

PROTECTION FROM UNJUSTIFIED PREMIUMS

HEARING
OF THE
COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS
UNITED STATES SENATE
ONE HUNDRED ELEVENTH CONGRESS
SECOND SESSION
ON
EXAMINING PROTECTION FROM CERTAIN PREMIUMS

APRIL 20, 2010

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



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

U.S. GOVERNMENT PRINTING OFFICE

76–034 PDF

WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
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PROTECTION FROM UNJUSTIFIED PREMIUMS

TUESDAY, APRIL 20, 2010

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

The committee met, pursuant to notice, at 9:34 a.m. in room SD-430, Dirksen Senate Office Building, Hon. Tom Harkin, chairman of the committee, presiding.

Present: Senators Harkin, Murray, Reed, Casey, Hagan, Franken, Alexander, and Coburn.

Also Present: Senator Feinstein.

OPENING STATEMENT OF SENATOR HARKIN

The CHAIRMAN. The Committee on Health, Education, Labor, and Pensions will come to order.

We're holding our first hearing on health care since President Obama signed into law the historic Patient Protection and Affordable Care Act. This committee will be an active participant in implementation and oversight of that law. As we all know, health reform is not complete with the signing of a bill, and we are fully committed to ensuring a smooth and successful implementation.

A major goal of health reform is to bring down the cost of health care and to reduce health insurance premiums. According to the independent Congressional Budget Office, reform will lower premiums by 14 to 20 percent for Americans buying insurance on their own. Now, those significant premium savings are the result of bringing everyone into the insurance pool, as well as administrative savings from larger purchasing pools and prohibiting medical underwriting for health status and preexisting conditions. And, of course, the Affordable Care Act includes an array of reforms to reward quality and value, which will reduce health care costs over the long-term.

But, today our focus is not on health reform and its impact on premiums. Today, our focus is on current market conditions and ensuring that premiums are justified, that working families' hard-earned dollars are going toward premiums that truly reflect the cost of health care. What we're talking about is protecting consumers from insurance companies jacking up premiums simply because they can. Protections must be in place to ensure that insurance companies do not take advantage of current market conditions before health reform fundamentally changes the way they do business in 2014.

The Affordable Care Act includes a requirement, effective in 2011, that insurance companies spend at least 80 percent of pre-

mium revenue on actual health care. This reform will provide an important check on unjustified premiums, and the CBO has said that it will, in fact, lower premiums.

In addition, the act establishes a process for the annual review of premium increases prior to their use and for public disclosure of how premium rates are determined.

While all of this will benefit consumers tremendously, and very soon, we can and should do more. Currently, about 22 States in the individual market and 27 States in the small-group market do not require a review of premiums before they go into effect. This is a gaping hole in our regulatory system; it's unacceptable. All consumers and small businesses are entitled to a rigorous and objective review of premiums to ensure that they are reasonable. And if that review determines that premiums are unjustified, that insurance companies are just trying to run up profits, corrective action must be taken.

Rate review authority is not a panacea for reducing health care costs. We all know that premiums are rising because health care costs are rising. That is why the reforms in the Affordable Care Act aimed at containing costs are so important. But, according to the National Association for Insurance Commissioners, and I quote, "Rate review can help keep insurers focused on constraining the growth of these costs." The NAIC has also stated that, "Rate review authority is an important tool for regulators, and can help keep insurance companies honest." That is why, just this past Sunday, on the front page of the *New York Times*, there was an article about how New York's insurance companies are vigorously fighting the Governor's proposal to reinstate prior approval of premiums.

I want to commend Senator Feinstein for her extraordinary leadership on this issue. Her proposal became an important provision in President Obama's health reform plan. Unfortunately, because of procedural rules, it could not be included in the final health reform package. But, make no mistake, we are redoubling our efforts, and we are committed to ensuring that unjustified premiums are corrected in every State.

I recognize Senator Alexander for an opening statement.

STATEMENT OF SENATOR ALEXANDER

Senator ALEXANDER. Thanks, Mr. Chairman.

Senator Feinstein, it's good to see you.

The difference of opinion in the health care debate was about, What is the best way to reduce premiums so more Americans can afford it? Fundamentally, the mistake in the health care law was a decision by the majority, who passed the law, to expand health care coverage rather than to focus on reducing health care costs so that more people could afford to buy insurance. In other words, we are aiming at the wrong target.

I'm afraid this proposal by Senator Feinstein does the same thing. In Tennessee, we'd say it's barking up the wrong tree. Health insurance companies' profits—and half of them are non-profit—equal about 2 days of the cost of health care spending in the United States. So, even if we were to take away all the profits of the so-called "greedy insurance companies," that would still leave 363 days a year when our health care delivery system costs

are expanding at a rate that our country cannot afford. So, again, we're focusing on a tiny part of the problem—health care insurance company profits—and ignoring the health care delivery system which is breaking the backs of American families, American businesses, and the American government.

It's worse than that. The new health care law actually increases premiums. I had a little discussion with the President about that in, I hope, a respectful way at our health care summit. I read the Congressional Budget Office report a little differently than the Chairman does. It says that—in the letter that was issued at the end of November—that the new law will increase premiums for individual Americans, people who buy insurance on their own, by 10 to 13 percent, on average. And it, naturally, would do that, because the new law has something in it called the “minimum credible coverage,” which says that if you buy an insurance premium in the individual market—if you buy on your own, which up to 32 percent of Americans will be doing under the new law—you have to have a certain kind of coverage. Senator Collins, who's a former insurance commissioner in Maine, says that, in her State, that means that 87 percent of the policies will cost more under the new law than they do today. Now, it is true that about half, or maybe 60 percent, of those people would get subsidies paid for by taxpayers to reduce the cost. But, even the remaining 40 percent or 50 percent will pay more. So, the minimum credible coverage provision of the law raises premiums. So does shifting the cost of 16 or 18 million new people into the Medicaid plans raise premiums, because doctors can't afford to see them at the costs they're reimbursed, and those costs are shifted onto those with private insurance. The new taxes will tend to raise premiums. Also, the new rating system will keep my premium lower at my age, but raise it for my sons and my daughters.

Basically, we passed a new health care law which raises premiums. And now we're considering another law which seeks to say to health insurance companies—half of them nonprofit—“We're going to take a look at your profits and that will solve the problem.” The real problem is the health care delivery system. And the real way to reduce premiums is to focus on reducing costs.

I look forward to hearing from Senator Feinstein, my colleague on the Appropriations Committee, who I greatly respect and work with. Just because I have such great respect for her doesn't mean I have to like every single bill that she offers up. And so, I'll have some questions about it. And I will be looking to see whether this proposal, instead, will lead us toward more shortages, more price controls, and eventually toward a system where only the government offers Americans insurance.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Alexander.

Dianne Feinstein was elected to the U.S. Senate by the State of California in 1992. Among her many accomplishments in the 111th Congress, Senator Feinstein assumed the chairmanship of the Senate Select Committee on Intelligence, where she oversees the Nation's 16 intelligence agencies. A member of the Senate Judiciary Committee and, as Senator Alexander said, on the Senate Appropriations Committee, where we all serve, she chairs the Sub-

committee on Interior Environment and Related Agencies on Appropriations. Senator Feinstein also serves on the Senate Rules and Administration Committee, which she chaired during the 110th Congress.

Senator Feinstein, along with Senators Boxer, WhiteHouse, Reid, and Sanders, introduced S. 3078 to provide for the establishment of a health insurance rate authority to establish limits on premium rating and other purposes.

So, I welcome Senator Feinstein to the committee. I look forward to hearing from you about your bill. And, Senator Feinstein, again, welcome. And please proceed as you so desire.

STATEMENT OF SENATOR FEINSTEIN

Senator FEINSTEIN. Well, thank you very much, Mr. Chairman.

I thank you for your comments. I happen to be strongly in agreement with them. I very much appreciate your having this hearing.

Senator Alexander, I've enjoyed working with you on Interior Appropriations. It won't surprise you that I, respectfully, disagree.

I don't know any large country that has tried to cover people, across the spectrum, that's been able to do it with such a heavy preponderance of for-profit medical insurance. Some countries do have a for-profit system, but not to the extent that we have. And as I began to look into this, I found that, early on, the companies were able to get a bill passed which enabled them to merge and acquire, through an antitrust exemption. Now, the only other entity that has an antitrust exemption, to the best of my knowledge, is major league baseball.

And so, with this antitrust exemption, these companies began to merge and acquire companies. This is very true in my State, California. In the city of Los Angeles, two companies control 51 percent of the premiums. Well, as they control the market share, obviously, they are able to raise premiums.

You are correct, Mr. Chairman, President Obama did put this bill in the reconciliation bill. A point of order would rest against it, according to the parliamentarian, because it was more policy than budget reduction. And so, this is the only recourse that remains.

Here's what I have found: This industry is extraordinarily large in profit-taking for the kind of industry it is. The five largest for-profit companies saw profits go up some 56 percent from 2008 to 2009. That's from 7.7 billion to 12.1 billion. During this period of time, premiums are going up for people. WellPoint, the corporate parent of Anthem Blue Cross, earned a \$4.7-billion profit in 2009. The CEO received a \$3.1-million salary in total compensation in 2009. That was a 51 percent increase.

Well, these increases came; it may have been from a different profit center, but what then happened is, WellPoint indicated, and has indicated, that, beginning on May 1, insurance premiums for 800,000 Californians—single policies—will go up to 39 percent, which, with the average, as I understand it, being a 25 percent increase.

At a time when California has 12.7 percent unemployment—almost 2.5 million people out of work—over the last 2 years, 2 million people have left the insured and become uninsured. So, these

premiums drive people out of insurance, and we have received a tremendous number of complaints, with human stories that I won't go into here. But, "How can I afford it?" You know, "I have three children. How can I afford a 39-percent increase on my premium?"

I think this is completely backwards. I think, if you make money from one profit center—the point of health insurance is to help people. It shouldn't be to become JPMorgan. And therefore, you ought to offset a profit from one center with the other, and have some sensitivity as to how you raise premiums, the timelines with which you raise premiums, and the size with which you raise premiums.

Now, they're not the only one. Blue Cross/Blue Shield of Michigan requested a 56 percent increase in individual market plans in 2009. Regency Blue Cross/Blue Shield of Oregon requested a 20-percent premium increase. Three plans in Rhode Island requested increases ranging from 13 to 16 percent. And Anthem requested a 24 percent increase for plans in the individual market in Connecticut.

Regulators, however, approved only a 16.5 percent increase. So, there was an increase—there was an indication of where there was a State regulator that was able to review it and say, "No, we don't find that justified. We do find a 16.5 percent increase justified." But, again, this is during a period of enormous profit-taking.

Now, as you said, insurance commissioners in some States have this authority already, and they would keep it. Commissioners have the authority for some insurance markets and not others. In about 20 States, including California, companies are not required to receive approval for rate increases before they take effect. This legislation simply creates a Federal fallback, allowing the Secretary to conduct reviews of potentially unreasonable rates in States where the insurance commissioner does not already have the authority or capability to do so. The Secretary would review potentially unreasonable premium increases and take corrective action. This could include blocking an increase or providing rebates to consumers. Under this proposal, the Secretary will work with the National Association of Insurance Commissioners to implement the rate review process and identify States that have the authority and capability to review rates.

States already doing this work should continue. This legislation would not interrupt them. However, consumers in States like California and Illinois deserve protections from unfair rate hikes.

The proposal would also create a rate authority, a seven-member advisory board, to assist the Secretary with these responsibilities. A wide range of interests would be represented, including consumers, the insurance industry, medical practitioners, and other experts.

I think the proposal strikes the right balance, because there is an enormous loophole prior to the opening of the exchanges in 2014. And I suspect, once we get past May 1, you are going to see other companies raise rates with dispatch.

There is no need for Federal involvement in States with insurance commissioners that are protecting consumers. So, the legislation I've introduced simply provides Federal protection for consumers who are currently at the mercy of large for-profit health in-

insurance companies whose top priority, candidly, is their bottom line.

You know, in California, we have a Public Utilities Commission. And the reason we have it is because electricity is found to be necessary for life. And therefore, the utilities are regulated. Pacific Gas & Electric, Southern California Edison, Semper—big utilities go before the Commission when they want a rate increase. They may get it. They may get some of it. They may not get it. Most of the time, they either get it, or get a part of it. But, there is a process to review these rates.

I think, at a time when the economy is what it is in our country, and we want to encourage people to have private insurance, that insurance has to be affordable. And premiums have to go up on a rate that people can endure and pay. To have rates of 40 percent or 50 percent or 30 percent in a given time, and then tell the individual, “In the middle of next year, we may have to raise your rate again,” that is a major discouraging factor to a family gaining health insurance.

So, I’m not going to go on and on, but I believe this issue passionately. If I had my druthers, I truly believe medical insurance should be nonprofit. But, it is for-profit. And there is a very large part of the premium dollar that goes for administrative expenses rather than medical care. The health care reform bill reduces that to 15 percent, and I think that’s good news.

To have an industry that really doesn’t have the moral compass to understand what people are going through, when they’re making enormous profits at the same time, I find extraordinarily difficult to endure.

Thank you very much, Mr. Chairman.

[The prepared statement of Senator Feinstein follows:]

PREPARED STATEMENT OF SENATOR FEINSTEIN

I would like to thank Chairman Harkin, Ranking Member Enzi and members of the committee for inviting me here today to address what I believe to be a missing piece of health care reform: the ability to block unreasonable premium increases.

