are in line with many other non-profit and state-agency hospitals in the United States and are designed to curb the escalating level of bad debt incurred by many providers, including M. D. Anderson.

Most importantly, I wish to clarify that a patient's medical need – not financial status – determines the type of treatment that each patient receives at M. D. Anderson. All M. D. Anderson patients receive the highest quality cancer care available anywhere, comparable to the care Mrs. Kelly continues to receive at M. D. Anderson today.

Mrs. Kelly has stated that we would not accept her health insurance policy because it covered only 50% of the estimated cost of her care. This is not accurate. Her limited insurance policy had a cap of only \$37,000, which was far, far less than the anticipated expenses for her care. Mrs. Kelly's insurance company reimbursed her for the expenses she incurred up to the \$37,000 limit of her policy. Further, it was clear through her testimony that she made the decision not to purchase health insurance for "five to six years" and then purchased a policy that she knew was "limited."

M. D. Anderson has a long-standing tradition of caring for uninsured, underinsured and medically indigent patients. However, patients like Mrs. Kelly, who have significant personal resources and income, do not qualify for our free care programs, which must be provided for Texans with the most need. As a state agency, M. D. Anderson must be a responsible steward of taxpayer dollars and the institution has state statutory guidance to ensure that adequate resources are generated to support its mission. (Texas Education

Code, Section 73.113: The institution shall ensure that institutional funds and the institution's hospital and clinic fees and patient base are sufficient to fund and achieve the mission and strategic plan of the institution and protect the state's investment in the development of the institution.)

Charity Care Provided at M. D. Anderson

The total unreimbursed cost of our indigent care and Medicaid programs in FY07 was approximately \$66 million. A total of 6,798 patients – or approximately 8% of all patients treated at M. D. Anderson – received care through these programs.

M. D. Anderson provides 12 part-time clinical faculty members, 18 part-time medical oncology fellows and five research nurses to staff the oncology program at one of Harris County's public hospitals, the Lyndon B. Johnson (LBJ) General Hospital, at no cost to the county or taxpayers. We recorded nearly 6,000 patient visits in 2007 and treated 1,413 patients, entirely at LBJ, most without any charges to patients. M. D. Anderson invested \$1.5 million in this program in FY07 and already has plans to increase that support to \$3.2 million in FY09.

In addition to charity care, unreimbursed care for patients covered by Medicare and other governmental agencies cost M. D. Anderson approximately \$89 million in FY07.

Financial Assistance Services

Our financial assistance program helps patients navigate the financial aspects of their battles with cancer, often times helping them qualify for financial aid or insurance that they are not aware of. For example, we assist cancer patients who are eligible to enroll in the Texas Medicaid program and other government-sponsored programs, with nearly 2,000 patients obtaining coverage under Medicaid last year.

Through our Enhanced Pharmacy Patient Assistance Program, we identify pharmaceutical company programs that can supply needed drugs to indigent patients. More than 5,000 patients received assistance through this program in FY 07.

For patients who have financial means, but do not have adequate insurance coverage, we require some payment in advance of treatment based on the anticipated cost of care. In some instances we offer discounts for prompt payment, and long-term payment plans are available for our patients. Medical review processes (a medical "override") also are in place to ensure that patients with acute illnesses are treated regardless of their financial status.

It is important to note that in FY07 only 6% of M. D. Anderson's annual operating budget came from an appropriation from the State of Texas. Philanthropy, as important as it is, accounted for only another 2.6% of all of M. D. Anderson's operating resources in FY07. The remainder was earned by M. D. Anderson through fees for patient care services rendered, scientific research grants and contracts, and other income. The margin

on those funds supports our comprehensive programs in cancer research, education and prevention that are improving the outlook for all patients burdened with cancer, worldwide.

There is no “profit” in the traditional sense at M. D. Anderson. Rather, every dollar received and every dollar earned is invested toward expanding the institutional mission to eradicate cancer. Patient care demand is growing at a rate of between 6% and 8% per year and net revenues provide for the resources necessary to accommodate this growth – additional clinicians, other health care professionals, treatment and diagnostic equipment and facilities. In FY07, we invested more than \$100 million from patient care revenues in many research projects of our faculty, from basic science investigations to clinical trials of potential new therapies. In order to support efforts to train specialists in a broad range of cancer fields, we invested another \$81 million in educational programs for scientists, oncologists and other medical professionals, as well as educational programs for patients and the community. More than 5,500 trainees participated in educational programs at M. D. Anderson in 2007.

M. D. Anderson is grateful for the many philanthropic and government resources it receives. We cannot consume these resources to pay for the care for all who seek free or subsidized cancer treatment, and at the same time continue to maintain a balanced mission of patient care, research, education and prevention that touches millions of people and plays such a pivotal role in eradicating cancer in the nation and world.

The nationwide need for a comprehensive plan to address the uninsured and underinsured requires everyone’s attention now. Some states, such as Texas, have an extremely high number of individuals and families who are uninsured or underinsured. When people cannot afford health insurance, or can afford adequate insurance but elect not to purchase it, the burden is often placed on the provider – the hospital and physicians to whom patients turn when severe illness strikes. The solution to this situation will require the collaboration of all involved in our nation’s health care.