Without further legislative action, I am concerned that health insurance companies will continue to do what they have done for far too long: put their profits ahead of people.

Premium increases are forcing Americans to choose between keeping health care coverage and making their mortgage payments, all while big national insurance companies enjoy increasing profits.

ANTHEM/BLEU CROSS

Everyone by now is familiar with the increases that Anthem/Blue Cross of California is seeking to impose on 800,000 Californians. Rates will go up, on average, 25 percent and as much as 39 percent for some consumers.

I find this unbelievable. Imagine the typical family, or individual, trying to find the money to pay another 39 percent for health care coverage—especially during these difficult economic times, with so much uncertainty.

Meanwhile, the health insurance company is doing better than ever.

- WellPoint, the corporate parent of Anthem/Blue Cross, earned a \$4.7 billion profit in 2009.
- The CEO of Wellpoint received \$13.1 million in total compensation in 2009, which was a 51 percent increase.

This is completely backwards. A CEO is rewarded for business decisions that result in huge increases for customers. This is completely wrong. It is unacceptable, and it must not continue.

The actions of Anthem in California have received a great deal of attention, but in reality, they are not all that unique. According to a report compiled by the U.S. Department of Health and Human Services:

- Blue Cross/Blue Shield of Michigan requested a 56 percent increase in individual market plans in 2009.
- Regency Blue Cross Blue Shield of Oregon requested a 20 percent premium increase.
- Three plans in Rhode Island requested increases ranging from 13 percent to 16 percent.
- Anthem requested a 24 percent increase for plans in the individual market in Connecticut. Regulators approved only a 16.5 percent increase.

Like Wellpoint, these companies are also enjoying financial growth. Even last year—a time of enormous economic distress for average Americans—was a good year for the health insurance industry. According to Health Care for America Now!, the five largest health insurers (WellPoint, UnitedHealth, Humana, Cigna, Aetna) saw profits increase 56 percent from 2008 to 2009, from \$7.7 billion to \$12.1 billion. Only Aetna saw their profits decrease.

Yet we see these continued premium increases. We can expect this trend to continue, especially until 2014, when newly created exchanges will give customers new tools to compare plans, and force companies to be more competitive.

SUMMARY OF LEGISLATION

The solution, I believe, is legislation to give the Secretary of Health and Human Services the authority to block premium or other rate increases that are unreasonable.

In many States, insurance commissioners already have this authority. In some States, commissioners have this authority for some insurance markets and not others. And in about 20 States, including California, companies are not required to receive approval for rate increases before they take effect.

My legislation simply creates a Federal fallback, allowing the Secretary to conduct reviews of potentially unreasonable rates in States where the Insurance Commissioner does not already have the authority or capability to do so.

The Secretary would review potentially unreasonable premium increases and take corrective action. This could include blocking an increase, or providing rebates to consumers.

Under this proposal, the Secretary will work with the National Association of Insurance Commissioners to implement the rate re-

view process, and identify States that have the authority and capability to review rates.

States already doing this work should continue—this legislation would not interrupt them. However, consumers in States like California and Illinois deserve protections from unfair rate hikes.

The proposal would also create a Rate Authority, a 7-member advisory body to assist the Secretary with these responsibilities. A wide range of interests would be represented, including consumers, the insurance industry, medical practitioners, and other experts.

This proposal strikes the right balance. There is no need for Federal involvement in States with insurance commissioners that are protecting consumers. The legislation I have introduced simply provides Federal protection for consumers who are currently at the mercy of large health insurance companies whose top priority is their bottom line.

UTILITY MODEL

Health insurance should be no different than utilities. Water and power are essential for life. So they are heavily regulated and rate increases must be approved.

Health insurance is also vital for life. It too should be strictly regulated so that people can afford this basic need.

CONCLUSION

I would like to thank the committee for holding this hearing. I urge you to consider and approve this legislation as quickly as possible.

It is a reasonable, measured proposal that will give all consumers, not just those in certain States, protection from unfair health insurance rate increases.

The CHAIRMAN. Well, thank you very much, Senator, for your eloquent statement and for your leadership on this issue.

We have a panel coming up here afterward that I'm sure we're going to get into a lot of these issues with. I know you have your own committee that—

Senator FEINSTEIN. I do.

The CHAIRMAN [continuing]. You have to go to, so. And I thank you very, very much—

Senator FEINSTEIN. Thank you.

The CHAIRMAN [continuing]. For being here, and for your leadership on this. And we'll see how this committee reacts and what we're going to do on this bill.

Senator FEINSTEIN. Thank you very much.

The CHAIRMAN. Thank you very much, Senator Feinstein. Thank you. Thank you.

Now I'd like to call up our panel. Phyllis Menke, city clerk, city of Fonda, IA; Michael McRaith, director of the Illinois Department of Insurance; Karen Ignagni, president and CEO of America's Health Insurance Plans; and Grace-Marie Turner, president of the Galen Institute, of Alexandria, VA.

We'll go in that order.

Again, all of your statements will be made a part of the record in their entirety. I will ask you if you could kind of sum it up in

5 minutes—5, 10, 15, 20—if you could sum it up in 5 minutes, or 6. When it gets around 7, I might get a little nervous. But, around 5 minutes, I'd sure appreciate. And then, we can get into questions and answers.

We'll start in the order in which I recognized people. First of all, Phyllis Menke is the city clerk and chief financial officer for the city of Fonda, has been for 25 years, also serves on the board of directors for Pocahontas County Economic Development Commission and the Pocahontas County Tourism Commission. Phyllis Menke—again, the city of Fonda is a small community of 648 people in northwest Iowa. And she contacted our office, and I thought that her points were something that needed to be brought out, in terms of what happens to small towns and communities that don't have a large pool.

So, we'll start off with you, Phyllis. And again, thank you for being here. Thanks for getting in touch with our office. And, as I said, your statement will be made a part of the record. If you could sum it up in 5 or 6 minutes or so, I'd sure appreciate it.

**STATEMENT OF PHYLLIS J. MENKE, CITY CLERK,
CITY OF FONDA, IA**

Ms. MENKE. Thank you, Senator Harkin and the other members of the committee. This is truly an honor, for me to be here.

As Senator Harkin said, Fonda is a small community of about 648 people. We're located in northwest Iowa.

We have three employees that get insurance that's paid by the city. And we've had a policy for about 20 years. The first policy that the city had was a \$250 deductible. I don't have the records; I can't tell you what that cost back then. But, if we fast-forward to 2005, the city purchased a Wellmark Blue Cross/Blue Shield policy. Our deductible is now \$1,500, and it's a cost-split of 90/20, and each of the employees have a \$6,000 out-of-pocket maximum. And this is still a pretty good policy. It's not as good as the \$250 deductible we had, but it's a pretty good policy. Our cost was \$705 per month.

In 2006, Blue Cross/Blue Shield notified us that our premiums were increasing 32.18 percent. The city went out for bids. The bids came back very high. So, we increased our deductible to \$2,000. We increased the cost-split from a 90/10 to an 80/20.

In 2007, our premiums increased by 18.4 percent, our deductible went to a \$3,000 deductible.

In 2008, our premiums were 13.33 percent increased. We made no change.

In 2009, our premiums increased 10.35 percent. Again, we made no change.

In September 2009, the city was notified by Blue Cross/Blue Shield that our premiums were increasing by 29.47 percent. The cost of our policy would go \$1,265 per person per month.

So, for the months of October, November, and December, I struggled, trying to find health insurance for the three full-time employees. I learned more about HSAs, HRAs, and group health insurance policies than I ever wanted to know. We went out for bids. They came back as high, or higher, than Blue Cross/Blue Shield. The city is no longer able to afford to offer its employees group health insurance.

So, the city council, after much discussion and research, decided that the employees should get their own individual policies. The city council or the city would reimburse the employees.

We've been with Blue Cross/Blue Shield for many years. We filed individual applications with them. I'll use myself as an example. But, my policy came back, that was going to have two preexisting-condition riders on it; and my husband, and I quote, "At this time, we regret to inform you that, due to multiple medical conditions, we are unable to accept John Menke for coverage, based on our review of your application information." But, they did appreciate my interest.

I don't know if any of you can relate to how I felt at receiving this letter that I'd been—you know, from the company that I'd been insured with for years, but it didn't feel good.

The only option left was that the city employees applied for what was called a "Blue Transition policy." It's a higher premium cost, but there's no preexisting conditions to it. We have a \$2,500 deductible. A family is required to meet three deductibles where, before, we only had to meet two. The cost for myself was \$751, which was quite a savings from the group health policy that the city had before, which would have been \$1,265. So, the city officially canceled our group health policy with Blue Cross/Blue Shield, effective December 31.

Now, if the city of Fonda had the same insurance policy that we had back in 2005, the cost for that would be \$1,631 a month. That's a 131 percent increase in 5 years, which is a 26 percent average per-year increase.

Going back to the Blue Transition policy that we got. We received notification from Blue Cross/Blue Shield that our policy rates were going up 25 percent, effective April 1. The Governor of the State of Iowa stepped in and demanded an independent review of those increases, even though Iowa is one of the States that has an insurance division that regulates our insurance rates. Anyway, that independent review, nothing changed in that.

Iowa also has what's called an "Iowa Governmental Healthcare Plan," and it is for governmental agencies to pool their employees together. I think this is a great idea, except for that you have to bring 50 employees to that pool. So, it doesn't help any of the small towns in the State of Iowa. And there are a lot of them in Iowa.

I believe that Blue Cross/Blue Shield monopolizes the insurance in Iowa, Illinois, Nebraska, and pretty much across the country. They are building a new \$250-million office in Des Moines. So, I know that they are not broke.

And I agree with Senator Alexander, it's not just the insurance companies; it's the cost of health care, too. So, I think it's a two-pronged sword there. But, something needs to be done. And progress is being made. I thank the Congress for that.

I want to thank you for having me here today.

[The prepared statement of Ms. Menke follows:]

PREPARED STATEMENT OF PHYLLIS J. MENKE

Dear Honorable Sirs and Madams: This testimony is in regards to Health Care Insurance.

The city of Fonda is a small community of 648, located in northwest Iowa. The city has provided its 3 full-time employees with group health insurance for many

years. The premiums kept increasing, year after year, sometimes at an increase of 30 percent. In an effort to contain costs the city has had to change insurance companies, raise the deductible four different times, they went from a 90/10 percent to an 80/20 percent cost split, they began to self-insure a portion of the deductible and they have discontinued offering dental insurance. The city has been with Wellmark BCBS of Iowa for many years.

- Twenty-two years ago the city began offering the employees Group Health Insurance. It was a Wellmark Blue Cross Blue Shield policy. The deductible was \$250. The city of Fonda paid 100 percent of the premium and continues to do so, only differently.

Fast forward to 2005 . . .

- 2005 we had a Wellmark BCBS policy. Our deductible is \$1,500, the cost split is 90/10, we have a \$6,000 out-of-pocket maximum and our co-pay is \$15. This is still a pretty good policy. The cost for family coverage was \$705.07 per month per employee.

- 2006 we are notified our premiums are increasing by 32.18 percent. The city went out for bids. We stayed with BCBS but increased our deductible to \$2,000, went to a 80/20 cost split, increased our co-pay to \$20 and our out-of-pocket maximum went to \$8,000.

- 2007 we are notified our premiums are increasing by 18.40 percent. The city increases our deductible to \$3,000, our co-pay goes to \$25 and our out-of-pocket maximum is now \$12,000.

- 2008 we are notified our premiums are increasing by 13.33 percent. The city makes no changes to our coverage.

- 2009 we are notified our premiums are increasing by 10.35 percent. For the second year, the city makes no changes to our coverage.

- 2010 in September 2009, we received our notice of renewal rates for 2010, our premiums are increasing by 29.47 percent. The cost would be \$1,265.76 per month per employee. So for the months of October, November and December I struggled with trying to find reasonably priced, decent insurance coverage for the city's employees. The city went out for bids, and the bids that came back were as high as or higher than the Wellmark BCBS rates. The city could no longer afford to offer its employees a decent group health insurance policy; in order to keep costs down we would have to raise the deductible again and that was determined to be unacceptable. The city will be canceling our group health insurance policy effective 12-31-2009.

- If the city of Fonda had the same insurance today that we had in 2005 it would cost \$1,631.44 per month per employee. That accounts for a 131 percent increase in premiums over the last 5 years and averages 26.2 percent per year. \$58,732 a year for the city to provide health insurance for three employees for this policy.

After much research and discussion, the result was that the employees would need to provide their own insurance coverage and the city would reimburse them. The employees went through the process of completing applications for coverage.

I will use myself as an example, but this was also true for the other two employees. I applied for health insurance coverage with Wellmark. Based on my medical history, they issued an amendment(s)/rider that exclude certain conditions from my health benefit coverage. Wellmark would not cover nor provide benefits in connection with any medical treatment, or medications for and I quote:

0205: Non-cancerous tumors or growths, including any treatment, operation, or complications thereof. This includes International Classification of Disease (ICD-9) codes 210.00-229.99

1006: Structural conditions of the female reproductive system, including treatment, operation, or complications thereof. This includes International Classification of Disease (ICD-9) codes 617.00-629.99

In addition to the riders they were placing on me, they notified me and I quote:

“At this time, we regret to inform you that due to multiple medical conditions, we are unable to accept John M Menke for coverage based on our review of your application information.”

They went on to say that “they appreciated my interest in Wellmark BCBS of Iowa.”

I don't know if any of you can relate to how I felt at receiving this letter from the company that the city had insured with for years.

Iowa has a group called the Iowa Governmental Health Care Plan. I.G.H.C.P. is a Benefits Trust for Shared Risk Pooling among Public Employers in the State of Iowa. It allows entities to enter into the trust based on claims experience, plan design and demographics. The entities are then pooled at renewal, using total claims

experience to develop renewal percentages. This is a GREAT idea! However, an entity must have a minimum of 50 employees to bring into this group plan. *It does not help the small cities in the State of Iowa*, only the larger cities and they already have a large employee base that offsets their experience rating. I.G.H.C.P. should be available to all Iowa government agencies, regardless of their size.

The only option left, and I repeat the *ONLY* option, was for the employees to apply and accept a **Blue** Transitions policy. It has a \$2,500 deductible, a family is required to meet three deductibles, and it is an 80/20 percent split. The policies went into effect on 01-01-2010. The cost for myself and my husband (age 54 and 59) was \$751.85 per month. We received notice from Wellmark BCBS on February 20 that effective 04-01-2010 our premium is going up 25 percent to \$937.55. So were the other employee's insurance costs. Could someone please explain this to me? Our policies haven't even been in effect for 2 months when we receive these types of increases.

I sent a letter to the Iowa Insurance Division Commissioner asking them this question and have attached a copy of their response. (Attachment A.) In summary BCBS initially asked for a 31 percent increase for Blue Transition policies. The Iowa Insurance Division was able to negotiate it down to 25 percent. Governor Chet Culver stepped in and asked for an independent study of the BCBS rate increases. The study has been completed and the increases were determined to be justified. The new rates go into effect May 1.

Wellmark BCBS monopolizes the insurance in Iowa, Illinois, Nebraska, etc. BCBS is building a new \$30-million office building in Des Moines so they are not broke. Every hospital in a 120-mile radius of Fonda has recently constructed major additions to their building; Des Moines just finished building a brand new hospital. The hospitals are not broke. Health care costs have skyrocketed. U.S. citizens can purchase their prescriptions cheaper from pharmacies in Canada, Mexico and India.

I am one of the lucky ones, I have insurance, my employer covers the cost and I am for the most part pretty healthy. Fonda's former Mayor does not have health insurance and hasn't for 32 years. His employer's did not provide it and he has health issues that prevent him from getting any standard insurance policy. He would have to get a "High Risk" policy and he is not able to afford it.

This testimony is long, too long, but I hope that you can feel my frustration and the frustration of small cities and businesses in Iowa and around the country that are trying to do the right thing and provide insurance for their employees. I hope you understand the frustration of working class people trying to provide their families affordable insurance.

Something needs to be done; progress is being made and I thank you for that.

ATTACHMENT A

From: Jeshani, Yasmin [IID] <Yasmin.Jeshani@iid.iowa.gov>
 Subject: RE: Small group rate increase—TEXT
 To: "phyllismenke@yahoo.com" <phyllismenke@yahoo.com>
 Date: Tuesday, March 2, 2010, 3:33 PM

Dear MS. MENKE:

1. Small group rates are not regulated like the individual market, however, carriers have to maintain compliance with the rating bands in chapter 513C of the Iowa Code. Small group law limits the variability of rates between groups which essentially forces the groups with the best experience to provide a little subsidization to the groups with the worst experience. You may view chapter 513C of the Iowa Code at the Iowa legislature's Web site at www.legis.state.ia.us.

2. The Blue Transitions policy is an individual policy and is subject to the individual rating laws of Iowa. Most of Wellmark's individual major medical policies are anniversary rated on April 1 of each year. Since major medical policies are normally adjusted annually to account for changes in utilization and underlying costs, Wellmark annually files for increases in December of each year for all of their individual policies. The company's proposal for Blue Transitions was nearly 31 percent, however, we negotiated that proposal down to 25 percent by getting them to agree to a high loss ratio target for that business. The loss ratios on Blue Transitions was significantly higher than what the law calls for so the company was clearly in compliance with the proposal. Your rate for Blue Transitions should be good until April 1, 2011. Basically anybody that purchased Blue Transitions in Dec./Jan. would be getting a notice in February that their rates are going up; just the luck of timing. The rates did not go up just because you purchased the policy.

We regret that medical costs are continuing to steadily increase. This is a result of increasing claims (more office visits, prescriptions and surgeries) and the increasing costs for these services. Rate increases are not based on your particular use of services, but on the services used by all members of a pool or group of policies. One individual may have only physicals and vaccinations, but others in the same pool may have had heart attacks, strokes, or other major surgery. It is the total claims of the entire pool of insureds that will determine whether the rate increase for the entire pool is approved. Medical claims presented to insurance companies are surpassing inflation, cost-of-living, or wage rates.

Wellmark has documented loss ratios of over 90 percent for calendar years 2008 and 2009. This means over 90 cents of every dollar of premium paid has gone to pay claims. In some pools, Wellmark has paid out more in claims than it received in premiums. When costs for rent, salaries, commissions, taxes, legal, accounting, etc. are included Wellmark is losing money on these policies. Ultimately, any business will fail if it operates at a loss. A rate increase was essential for Wellmark to continue to stay open and pay future claims.

We want you to know that the Division thoroughly reviewed Wellmark's individual proposals and that it was our belief that the company was in compliance with the applicable individual rating laws. We fully understand the health care and insurance crisis in this country. We also fully sympathize with Iowa's citizens in dealing with these hardships.

YASMIN JESHANI,
Market Regulation Bureau,
Iowa Insurance Division.

The CHAIRMAN. Thank you very much, Phyllis.

And I might just add a parenthetical note, myself. Wellmark Blue Cross/Blue Shield and United Healthcare have 80 percent of the market in Iowa——

Ms. MENKE. Yes.

The CHAIRMAN [continuing]. Between the two of them. Eighty percent.

Now we'll turn to Mr. McRaith—Mike McRaith—director of the Illinois Department of Insurance. Before that, he worked 15 years in private practice as an attorney in Chicago. Director McRaith represented national and regional financial institutions, including insurers in finance-related litigation. He serves as president of the board of directors for the Illinois Comprehensive Health Insurance Plan, a high-risk health insurance pool. He supervises the State senior health insurance program and has actively participated in developing, drafting, and advocating for statewide and national health insurance modernization. Mr. McRaith serves on the executive committee of the board of directors for the AIDS Foundation of Chicago and board of directors for the American Foundation for Suicide Prevention, Chicago Chapter. So, very active in many, many areas of health care.

Mr. McRaith, welcome, again. Your statement will be made part of the record. If you could sum it up in 5 minutes or so, I'd appreciate it.

**STATEMENT OF MICHAEL T. McRAITH, DIRECTOR, ILLINOIS
DEPARTMENT OF INSURANCE, SPRINGFIELD, IL**

Mr. McRAITH. Chairman Harkin, Senator Alexander, Senator Franken, thank you for the invitation to join you this morning.

I'm Michael McRaith, director of insurance in Illinois, and, in that capacity, I speak today.

Thank you for your attention to unjustified health insurance premium increases in the Feinstein-Schakowsky bill.

To be sure, Illinois families will see landmark improvements in health insurance performance, accountability, and transparency, due to the Patient Protection and Affordable Care Act. Illinois families are now denied health insurance for any reason other than race, color, religion, or national origin. One woman was denied health insurance for herself and three children—all healthy—because she attended grief counseling after her husband died of a heart attack. For that widowed mother, even grief was a pre-existing condition. An NAIC survey revealed that Illinois has more rescissions than any other State, almost 50 percent more than California. One insurer rescinded coverage for a teenaged girl whose parents failed to disclose, on the family application, that she had a congenital deformity; she had braces. Women are charged as much as 57 percent more than a man, independent of maternity benefits. An individual renewing a policy pays a penalty, moving the healthy into cheaper policies, sending the sick into the premium death spiral. Small businesses, hoping to retain skilled employees, cannot offer health insurance, because of premium volatility. The talented, entrepreneurial, and ambitious forego dreams of self-employment in order to retain health care for themselves or a dependent.

January 2014 will not come soon enough for families and businesses in our State. With much mythology and reports of health-insurer profits, the justification for rate increases merely substantiated the impetus for reform.

In Illinois, health insurers are not required to provide actuarial justification for rate changes. We receive percentage rate changes for the individual market. Exhibit B to my written testimony is the department report of base-rate increases from 2005 to the present. The report illustrates that dramatic rate increases in Illinois began long before 2009. For our small business market—2 to 50 employees—this is the entirety of a rate filing. We know neither the dollar amounts charged to small groups nor the percent increase annually. For large groups, we do not receive any information at all.

Twenty-seven States have rate approval authority for the individual market. Twenty-two States have that authority for the small-group market. With an entirely for-profit health insurance industry, Illinois has zero authority to deny any rate, except if a company's pricing is too low. For property and casualty insurance, in the absence of hurricanes and major earthquakes, Illinois neither has nor needs rate approval authority.

But, health insurance differs. Our dysfunctional health insurance market stifles economic growth and life quality. Small employers face rate increases of 30 to more than 50 percent if only one or two employees are sick or injured, while employers who grow beyond 50 employees lose the guaranteed offer and protection of the small-group laws.

With reforms like loss-ratio standards, elimination of lifetime caps, and coverage for children with preexisting conditions, our department needs additional tools. We are concerned that families may be priced up and out by less responsible insurers, in anticipation of 2014. We welcome Feinstein-Schakowsky and its deference to the States.

To be clear, Illinois unequivocally supports State-based insurance regulation. The bill would not preempt those States with existing rate approval authority, but may incentivize States like Illinois to adopt rate approval suitable for that State. Feinstein-Schakowsky would enhance Illinois' market efficiency. Illinois families and businesses would know that hard-earned premium dollars are used for health care.

Health insurance rate regulation ought not be viewed in an ideological or academic vacuum. We are not talking about the regulation of an investment product. For Illinois, rate review will promote access to care, financial security for our families, our brothers and sisters, spouses fighting cancer, our partners with bipolar disorder, our children diagnosed with autism.

Thank you for your attention. I look forward to your questions.
[The prepared statement of Mr. McRaith follows:]

PREPARED STATEMENT OF MICHAEL T. MCRAITH

SUMMARY

I am the Director of the Illinois Department of Insurance (the "Department"), and I speak today in that capacity. Consumer protection has been, is and will remain priority one for State insurance officials.

Insurance regulators regulate and control for a health insurer's capital to assure solvency but do not restrict the accumulation of capital, thereby rendering standard notions of insurer "profitability" as unreliable.

The Department's only authority to regulate health insurance premiums is to assure the rates charged by a health insurer are not inadequate.

The Illinois health insurance marketplace is dysfunctional.

In Illinois, health insurance premium increases are not required to be actuarially justified.

In Illinois, "base rates," while illustrative, are not comprehensive. Other factors greatly increase a premium beyond a base rate.

Beginning in 2005, individual market base rate increases routinely exceed 30 percent. The Department does not even receive information regarding rate increases for non-HMO groups.

Health insurance rate regulation will improve the performance, transparency and accountability of the health insurance market for employers and families in Illinois.

The State of Illinois, Governor Quinn, and the Department, strongly support State-based insurance regulation.

Feinstein-Schakowsky (S. 3078/H.R. 4757) warrants the support of the Department.

INTRODUCTION

Chairman Harkin, Ranking Member Enzi, and distinguished members of the committee, thank you for the invitation to talk with you about the need for regulatory approval of health insurance premium changes. My name is Michael McRaith. I am the Director of the Illinois Department of Insurance, and I speak today in that capacity.

As regulators of the insurance sector, State insurance officials have a demonstrable record of successful consumer protection and industry oversight. Consumer protection has been, is and will remain priority one for State insurance officials. Each day our responsibilities focus on ensuring the insurance safety net remains available when individuals, families and businesses are in need. We advocate for insurance consumers and objectively regulate the U.S. insurance market, relying upon the strength of local, accountable oversight and national collaboration.

With continually modernized financial solvency regulation, State insurance regulators supervise the world's most competitive insurance markets. Twenty-eight (28) of the world's fifty (50) largest insurance markets are individual States within our Nation. By gross premium volume, Illinois is the 16th largest jurisdiction in the world. As a whole, the U.S. insurance market surpasses the combined size of the second, third and fourth next largest markets. The insurance markets in California,

New York and Florida are each larger than the markets in India, Ireland or South Africa.

Insurance regulators monitor, examine and verify the financial status of insurance companies. For example, insurance regulators not only restrict the types of assets in which an insurer can invest but, also, restrict how much an insurer can invest in any one type of asset. With respect to capital sufficiency, regulators measure insurers based on the nationally uniform standard of “risk-based capital” (or “RBC”).¹

RBC measures an insurer’s financial strength by testing actual capital levels and includes an analysis of the line of insurance, size of insurer, the insurer’s appetite for risk, and other factors. For health insurers, regulatory intervention occurs, as a matter of law, if the risk-based capital level is 200 percent or less. Since regulators do not limit or control *how much* capital a health insurer can accumulate, standard notions of health insurer “profitability” are unreliable.

To the extent that the Department currently has authority to regulate health insurance rates, that authority is limited to assuring the solvency of the insurer or, rather, to assuring that rates charged by the health insurer are not too low.

THE “ILLINOIS MODEL” OF RATE REGULATION

Illinois proudly, and appropriately, embraces the “Illinois model” for rate regulation in the life and property and casualty lines of insurance. Where many States require prior approval by the insurance regulator before an insurer’s use of a proposed rate, Illinois allows competition and a dynamic marketplace to generate prices for commonly required insurance—like auto and homeowner.

The “Illinois model,” as often cited by proponents for deregulation of insurance markets, does not repose rate approval authority in the Department, or any other State agency, for any line of insurance other than Medicare Supplement, long-term care, the auto and home residual markets, and the worker compensation assigned risk pool. Until recently, Illinois law required prior approval on medical malpractice liability insurance rates if a proposed increase exceeded six percent (6 percent).²

For property and casualty insurance, Illinois has an exceptionally competitive market. More companies offer auto, homeowner and worker compensation insurance in Illinois than in any other State. Despite exceptional demographic and geographic diversity, Illinois has rates average among all States, and insurer profitability for personal lines is typically in the middle third of all States. Participation in the auto and homeowner insurance residual markets is nominal.³

For property and casualty insurance, the “Illinois model,” while not entirely beyond reproach, performs well for Illinois families, businesses and insurers. In contrast, the absence of prior approval rate regulation for health insurance exacerbates the dysfunction in a health insurance marketplace that fails to perform efficiently or effectively for Illinois’ businesses and families.

In Illinois, individuals and families can be denied insurance for any reason other than “race, color, religion or national origin.” 215 ILCS 5/424. In at least one instance, one applicant was denied insurance for herself and her three healthy children because she attended grief counseling after her young husband died.

A recent survey by the National Association of Insurance Commissioners (NAIC) revealed that Illinois has more rescissions by volume than any State in the entire country—almost 50 percent more than California. *See* Exhibit A.⁴ In at least one instance, an insurer attempted to rescind a teenager’s coverage on her family policy because her parents failed to disclose her congenital deformity—she wore braces.

Illinois law does not limit the rate variance between genders, the price impact of health status, the price impact of age, or the impact of any one rating factor on renewal. If a woman and man are of the same age, live in the same house, have the same health status, and see doctors in the same hospital, the woman can be charged as much as 57 percent more than the man—independent of maternity benefits.

Unlike the property and casualty insurance market—in which every willing buyer receives an offer—Illinois families are denied offers of coverage, or denied coverage

¹ Risk-based capital levels are confidential and not available to the public. To calculate an RBC, regulators compare an insurer’s Total Adjusted Capital (the actual amount of capital and surplus) to its Authorized Control Level Risk-Based Capital (the minimum levels of capital for an insurer with the subject insurer’s characteristics).

² *See Abigaile Lebron, a minor, et al., v. Gottlieb Memorial Hospital, et al.*, Nos. 105741, 105745 (Ill. Feb 4, 2010).

³ As a percentage of the total insurance premiums, the residual market for auto was 1.10 percent and for home .26 percent.

⁴ Exhibit A may be found at <http://insurance.illinois.gov/hirc/rescissionDataCall.pdf>.

at an affordable price. Illinois' dysfunctional health insurance market serves too few families because willing buyers do not even receive an offer.

Small employers offering health insurance to employees nearly always experience explosive rate volatility because, even though rates are subject to "bands," or variance limits, at the time of issuance, the Illinois small group rate bands are among the Nation's broadest. For this reason, small employers in Illinois, even with only one injured or ailing employee, can experience rate increases in excess of 50 percent on renewal.

Exclusive of Medicare and long-term care, health insurers in Illinois collect more than \$15b in premiums. Illinois is one of three States (with Utah and Louisiana) that fund the payment of high-risk pool health care claims with direct general revenue fund, or taxpayer support.⁵ For the right to reject people who are or might become sick, the Illinois health insurance industry pays only an assessment to fund the HIPAA-compliant high-risk pool which, in 2009, totaled \$43,371,000.

ILLINOIS—CURRENT OVERSIGHT OF HEALTH INSURANCE PREMIUMS

Illinois law does not require that either individual or group plan rate increases must be actuarially justified.

INDIVIDUAL MAJOR MEDICAL

As provided in Illinois law, individual market premiums are effective when the insurer submits a "classification of risks and the premium rates pertaining thereto have been filed with the Director." 215 ILCS 5/355. Consequently, the Department receives an individual major medical rate increase filing, notifies the insurer that the filing has been received, and the insurer may then rely upon and use that rate change.

HEALTH MAINTENANCE ORGANIZATIONS

Health Maintenance Organizations (HMO) comprise a small and shrinking percentage of Illinois' commercially insured, with some estimates as low as 15 percent of all covered lives. HMO's must file with the Department "schedules of base rates to be used," 50 Ill. Admin.Code 5421.60, and submit to the "Director, prior to use, a notice of any change in rate methodology[.]" 215 ILCS 125/4–12. As with individual major medical insurance, even though HMOs submit rate-related information, the Department does not have authority to approve or deny any HMO rate change.

SMALL EMPLOYER GROUPS (2-50)

For non-HMO small group plans—by far the largest share of the Illinois small group market—insurers are not required to file with the Department the amount of a base rate or the percentage change of a base rate from year-to-year. In fact, insurers are only required to file annually "an actuarial certification certifying that the carrier is in compliance" with the Illinois Small Employer Health Insurance Rating Act, or "SEHIRA." 215 ILCS 93/30.

The broad rate bands in SEHIRA provide health insurers with expansive latitude to price a small employer. While small employers enrolled in the first year pay premiums dependent upon health status of employees, the renewal years bring profound rate volatility due not only to employee health status (up to 15 percent) but also a lack of limitation on the base rate increases. 215 ILCS 93/25(3)(A) and (B). In Illinois, a small group "base rate" is the lowest rate charged to a small employer. Small employer premiums can also increase, without limitation, due to "case characteristics," otherwise known as age, gender and geography. 215 ILCS 93/25(C).

LARGE EMPLOYER GROUPS (50+)

Illinois law is silent on rate oversight for employers with more than 50 employees. In fact, unlike employer groups of 50 or fewer, health insurers can—and do—deny applications from employers with more than 50 employees.

"BASE RATES"—ONLY ONE INDICATOR

Base rate information can be illustrative but is far from conclusive. For example, Illinois policyholders can be charged more than the base rate due to health status,

⁵ In 2009, the Utah general revenue fund contributed \$9.3m and the Louisiana general revenue fund contributed \$2m. In Illinois, taxpayers contributed \$28.9m to support the high-risk pool.

geography, gender and age. For individual major medical policies, the Department does not receive information regarding the percentage of covered lives who pay more than the base rate versus those who pay less than the base rate, or how much those covered lives pay.

RENEWAL PENALTY

In addition, some health insurers in Illinois offering individual health coverage impose a renewal penalty of 3–5 percent. Since individual policies are “guaranteed renewable,” only those who have filed claims in the preceding year will renew because, of course, failure to renew will result in outright denial of that person’s coverage, or an exclusion rider. The renewal penalty, therefore, incentivizes the healthy insured to move to a less expensive block of the insurer’s business, promoting risk segregation that leads to the proverbial “death spiral.” Illinois law does not limit rate increases for any individual major medical health insurance block of business.

ILLINOIS INDIVIDUAL MAJOR MEDICAL HEALTH POLICY RATE FILING REPORT

With the public discussion leading to the March 21, 2010, U.S. House of Representatives vote on the Patient Protection and Affordable Care Act (the “PPACA”), the Department posted on its Web site (Insurance.Illinois.gov) a report of individual market health insurance premium increases, the “Individual Major Medical Health Policy Rate Filing Report” (the “Report”). Since the initial Report, the Department has expanded the retrospective to include all individual market filings since January 2005. *See Exhibit B.*⁶

The Report illustrates that Illinois families and individuals covered or seeking coverage in the major medical marketplace have experienced dramatic base rate increases into 2010 and beginning at least in 2005. Base rate increases have frequently exceeded 30 percent since at least January 2005.

HEALTH INSURANCE RATE REGULATION—A NECESSARY STEP FORWARD

Rate approval authority, vested with the Department, would improve the performance, transparency and accountability of the health insurance market for employers and families. With an entirely for-profit health insurance industry, Illinois is uniquely well-positioned to benefit from an additional regulatory tool such as rate regulation for health insurers and HMOs.

Rate regulation need not be a punitive or contentious exercise. Consistent with the priorities of Illinois Governor Pat Quinn, the Department pursues the regulatory mission in a professional, direct and collaborative manner, an approach that will continue through all phases of PPACA implementation.

Consistent with the Department’s core mission to protect the solvency of the insurance industry, rate regulation complements the insurance reforms of PPACA. For example, effective September 23, 2010, insurers will be required to report medical loss ratios, and minimum medical loss ratios are required for plan years beginning January 1, 2011. *See PPACA section 1001.*

Even now, the U.S. Department of Health and Human Services and the States are working to establish a process for the annual review of unreasonable premium increases. *See PPACA section 1003.* In that same section, insurers are required to post on company Web sites “a justification for an unreasonable premium increase prior to implementation of the increase.”

With other reforms effective September 23, 2010, including the removal of lifetime limits and coverage for children with pre-existing conditions, the Department has heightened concerns about health insurer solvency. With heightened concern, the Department also needs sharper tools and more opportunities to learn about the rate-making strategies of health insurers.

In addition, less responsible insurers may opt to increase premiums dramatically, and unnecessarily, in anticipation of the comprehensive reforms effective January 1, 2014. Health insurer rate regulation, therefore, is essential to prevent both inadequate and excessive premiums.

Even without the improvements from PPACA, health insurance consumers in Illinois would benefit from health insurance rate regulation. Most Illinois families scrape and save to pay premiums with hard-earned dollars. Small businesses, trying to retain skilled employees to facilitate growth, spend income earned through dreams, sweat and dedication just to offer meaningful health insurance to those employees. Illinois families and businesses, trying to obtain financial security with the

⁶Exhibit B may be found at http://insurance.gov/Reports/special_reports/IMMHPFRFG.pdf.

purchase of health insurance, are entitled to know that those premiums are reasonable, fair, and not an insurer's exploitation of an overly passive or archaic regulatory ideology.

FEINSTEIN-SCHAKOWSKY (S. 3078/H.R. 4757)

To be clear, the Department, reflecting the priorities of Governor Quinn, supports State-based insurance regulation. Insurance regulation at a State level affords consumers access to direct, prompt, meaningful interaction with regulators who understand the communities in which we live, the markets in which we buy, the insurers from whom we buy, and the producers who aid in our purchase of insurance. This reality is apparent in every line of insurance, but especially visible with health insurance.

State regulators approve health insurance policies sold in each State, the provider networks offered by insurers, the provider communities in areas as diverse as Chicago and down-state Marion, and the relative impact of one change versus an "unintended consequence." For that reason, the Feinstein-Schakowsky bill, which would establish the "Health Insurance Rate Authority," warrants the support of the Department.

Congress, in passing Feinstein-Schakowsky, would provide a Federal "tools" approach to health insurance rate oversight. In effect, a Federal "tools" law imposes on the States an obligation to act. Failure to act would result in Federal preemption. This approach has been previously used for insurance purposes, including for Medicare Supplement guidelines, the Health Insurance Portability and Accountability Act, and Gramm-Leach-Bliley. In addition to differing regulations for rate approval, States have different health insurance markets: some are predominantly non-profit, some almost evenly split between for- and non-profit, some more for-profit, some have medical loss ratio standards and some do not.

For those States that have rate oversight authority—27 currently have some form of health-related rate approval authority—Feinstein-Schakowsky would be supplementary and not a new or lower level of authority. For those States that do not have health insurance rate regulation—of which Illinois is one—Feinstein-Schakowsky would provide an impetus.

In short, Feinstein-Schakowsky vests the States with discretion about whether and how to regulate rates. For those States that do not opt to supervise proposed rates, the families and businesses of those States will have the opportunity for Federal oversight.

The funding available to States to support the enhanced rate regulatory authority, or some portion of \$250 million, would bolster the Department's efforts to afford Illinois families and businesses better health insurance performance and accountability. At a minimum, rate regulation will assure Illinois' families and businesses that hard-earned premium dollars are used primarily for health care.

CONCLUSION

Not every State seeks health insurance rate approval authority. For Illinois, with our dysfunctional health insurance market and with the enactment of PPACA, rate approval authority will enhance the performance, transparency and accountability of the health insurance our families and businesses strive to purchase. While regulation for the sake of regulation does not comprise an end worth pursuing, increased efficiency of health insurance products will improve the quality of life for Illinois' families and the prospects for growth of Illinois' small businesses.

We welcome the interest of Congress and this committee in this important question of consumer protection. As the entire country moves forward with implementation of health insurance reform, we pledge to share our experience and expertise with Congress and to work with the members and staff of this committee.

Regulation of all financial sectors must allow for evolution to facilitate but monitor innovation and efficiency. Here, as we work toward affordable and accessible health insurance coverage for all families and businesses, the Department seeks additional rate approval tools with which to limit, if not eliminate, the potential abuses of inadequate or excessive rate changes.

After all, health insurance differs from other personal lines of insurance: we can choose the car we drive and we can choose our home. We do not choose breast or prostate cancer. We do not choose a heart attack. We do not choose autism.

Thank you for the opportunity to testify. I look forward to your questions.

The CHAIRMAN. Great. Thank you very much for an eloquent statement.

Now we turn to Karen Ignagni, president and CEO of America's Health Insurance Plans. No stranger to this committee, Karen's been here many times in the past and worked with us on all the health care bill for the last couple of years. So, a very distinguished background.

And, Karen, again, your statement will be made a part of the record, please proceed.

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

Ms. IGNAGNI. Thank you, Mr. Chairman. Thank you for the opportunity—Senator Alexander, Senator Franken—thank you, on behalf of all of our members.

I think the first thing that's important to say is to let all of you know that our members are working very, very hard to implement the current program. And I think, as evidenced by the announcements that have been made over the last couple of days, we're working to find opportunities where we can help to maintain continuity of care. In particular, over the recent days, the announcements related to folks on parents' coverage who would otherwise transition off before September. And you'll hear more from our members about that.

Second, I think it's very important, in listening to Mrs. Menke's testimony, that I convey, on behalf of our members—they are fully cognizant of the burden of rising health care premiums on families and on small businesses and large businesses. And, in fact, that's what our advocacy in health care reform had been all about. We were very, very concerned, as we saw costs exploding. And there's been, now, tremendous evidence of that being documented in the press and in research studies, that we were very concerned that not enough was being done in that area.

Health plan premiums are a symptom, not a cause, of the problem. And according to government data, just to level-set, we're 4 percent of national health care expenditures—the profits of our industry, according to Fortune magazine, that does a very deep dive of profits in all the sectors, in 2008 were roughly 2 percent; in 2009 were about 3.2. That's where we are, relative to other stakeholders in the health care sectors that have three and four times those levels, just to level-set.

Our health plan profits in the legislation have been capped. Administrative costs are capped. And all parts of our businesses and operations have been regulated. We provided a chart to illustrate that in our testimony so you could see the full gamut of the regulation.

But, I think the concerning issue that's relevant today is that Federal and State data have shown that premium increases are being driven by the growth in the underlying costs of health care services and the utilization of these services. And new spending projections by CMS has found that health care as a percentage of gross domestic product had the largest 1-year increase on record. The only way premiums will be brought under control is for the country to more directly take on these challenges.

We think Massachusetts is a cautionary tale. Notwithstanding an in depth report by Attorney General Martha Coakley that docu-

mented why costs were rising because of the increases in the cost of care, the strategy being pursued there is to arbitrarily cap premiums without any linkage to the factors that are driving them. We're very concerned that that will create insolvency, volatility for consumers, unpredictability. Indeed, in New York, that had previously had prior approval, they had to rescind that, and they changed that legislation, because the market was in a State where the businesses were becoming insolvent.

We believe there are new provisions in the legislation that will increase costs and oversight, and they're important to take into account today. The new legislation creates an annual review of unreasonable premium increases. It requires justification of rates and provides financial support through grants for States to help carry out these functions. Those are important changes, which we believe will help create more consistency across the country.

So, we're delighted to be here. We look forward to participating in the discussion. And, Mr. Chairman, we hope that this will begin a process of enlarging the conversation. We want to do our share. We're here to participate. We want to come with solutions, and we're committed to that.

Thank you very much.

[The prepared statement of Ms. Ignagni follows:]

PREPARED STATEMENT OF KAREN IGNAGNI

I. INTRODUCTION

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

We appreciate this opportunity to testify on issues affecting the affordability of health insurance coverage. Our written testimony addresses the following issues:

- What our community is doing to create a bridge to a more modernized health care system;
- How premiums relate to costs;
- How premiums are evaluated at the State level;
- What is changed by the new law;
- Principles for a workable system; and
- Unmet challenges.

We hope this information will be helpful to the committee and we look forward to working with you to address the factors that are causing premiums to increase.

II. WHAT OUR COMMUNITY IS DOING TO CREATE A BRIDGE TO A MORE MODERNIZED HEALTH CARE SYSTEM

Our community is strongly committed to the successful implementation of the "Patient Protection and Affordable Care Act" (PPACA), and we already have begun taking important steps to lay the foundation of a health care system that rewards value, not volume. Health plans are pioneering new initiatives for improving patient care, enhancing quality, and helping enrollees receive the highest possible value for their health care dollars.

Administration Simplification

Health insurance plans have recognized the importance of working with clinicians and hospitals to reduce the complexities of administrative transactions and improve patient care. Our primary goal for administrative simplification has been to improve the ease with which health care providers electronically connect with health insurance plans to exchange administrative and clinical information, and simplify the system for consumers.

Through a partnership with the Council for Affordable Quality Healthcare (CAQH), our members are participating in an initiative, known as CORE, that is focused on developing a single set of operating rules to expand and enhance the standards for administrative transactions in the health care industry. The goal of these rules is to streamline and automate the claims payment cycle by encouraging interoperability between health plans and providers. This goal is being achieved through a phased approach that results in a reduction in administrative costs and time.

The CORE collaboration started in 2005 and approximately 115 entities are now participating. Participants include health insurance plans, providers and provider groups, health IT companies, standard setting organizations, Federal and State agencies, and other health industry trade associations.

Once the CORE initiative is fully implemented, the operating rules will enable all administrative transactions to be performed electronically. All parties will be able to exchange information in a consistent, predictable manner—ensuring that clinicians have the information they need on any patient, covered by any insurance, when they need it. This is comparable to the standards work that was done to allow banks to offer ATMs to consumers. This initiative also lays the groundwork that will enable the administrative simplification provisions of the new law to work.

Physician Portals

Building on the development of common standards, AHIP and the Blue Cross and Blue Shield Association (BCBSA) are working with our members in New Jersey and Ohio where State-based initiatives have been launched to simplify the flow of information between health plans and physicians' offices. These initiatives allow physicians to use a single web portal to conduct electronic transactions with all of the health insurance plans that insure their patients, helping them to streamline and fully automate key office tasks. The lessons learned from these initiatives, including feedback from physicians, will be applied to future administrative simplification efforts as health insurance plans work to help physicians improve customer service for their patients and reduce personnel and billing costs for medical practices. Savings potentially could reach hundreds of billions of dollars as the entire health care system achieves efficiencies through similar moves to automation and consistent business practices. For consumers, the operating rules and the physician portal will enable the seamless exchange of health information without the hassles of clipboards and repetitive requests for information.

Payment Reforms

Health insurance plans also have implemented innovative payment models to reward quality and promote evidence-based health care using clinical guidelines that are equivalent in some respects to aviation protocols. When properly applied, evidence-based clinical guidelines allow doctors to do what they were trained to do while reducing the chance of under-treatment, over-treatment, and mistreatment. A 2006 *New England Journal of Medicine* article reported that at least half of the Nation's health insurance plans, representing 80 percent of all enrollees, included some pay-for-performance incentives in their provider contracts. For patients, this progress means greater safety and improved outcomes. For providers, it means being recognized and rewarded for practicing to the highest professional standards.

Health insurance plans are committed to engaging physicians, hospitals, and other health care professionals in the design and implementation of payment reforms. Our members also are working with various stakeholders to make performance measurement more consistent. We urge the committee and policymakers to assess these efforts and consider building upon the PPACA initiatives to ensure a system-wide approach to delivery reform.

Reducing Preventable Hospital Admissions, Re-admissions, and Emergency Room Visits

Reducing preventable hospital admissions, overall re-admissions, and emergency room visits has become an important national priority for both quality improvement and cost control. Health plans are advancing this goal through a variety of initiatives that transform patient experiences with care. These include:

- Information and support programs for patients transitioning from hospital to home;
- Medical home innovations that expand patients' access to primary care and support primary care physicians with multidisciplinary teams of medical, behavioral health, and social service professionals;
- Case management to help patients at high risk of hospitalization access all of the medical, behavioral health, and social services they need;
- Home medical visits for patients who have difficulty reaching the doctor's office;

- Programs to help frequent emergency room users connect with quality care on an ongoing basis; and
- Initiatives to align end-of-life treatment plans with patients' preferences.

While implementing these initiatives, our members have demonstrated that effective care is about personal connections. Personal phone calls from nurses, social workers, or case managers to check on patients' needs following hospitalization help patients overcome barriers to following care plans, avoid medication errors, and significantly reduce potentially avoidable hospital admissions, re-admissions, and emergency room visits. In addition, patients face tremendous challenges in taking medications correctly, and these challenges have created an important new analytical and teaching role for pharmacists in the health care system.

Research findings demonstrate that these innovative strategies are working to help keep patients out of the hospital and avoid potentially harmful complications. In December 2009, AHIP released the second in a series of working papers,¹ comparing patterns of care among patients enrolled in two large, multi-state Medicare Advantage HMO plans and in Medicare's traditional fee-for-service (FFS) program. The preliminary results from this study are consistent with the results gathered in an earlier eight-company AHIP study² of smaller and regional Medicare Advantage plans. Based on the simple average of all 18 areas studied in all 10 companies, the risk-adjusted comparisons indicate that these plans improved health care for their enrollees by:

- reducing emergency room visits by 24 percent;
- reducing hospital re-admissions by 39 percent;
- reducing certain potentially avoidable hospital admissions by 10 percent; and
- reducing inpatient hospital days by 20 percent.

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

Recognizing that these preliminary findings demonstrate dramatic improvements relative to FFS coverage, we are seeking verification of these results through additional research using different data sources and risk adjustment mechanisms. We also should note that our research found that outpatient visits were roughly the same for Medicare Advantage and FFS enrollees and that physician visits for Medicare Advantage enrollees were substantially higher.

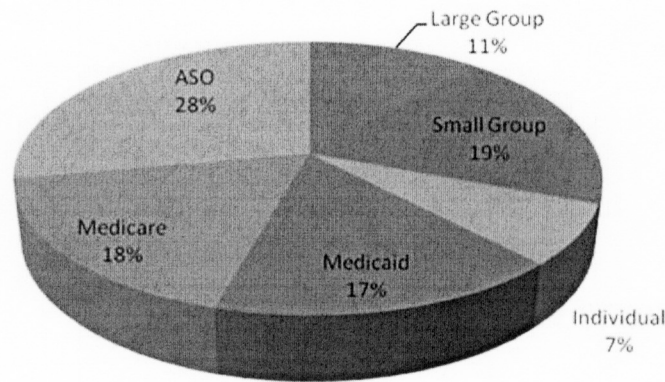
III. HOW PREMIUMS RELATE TO COSTS

As the committee conducts its review of why premium costs are increasing, the chart below illustrates how Americans are covered today. The major focus of the health reform debate has been the individual health insurance market, which accounts for 7 percent of the insured population in the United States (or 18 million people).

¹AHIP Center for Policy and Research, *Working Paper: Comparisons of Utilization in Two Large Multi-State Medicare Advantage HMOs and Medicare Fee-for-Service in the Same Service Areas*, December 2009.

²AHIP Center for Policy and Research, *A Preliminary Comparison of Utilization Measures Among Diabetes and Heart Disease Patients in Eight Regional Medicare Advantage Plans and Medicare Fee-for-Service in the Same Service Areas* (revised September 2009). See also, AHIP Center for Policy and Research, *Reductions in Hospital Days, Re-Admissions, and Potentially Avoidable Admissions Among Medicare Advantage Enrollees in California and Nevada*, (revised October 2009).

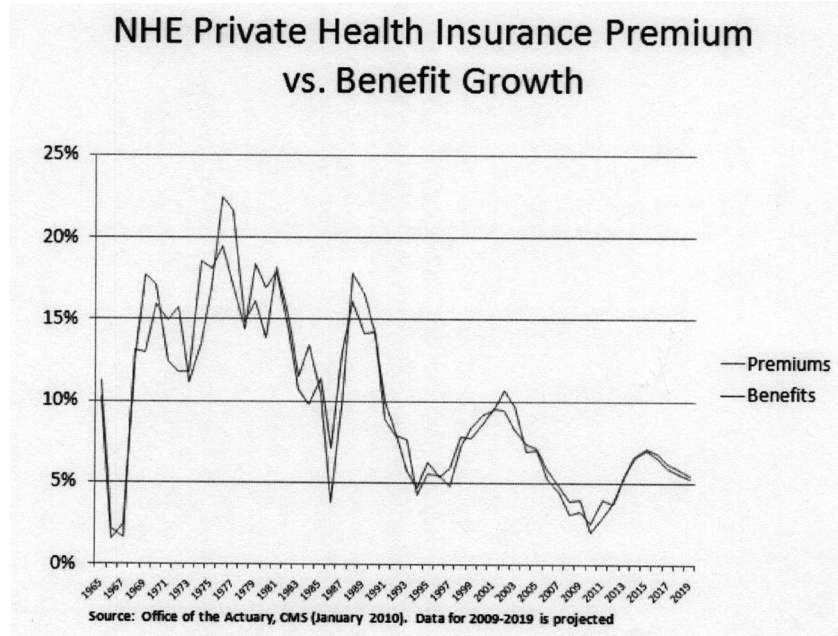
Health Insurance Coverage in the United States, 2008



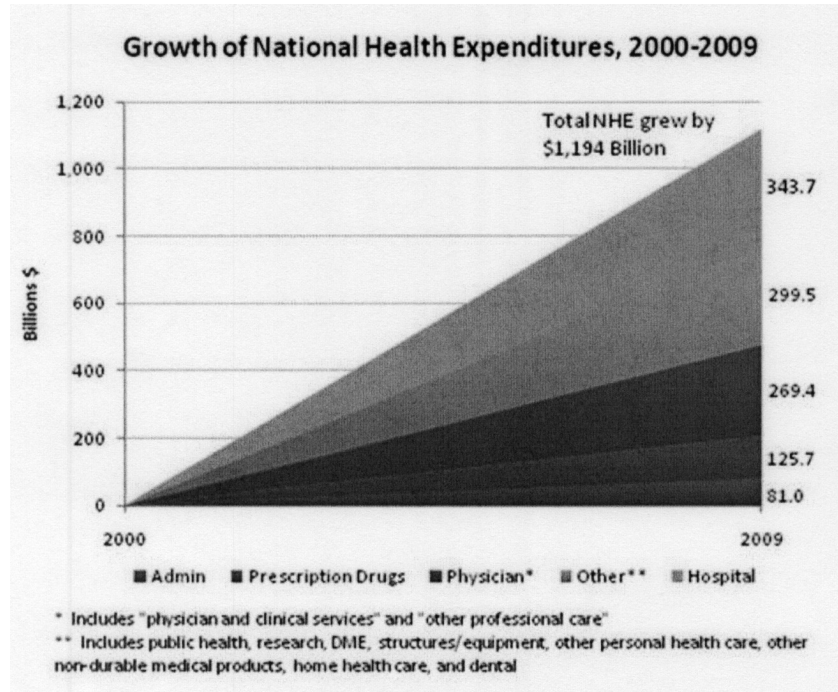
The individual market has unique challenges, including the fact that participation will continue to be voluntary until the individual coverage requirement takes effect in 2014. As a result, the risk of adverse selection is much higher in the individual market than in other markets. Indeed, with the recession, a number of individuals purchasing coverage in the individual market have dropped coverage.

In the small group market, a different type of adverse selection has occurred, with layoffs generally affecting individuals most recently hired, small groups have become older and sicker which has been a factor in premium increases for this market segment. Rising costs, along with other factors explained below, are driving premiums in all markets.

When the cost of health care services increases, the cost of providing health benefits also rises. The Federal Government's data on national health expenditures (see chart below) indicate that over the past 20 years (1989–2009) health benefit costs have increased by an average of 7.2 percent annually and premium increases likewise have averaged 7.1 percent annually. This trend clearly demonstrates the importance of addressing underlying medical costs through measures that achieve system-wide cost containment.



Furthermore, the chart below shows that the administrative costs of health plans increased much less than spending on prescription drugs, physician services, hospitals, and other health expenditures from 2000–9. In fact, last year, the percentage of premiums that went toward administrative costs and profits declined for the sixth consecutive year—from 13.67 percent in 2003 to 11.15 percent in 2009.



Additionally, as we examine issues surrounding health insurance premiums and medical costs, it is important to look at recent history, particularly the decade of the 1990s when premium growth was well below historical trend and stable for several years, contributing toward economic growth and growth in coverage. We know from this experience that health plans can hold down premiums when they are able to use care management tools to reward the delivery of high quality, appropriate and efficient care.

In today's health care system, we face new challenges—most notably, rapid increases in the unit price of medical services—that are contributing to higher health care costs. In fact, according to the 2008 National Health Expenditures (NHE) report issued in January 2010, price increases constituted two-thirds of the year-over-year increase in health spending. Specifically, of the 4.6 percent annual increase in personal health expenditures reported in 2008, price accounted for 3.1 percentage points, while 1.5 percentage points was driven by non-price factors. The NHE report also indicated that for 2008, health insurance premiums increased at 3.1 percent, approximately one-third below the increase in total health spending.³

Further evidence of the changing impact of price increases on premium rates can be found in a February 2010 article⁴ published on-line by *Health Affairs*. In this article, authors Paul Ginsburg and Robert Berenson (both with the Center for Studying Health System Change) noted that "providers' growing market power to negotiate higher payment rates from private insurers is the 'elephant in the room' that is rarely mentioned." To that end, the authors note that in some cases payment rates to hospitals and physician groups approach or exceed 200 percent of the amount paid by Medicare. This concern is reinforced by the following examples of unsustainable cost increases we have uncovered through AHIP research and discussions with our members:

- One AHIP member operating in a large State reported facing hospital rate increases ranging between 7 percent and 90 percent, with the average request at 29 percent.

³ *Health Affairs, Health Spending Growth at Historic Low in 2008*, Hartman.

⁴ *Health Affairs, Unchecked Provider Clout In California Foreshadows Challenges To Health Reform*, by Robert Berenson, Paul Ginsburg, and Nicole Kemper, February 2010.

- Another AHIP member reported that a “must have” hospital was demanding a 40 percent increase in payment and insisting on contractual terms that would prohibit the plan from sharing the facility’s quality information with consumers.
- Another AHIP member reported that a hospital in suburban New Jersey—the only hospital in its community—is demanding that health plans pay an extra 15–16 percent to compensate for Medicaid and Medicare payments that are rising by 4–5 percent less than the hospital’s costs.
- A hospital in the Northeast charges health insurance plans 50 percent more than it charges the plan owned by its own hospital system.
- Charges for a colonoscopy vary widely among three hospitals in a 20-mile radius in California—with no apparent linkage to quality—with the minimum typical price ranging between \$2,192 and \$3,786 and the maximum typical price ranging between \$2,590 and \$4,185.⁵
- An August 2009 AHIP survey⁶ of out-of-network fees found that a patient in Arizona was charged \$72,000 for lower back spinal fusion when Medicare’s fee was only \$1,683; and for total hip replacement surgery, a patient was charged \$45,601 when Medicare’s fee was only \$1,431. A patient in California was charged \$15,870 for cataract surgery when Medicare only pays \$638.

In the face of these exploding costs, our members are deploying the next generation of medical management tools to promote a high-value health care system, including:

- Targeting disease management services to enrollees who stand to benefit the most from pro-active interventions;
- Working with primary care physicians to expand patient-centered medical homes that promote care coordination and accountability for clinical outcomes;
- Providing incentives to promote the use of decision-support tools and health information technology;
- Providing quality improvement reports for physicians to monitor their progress in managing disease;
- Offering personalized risk assessments and wellness programs;
- Encouraging electronic prescribing and consumer safety alerts;
- Providing peer-to-peer comparisons to demonstrate the appropriate use of health care services across specialists and manage the use of high-cost imaging services.

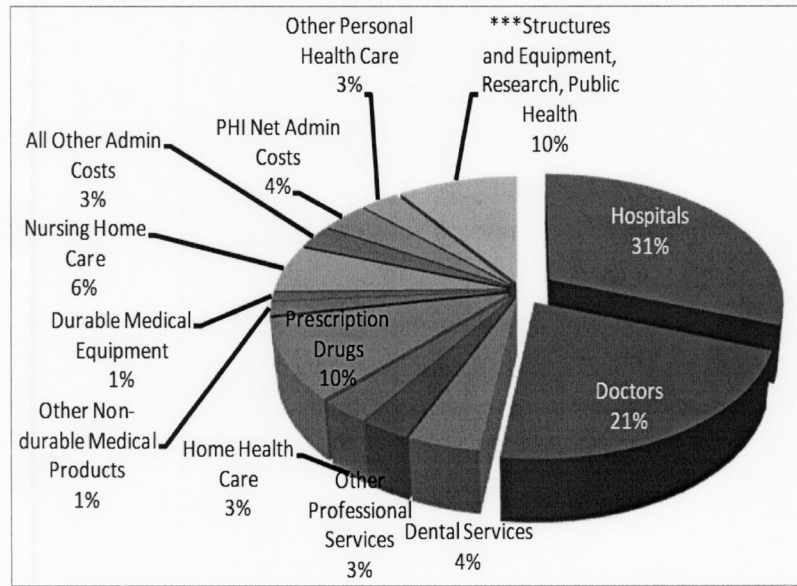
Many of the quality programs and innovative initiatives being implemented in various markets across the country by the private sector would improve the delivery of care and patient outcomes in a more timely and efficient manner if public programs were part of the local initiatives. Expanding these programs to encompass the full health care system—both public and private payers—is an important step toward identifying gaps in care, pursuing opportunities for improvement, and evaluating innovations so adoption can occur more broadly.

While our members are taking aggressive steps to address the cost crisis, a discussion of premiums needs to look at all components of expenditures. The chart shown below, based on annual national health expenditure data published by the Centers for Medicare & Medicaid Services (CMS), indicates that the costs associated with health insurance—including plan profits and administrative costs—account for only 4 percent of all national health expenditures. The other 96 percent of costs can be attributed to hospitals, physicians, pharmaceuticals, home health care, and other components of health care spending.

⁵Based on data from Anthem Care Comparison Tool.

⁶AHIP, *The Value of Provider Networks and the Role of Out-of-Network Charges in Rising Health Care Costs: A Survey of Charges Billed by Out-of-Network Physicians*, August 2009.

Components of National Health Spending



Source: CMS National Health Expenditure Data, Projections for 2009

How Are Premiums Built?

Health care costs are impacted by a number of direct cost drivers including:

Factors Affecting Premiums

- Price per service.
- Utilization of services.
- Adverse selection.
- New medical technology.
- Cost-shifting.
- State insurance taxes and fees.
- Assessments for high-risk pools.
- Regulatory compliance.
- Aging of the population.
- Unhealthy lifestyles.

• **The price per service** (as discussed in detail above) is the cost charged by medical providers, such as doctors, hospital and pharmacies, for a particular service. The amount providers charge varies greatly, according to the provider's location, how the group is structured and organized, and how many other providers are located nearby. Lack of competition and shortages of health care providers are significant factors in a number of markets where consolidation among hospitals and other providers is increasing costs and health plans are facing higher rate increases from hospitals and medical groups with dominant positions.

• **The utilization of services** refers to the amount of medical services that are used. Increased utilization drives costs higher.

• **Adverse selection** is what occurs when less healthy individuals stay in the market while healthy individuals and families drop coverage. Moreover, at a time when many small businesses are financially strained because of the weak economy, our members are observing that some companies with young, healthy workforces have stopped offering coverage. Another related trend is that as it becomes more difficult for employers to continue offering coverage, some are forced to reduce the portion of the premium they cover and increase employee cost-sharing. In response

to these decisions, more employees—usually those with below average health costs—are declining to participate. The net impact of these developments is that some employers may find it less viable to offer coverage or costs may rise as the remaining risk pool is more heavily weighted with older, less healthy persons, resulting in higher average costs per enrollee for those who maintain coverage.

- **Cost shifting** occurs, from public programs to private payers, as a result of reimbursement rates that Medicare and Medicaid pay to hospitals and physicians, which often fail to cover the cost of providing health services. According to a December 2008 Milliman study,⁷ an average family of four already pays a hidden tax of more than \$1,700 annually on their premiums because Medicare and Medicaid significantly underpay hospitals and physicians, compared to their actual costs of delivering medical care. To offset these inadequate payments, providers pass on higher costs to individuals, families and employers in the private sector. Additional cost-shifting results from uncompensated care provided to the uninsured. According to a May 2009 Families USA study,⁸ the cost-shift associated with uncompensated care adds more than \$1,000 annually to family premiums.

- **State fees and taxes, assessments for high-risk pool programs, and the costs of complying with regulatory requirements** also contribute to the cost of health insurance coverage. As we discuss below, the “Patient Protection and Affordable Care Act” includes a number of provisions that regardless of their public policy merit will ultimately increase the cost of coverage.

IV. HOW ARE PREMIUMS EVALUATED AT THE STATE LEVEL

States generally have the authority to examine and regulate rates, either through a specific grant of authority or through their authority to regulate unfair practices. This authority meets States’ obligation to assure that not only are consumers charged fair premiums, but also that insurers remain solvent and are able to pay future claims.

Rates must be adequate to cover the costs of medical care utilized by insured members, and administration of health insurance services (enrollment, customer service, claims processing, care management and quality review, etc.). Additionally, rates must be adequate to assure that health plans remain solvent to meet the promises of paying claims, and meeting customers’ expectations by having adequate reserves on hand to meet those obligations.

Insurance regulators want premiums to be:

- Financially sound—able to pay claims and costs, and allow insurers to remain solvent;
- Fair and reasonable—in relation to the benefits offered, thus ensuring value for consumers; and
- In compliance with the rules—incorporate States’ consumer protections embodied in States’ rating rules and standards.

Before offering any product to consumers, virtually every State requires the policy form and the related rate structure to be filed prior to sale. These requirements apply to both individual and small group health insurance policies. The vast majority of States regulate small group rates by way of requiring an actuarial certification that the insurer is in compliance with the rate band requirements that are the law in most States. And every insurance department has the authority to conduct market conduct exams to assure compliance.

Health insurance premiums tend to be more actively monitored than other lines of insurance. The majority of States have some form of “file and use” standards for health insurance premiums for rate changes. What this means is that insurers must file rates prior to use, with approval deemed after the expiration of the review timeframe (generally 30 to 60 days), to allow the regulators time to discuss questions or concerns they have about the filing—which includes actuarial and trend data supporting the requested rate change—with the plan.

Prior approval States are challenged to meet timeframes of review, often taking significantly more time than the timeframes for “file and use” rates—sometimes taking more than a year to finalize review of rates. This is exacerbated by the States’ own financial challenges—budget cuts throughout the Nation have reduced State government budgets and staff. The National Association of Insurance Commissioners has noted⁹ that prior approval “can be a very labor intensive and expensive

⁷ Milliman, *Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid and Commercial Payers*, December 2008.

⁸ Families USA, *Hidden Health Tax: Americans Pay A Premium*, May 2009.

⁹ Letter from NAIC CEO Dr. Terri M. Vaughan to Chairman John Dingell, February 23, 2010.

process” because it adds costs and delays to the system, which creates unintended consequences for consumers. We also have seen an increasingly political approach taken in these reviews with efforts to cap rate increases, without taking into account all of the factors that premium rates reflect.

Capping rates only delays the increase needed and compounds the subsequent increases. Regulators who establish artificial caps on premium rates that do not reflect the underlying components place health plans in jeopardy of weakened financial conditions, creating larger fluctuations in premiums and needless volatility for consumers.

V. WHAT CHANGES UNDER THE NEW LAW

The debate leading up to passage of health care reform ultimately became framed as a need for insurance market reform and greater regulation of health plans, creating legislation disproportionately focused on health plans, which make up *only* 4 percent of national health expenditures, and doing little to address the underlying drivers of health care costs, which have a substantial affect on premium increases.

The extent of this new regulation is illustrated in the chart on the following page. As the illustration demonstrates, the new legislation affects every part of health plan operations, will add new layers of regulation *on top of* the regulatory framework that already exists at the Federal and State levels. A second chart appended to our statement illustrates the full impact of this point. What is necessary now is not further legislation aimed at only 4 percent of the health care system, but broader consideration of the other 96 percent.

The point of these charts is to illustrate how the new law has capped health plan administrative costs and profits and regulated every part of health plan operations. In addition, the medical loss ratio (MLR) provision called for in the new law already serves as a direct form of rate regulation. While great care is required in implementing this provision in order to avoid significant disruptions in coverage and instability, particularly in the individual market, during the period prior to the creation of the exchanges, the MLR provision needs to be viewed in tandem with the new premium review provisions also in the law.



Impact of Health Reform on Health Plan Operations

<u>New Regulations on Operations</u>	<u>New Regulations on Product Design</u>	<u>New Required Fees and Taxes</u>
<div>Caps on Medical Loss Ratios PHSA Sec. 2718</div>	<div>Required Essential Health Benefit Package PPACA Sec. 1302</div>	<div>40% Excise Tax on High Cost Plans IRC Sec. 49801</div>
<div>Prohibitions on Lifetime Limits PHSA Sec. 2711</div>	<div>Required Dependent Coverage PHSA Sec. 2714</div>	<div>Payment for Reinsurance Program for Individual Market PPACA Sec. 1341</div>
<div>Regulated Annual Limits PHSA Sec. 2711</div>	<div>Required Preventive Services PHSA Sec. 2713</div>	<div>Annual Fee on Health Insurance Providers PPACA Sec. 9010</div>
<div>Guaranteed Issue PHSA Sec. 2702</div>	<div>Required Coverage for Approved Clinical Trials PHSA Sec. 2709</div>	<div>Fees to Fund Comparative Effectiveness Research IRC Secs. 4375, 4376, and 4377</div>
<div>Guaranteed Renewability PHSA Sec. 2703</div>	<div>Federal Standards for 'Qualified' Health Plan PPACA Sec. 1301</div>	<div>Pass-Through of Manufacturers' Fees PPACA Secs. 9008 & 9009</div>
<div>Premium Rate Review PHSA Sec. 2794</div>	<div>Required Uniform Summary of Benefit and Coverage Documents and Standard Definitions PHSA Sec. 2715</div>	<div>Tax Treatment for Certain Health Organizations PPACA Sec. 9016</div>
<div>No Preexisting Condition Exclusion or Discrimination PHSA Secs. 2704 & 2705</div>	<div>Required Emergency Room Services Coverage PPACA Sec. 1301</div>	<div>Limitation on Deduction for Compensation for Health Insurance Executives PPACA Sec. 9014</div>
<div>Regulation of Waiting Periods PHSA Sec. 2708</div>	<div>Quality Reporting Requirements for Coverage & Provider Reimbursement PHSA Sec. 2717</div>	<div>Risk Corridor Payment Adjustment System PPACA Sec. 1342</div>
	<div>Standards for Health Data and Information Systems PPACA Sec. 1104</div>	

* Requests for comments for these consumer protection provisions were issued in the April 14, 2010 Federal Register.

Note: There are many provisions within the PPACA which, although not explicitly granting the Secretary of a federal agency regulatory authority, will require the federal agencies to issue regulations pursuant to its general regulatory authority. We are also aware that conforming regulations will likely be issued across several federal agencies.

Note: PPACA is the Patient Protection and Affordable Care Act as amended by the Health and Education Reconciliation Act of 2010; PHSA is the Public Health Services Act as amended by the PPACA; and the IRC is the Internal Revenue Code as amended by the PPACA.

The new law requires the HHS Secretary and the States to work together to establish a process for the annual review of "unreasonable increases" in premiums and requires public justification and disclosure prior to the implementation of the increase. In addition, the legislation establishes a grant program that will provide the States the assistance they need to implement these requirements.

Implementation will require that these terms be defined, with the opportunity to do so in a way that ensures a consistent standard of review throughout the country, takes into consideration all of the factors that drive premiums and must be considered in order for rates to be considered actuarially sound, and provides transparency on all of these factors to improve public confidence in the process. Advancing the principle of transparency should also entail steps to focus similar attention to the rates in other health care sectors. As noted above, virtually all States have the authority to examine rate increases to ensure that they are actuarially justified, and implementation of the grant program along with the requirement that all States conduct an annual review in conjunction with the Secretary will work to ensure that there is a rate review process across the country.

The net effect of these provisions is that health plan spending as it relates to administrative costs and profits is capped, and that “unreasonable increases in premiums” will be reviewed annually, with the important caveat that the term “unreasonable increase” needs to be clearly defined in relation to actuarial soundness lest this standard encourage an arbitrary process of review that diverts attention from the real issues driving health care costs.

Looking further down the road, the new premium tax and the high-value health plan tax will further increase the cost of coverage in future years.

Cautionary Tales From Massachusetts and California

Massachusetts and California provide high profile examples of a public discussion about insurance rates entirely delinked from an examination of the factors driving these rates.

In the case of Massachusetts, a comprehensive and in-depth report from Attorney General Martha Coakley recently reported two findings: that the market leverage of providers was leading to higher prices, without any noticeable difference in quality; and that increases in the price of health care services had caused most of the increase in health care costs—not utilization.

Nonetheless, State regulators have placed arbitrary caps on premium increases without taking these factors into account. By focusing just on regulating premiums, the policymakers in Massachusetts are missing an opportunity to bring increases in underlying medical costs under control. Thus, even if policymakers force premiums down through legislative action, individuals, families and employers, as the *Boston Globe* correctly notes, will still “confront ballooning levels of reimbursements for providers.”

The situation of provider consolidation leading to higher premiums is not unique to Massachusetts. In fact, the *Health Affairs* article we mentioned earlier, authored by Robert Berenson and Paul Ginsburg, analyzes the affect of providers’ growing market power and using this power to negotiate higher payment rates from private insurers in California. Berenson and Ginsburg cautioned that “provider dominance could offset some or all of the potential of reforms to lower premiums through increased efficiency in delivery.” While there has been considerable discussion of specific premium increases proposed in California, there has been little national discussion about the implications of the findings in the *Health Affairs* article and how these factors might be a root cause of the reported increases.

Capping premium increases without looking at the underlying components is similar to capping the prices automakers can charge consumers, while allowing the steel, rubber, and technology manufacturers to charge the automakers whatever they want. This will lead to financial instability throughout the system. What has occurred in Massachusetts is a politicization of processes related to premium review and approval, creating benchmarks for review that do not reflect the underlying cost drivers. Setting arbitrary caps on premiums does nothing to cure the root causes of health care price increases, according to a 2004 study¹⁰ done for the California HealthCare Foundation. Similarly, a February 2010 Milliman report¹¹ makes the point that “simplistically limiting premium rate increases to some predetermined inflation index fails to recognize the fundamental elements involved in setting health insurance rates, and would likely have severe consequences within a short period of time.” These serious consequences involve significant long term risks for health plan solvency, competition in the market, and the availability of coverage choices.

VI. PRINCIPLES FOR A WORKABLE SYSTEM

States Are the Appropriate Venue for Review: The expertise and resources for considering rates lies at the State level and State standards and processes are at the core of the country’s regulatory system for safeguarding solvency as explained above. As such, the new health care reform law recognizes that States properly serve as the primary regulators for health plan activities, subject to new and consistent Federal standards impacting a wide range of activities, including annual rate review.

States are responsible for establishing solvency requirements for health plans to operate across the country and have long developed and maintained an underlying system and structure of regulation that has helped to protect the public—even in the face of extremely challenging economic times—from significant incidences of health plan insolvency. Indeed, one of the most important protections States provide

¹⁰ California HealthCare Foundation, *Should California Regulate Health Insurance Premiums?*, March 2004.

¹¹ Milliman, *The Difficulty of Legislating Premium Rate Increases*, by Jonathon Shreve, February 2010.

consumers is to ensure that health plans maintain financial stability to ensure that beneficiaries can receive benefits. Health plan solvency also is important to providers, who rely on insurers having the financial wherewithal to pay claims.

Separating financial solvency from rate review, as would occur if rate review occurred principally at the Federal level, would create a significant risk of financial instability. At the same time, Federal rate review would do nothing to address the underlying factors driving health care costs.

Actuarial Soundness: It is essential to maintain and protect the critical link between the creation of premiums and “actuarial soundness,” that is, the development of rates that are reasonable in relation to the benefits provided and that ensure solvency, taking into account factors such as the underlying medical costs and trends facing a particular health plan, adverse selection, benefit plan changes, and demographic changes in the population covered. We are committed to working with the NAIC to ensure that actuarial certifications that accompany rate filings are required to be prepared in accordance with generally accepted actuarial principles, that the components of rate increases are clearly presented, and that States undertake a review of underlying cost trends and provider consolidation.

Transparency: To increase public confidence, information should be disclosed about rates and their composition, without undermining competition, and we are taking the steps described below to support this objective. Parallel requirements should be imposed on other health care sectors with respect to their rates and associated underlying components that highlight both the utilization and unit cost-related elements of those charges.

The new law adds to an existing regulatory structure that places primary enforcement authority with the States, but that gives the Federal Government the authority to step in if a State is not substantially enforcing Federal standards. How these new provisions are implemented will be an important determinant of whether new regulations and requirements improve confidence with respect to the operation of health plans without increasing costs, reducing choices, or creating solvency issues throughout the system. The real question, therefore, is not whether additional legislation is needed to further address the operation of 4 percent of the health care sector as a percentage of total spending, but whether policymakers will now broaden their focus to address sectors accounting for the remaining 96 percent of our health care system.

Allowing Implementation to Proceed: There are significant provisions in the “Patient Protection and Affordable Care Act” that should be given time to be implemented and evaluated.

ADDITIONAL STEPS HEALTH PLANS ARE TAKING

Following a meeting between Secretary Sebelius, the President, NAIC leadership, and the CEOs of five health plans, the Secretary on March 8 addressed a letter to the company representatives asking them to make information on rates and rate increases transparent. She requested that these companies publicly display information regarding, among other things:

- the drivers of rate increases;
- the number of individuals impacted by rate increases;
- the estimates on medical costs and utilization increases and the assumptions behind them;
- explanations of what the companies are doing to control premium increases; and
- medical loss ratio information for each premium increase.

The companies all agreed to accept the challenge to make information regarding premiums, cost drivers and premium increases transparent in a way that would be meaningful and understandable both to health plan enrollees and to policymakers, and to work with the NAIC as they do so. A detailed template is under development for explaining the factors that go into premiums, the factors that go into premium increases, and the steps companies are taking to control costs and increase quality. To ensure that this information is complete and informative, we are working with company actuaries from a broad array of health plans of all sizes and models as well as the insurance commissioners.

VII. UNMET CHALLENGES

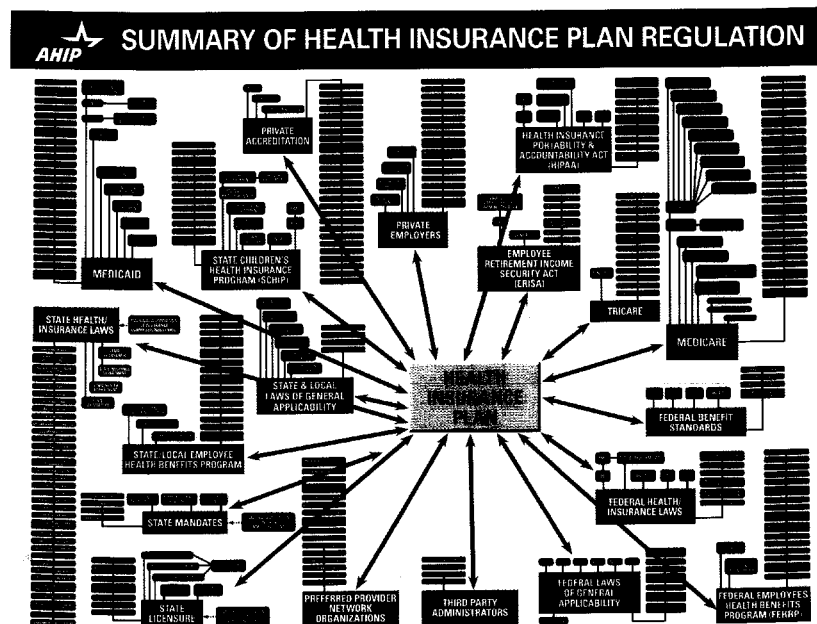
To succeed on a long-term basis, health reform ultimately must include bolder steps to achieve system-wide cost containment. We believe this can be achieved with a more comprehensive effort to reduce the rate of increase in costs, better alignment of public and private sector payment reform efforts, and broader medical malpractice reform. Perhaps most important, we believe that efforts to reduce costs are complementary to our Nation’s effort to improve quality as policymakers attempt to

drive greater value in the delivery of care. Focusing only on premiums and not the components that are driving premiums makes little sense.

In California, a similar effort was made to cap prices charged by energy distributors and ignore supplier costs, leading to “brownouts” and reduced service for consumers. Health plan enrollees may face a similar outcome if Congress attempts to reduce the soaring costs of medical care by regulating premiums. The current situation in Massachusetts offers important lessons about the significant disruption that can occur if a premium review process disregards the linkage between the components driving premiums and the premiums themselves.

VIII. CONCLUSION

Thank you for this opportunity to testify. Our members remain strongly committed to working with the committee to ensure the successful implementation of the new health reform law, while also working to slow the growth of underlying medical costs to make health insurance more affordable.



The CHAIRMAN. Thank you very much, Karen. And thanks for being here, and for your testimony. We'll certainly get into a discussion.

And last, we have Grace-Marie Turner, president of the Galen Institute, a public-policy research organization that she founded in 1995 to promote an informed debate over free-market ideas for health reform. Grace-Marie is a founder and facilitator of the Health Policy Consensus Group, and serves as a forum for analysis for market-oriented think-tanks around the country to analyze and develop policy recommendations. She served as executive director of the National Commission on Economic Growth and Tax Reform in the mid-1990s; for 12 years, president of Arnett & Co., a health-policy analysis and communications firm.

So, Ms. Turner, welcome again. Your statement will be made a part of the record. Please proceed.

**STATEMENT OF GRACE-MARIE TURNER, PRESIDENT,
GALEN INSTITUTE, ALEXANDRIA, VA**

Ms. TURNER. Chairman Harkin, thank you very much. Senator Alexander, Senator Franken.

I do bring my entrepreneurial spirit to my policy work, as well, thank you very much.

Grace-Marie Turner, president of the Galen Institute. We are based in Alexandria and are a think-tank devoted to free-market ideas in health reform.

In my testimony today, I will talk about the proposal under consideration to give the Federal Government authority to review health insurance premiums and use the example of Massachusetts as evidence that I'm concerned that this proposal is not going to work.

In addition, I will highlight some of the progress that's being made through innovation and care delivery, to show that a truly competitive free market can indeed work to bring prices down. I think that part of the reason we don't have lower health insurance premiums is because there is so little competition in States like yours and others. I was just in Alabama. One carrier controls 87 percent of the market. So, it's very difficult to have true competition.

States have decades of experience in regulating health insurance markets. And I'm very concerned about proposals that would give the Federal Government authority, because it has very little experience in this field.

The National Association of Health Insurance—of Insurance Commissioners concluded that Federal control over rate authority could be ineffective and could actually cause harm. It said, in a letter to Congress, that,

“Providing the Federal Government with authority to override State regulatory determinations on rates, while insolvency regulation remains at the State level, risks uncoordinated financial regulation that would greatly increase the risk of insurer insolvency without providing additional protection to consumers.”

Further, they said, “This Federal rate review authority can do nothing to reduce claims expenses, which are the biggest component of the premium dollar.”

I'm concerned that this proposal would be like trying to tighten the lid on a pressure-cooker while the heat's being turned up. The Congressional Budget Office has said that, in the individual health insurance market, there will be a steady increase in health insurance premiums, and that they will go up by \$2,100 by the year 2016, over and above the rate that they would have otherwise increased. So, that means that families would be paying \$15,200 for insurance in 2016 with this new legislation, and \$13,100 otherwise.

Several provisions in the health reform law that take effect this year are sure to increase health insurance premiums in the short term, including the removal of lifetime and annual health insurance caps, expanded dependent coverage, and 100 percent coverage for preventive care. Not that these are not all helpful to some con-

sumers, but I think it's important to recognize they are going to increase costs.

In addition, coming forward, there are \$20 billion in taxes on medical devices, \$60 billion in taxes on health plans, \$27 billion in taxes on drug companies, more expensive federally mandated benefit packages, and higher premiums for young people, in order to try to lower premiums for older people. So, it's not just overall rate increases, it's what individual people are going to be experiencing.

Massachusetts' experience shows that reforms similar to those enacted by the Congress, and, in fact, signed into law 4 weeks ago today, show that costs will continue to be a problem in the future. I believe Massachusetts really is a harbinger for the future.

For example, the State's individual mandate is having the effect of increasing health insurance premiums in the individual and small-group market. The Boston Globe reported that some people are taking advantage of the guaranteed-issue provisions in the law. It said that thousands of the consumers are gaming Massachusetts' 2006 health insurance law by buying insurance when they need it to cover pricey medical care and then dropping it after they have had their treatment. The typical monthly premium for these short-term members was \$400, but their average claims exceeded \$2,200.

In a complaint filed against the State last week, the major health insurers in Massachusetts say they could, collectively, lose more than \$100 million this year. And these are all nonprofit companies. They say these losses will deplete their individual revenues, weaken their financial stability, and, in some instances, threaten near-term solvency. So, the impact of these premium caps in Massachusetts could, in fact, have the result of forcing many companies out of the market, which is the exact opposite of what we need, to induce more competition.

Many of the problems, I believe, facing this country involving health costs could be addressed by encouraging more competition and empowering consumers to have greater control and authority over their health insurance decisions, including long-term care of health—long-term ownership, to get away from the problems of moving in and out of markets and preexisting conditions.

I have a chart—and I will conclude with this—on page 9 of my testimony that I think shows that employers are really having quite a good deal of success in lowering their health insurance costs. The total health-benefit cost increases per employee over the last, now, 5 years have been between 5 and 6 percent. And it shows what employers can do in this relatively lightly regulated ERISA market, where they can have control over the kind of benefits that their employees receive, coordinated-care efforts, being able to induce their employees to be partners in managing health care costs. I'm concerned that the legislation that puts more Federal control, takes more control away from consumers, moves in the wrong direction.

Thank you very much.

[The prepared statement of Ms. Turner follows:]

PREPARED STATEMENT OF GRACE-MARIE TURNER

EXECUTIVE SUMMARY

The proposal under consideration today to give the Federal Government authority to review health insurance premiums and to impose penalties if they are deemed “unreasonable” is unlikely to succeed in lowering health insurance costs.

The National Association of Insurance Commissioners concludes this policy would be ineffective and could actually cause harm, saying in a letter to Congress: “Providing the Federal Government with authority to override State regulatory determinations on rates while solvency regulation remains at the State level risks uncoordinated financial regulation that would greatly increase the risk of insurer insolvency without providing additional protection for consumers.” Further, this Federal rate review “can do nothing to reduce claims expenses, which are the biggest component of the premium dollar.”

The Congressional Budget Office says health insurance premiums will continue their steady upward climb and that they will accelerate faster in the individual market as a result of the Patient Protection and Affordable Care Act of 2010. It found that families purchasing insurance in this market would see a premium increase of an additional \$2,100 in the year 2016. That means those families would be paying \$15,200 in 2016 for health insurance as a result of passage of health reform, and \$13,100 otherwise.

Several provisions in the health reform law that take effect this year are sure to increase health insurance premiums in the short term, including removal of lifetime and annual limits on health insurance, expanded dependent coverage, and 100 percent coverage of preventive care.

Massachusetts’ experience with reforms similar to those enacted at the Federal level shows that costs will continue to be a problem in the future. For example, the State’s individual mandate is having the effect of increasing health insurance prices in the individual and small group market. The *Boston Globe* reports that some people are taking advantage of the guaranteed issue provisions:

“Thousands of consumers are gaming Massachusetts’ 2006 health insurance law by buying insurance when they need to cover pricey medical care, such as fertility treatments and knee surgery, and then swiftly dropping coverage, a practice that insurance executives say is driving up costs for other people and small businesses. The typical monthly premium for these short-term members was \$400, but their average claims exceeded \$2,200 per month.”

Many of the problems the country is facing involving health costs could be addressed by encouraging much more competition and empowering consumers to have greater control over decisions involving their care and coverage. In a truly competitive market for insurance where consumers have more power over spending decisions, price transparency and a larger choice of options would drive out insurers who price their products exorbitantly.

Thank you, Chairman Harkin, Ranking Member Enzi, Sen. Alexander, and members of the committee for the opportunity to testify today on the issue of health insurance rate authority and premium costs. My name is Grace-Marie Turner, and I am president and founder of the Galen Institute, a non-profit research organization based in Alexandria, VA, devoted to advancing an informed debate over market-based health reform ideas.

In my testimony, I will discuss the proposal under consideration today to give the Federal Government authority to review health insurance premiums and to impose penalties if they are deemed “unreasonable.” I will use the example of Massachusetts’ health reform initiative as evidence that this approach is unlikely to succeed.

In addition, I will highlight some of the progress that is being made through innovations in care delivery, in creative benefit offerings, and in lowering the cost of insurance and medical care to show that the competitive market can respond to the demands of consumers for better quality coverage and care at more affordable prices.

CHANGE IS INDEED NEEDED

American consumers and businesses have been saying for years that the cost of health insurance and health care is a top concern. However, I do not believe that the approach taken in the Patient Protection and Affordable Care Act of 2010 (PPACA) will contain health costs, and evidence shows it likely will exacerbate them. In addition, I believe PPACA will be hugely disruptive to the individual and

small and large group health insurance markets as well as to the overall economy and the Federal budget.

The fact that this hearing has been called today, I think, supports the concern that the legislation fails to address the central issue of rising health costs.

Just in the few weeks since its enactment, we already are seeing evidence of the flaws in this legislation regarding the lack of clarity involving coverage for younger people with pre-existing conditions and the ambiguity over coverage for members of Congress and staff, for example. These are likely only harbingers of the many, many problems we are likely to see as a result of enactment of this seeping legislation that centralizes control over our huge and extraordinarily complex health sector.

I am not an authority on the entire law and believe that very few people are at this point, but I would like to address today the legislation you are considering to give the Federal Government authority to establish limits on health insurance premium increases. I believe that this proposed legislation would take the wrong approach by imposing more top-down, government regulatory power. It also would give the Federal Government power to regulate a sector of the economy in which it has little or no experience or capability.

DANGERS OF DUAL REGULATORY AUTHORITY

In 47 States and the District of Columbia, insurers are required to file individual market premiums with State regulators. Twenty-eight of them require prior approval before carriers can increase their rates. States have decades of experience in regulating these markets and are able to consider the many forces in their individual States that may impact premium costs. Federal regulators would have much less ability to recognize these differences among States and would therefore be much more likely to inflict damage on health insurance markets.

Health insurers must collect premiums sufficient to pay claims as well as to maintain capital reserves to meet solvency requirements so the company will be able to continue to pay claims. Rate reviews must consider these and other factors when reviewing overall premium prices.

Capping premiums without recognizing the forces that are driving up costs would be like tightening the lid on a pressure cooker while the heat is being turned up. The National Association of Insurance Commissioners¹ (NAIC) writes that “the single most significant contributor to rising health insurance premiums has clearly been the continued growth of health care spending in the United States.” The NAIC cites advances in medical technology, multiple treatments available to treat diseases, and the growing reliance on subspecialists, as well as obesity and smoking that lead to health conditions requiring expensive and long-term treatment. In addition, the individual market is subject to much higher risk of adverse selection because people are more likely to seek insurance if they anticipate needing expensive medical care.

The NAIC concludes:

“Providing the Federal Government with authority to override State regulatory determinations on rates while solvency regulation remains at the State level risks uncoordinated financial regulation that would greatly increase the risk of insurer insolvency without providing additional protection for consumers.”

Further, this Federal rate review “can do nothing to reduce claims expenses, which are the biggest component of the premium dollar.”

HEALTH COSTS WILL CONTINUE TO RISE

The Congressional Budget Office says health insurance premiums will continue their steady upward climb in its analysis of the Senate legislation.² Families purchasing insurance in the individual market would see an increase of an additional \$2,100 in the year 2016, over and above increases they already will be facing as health insurance premiums continue to rise faster than the rate of general inflation.

That means these families will be paying \$15,200 in 2016 for health insurance under the new law, and \$13,100 otherwise. Families who get health insurance through small businesses will be paying \$19,200 in 6 years, and those working for large firms, \$20,100. PricewaterhouseCoopers released a study, commissioned by America’s Health Insurance Plans, which showed the cost of a family plan in 2019

¹Therese M. Vaughan, CEO, National Association of Insurance Commissioners, letter to The Honorable John Dingell, February 23, 2010.

²Congressional Budget Office, “An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act,” Letter to the Honorable Evan Bayh, November 30, 2009, at <http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf>.

would be \$4,000 a year higher under the reform law than otherwise.³ While the insurance coverage will be more generous, citizens will have many fewer options to select more modest coverage that they may prefer and that likely would be more affordable.

The Patient Protection and Affordable Care Act of 2010 provides subsidies that will help to make this coverage more affordable for some. But the Congressional Budget Office estimates that only 17 million people will be getting subsidized insurance through the State-based exchanges in 2016. However, there are as many as 130 million people in the income categories eligible for this subsidized coverage—between 133 and 400 percent of the Federal poverty line.⁴

As a result, the great majority of Americans will be subject to the mandate to purchase generous and expensive health insurance but only a relative few will qualify for Federal subsidies through the exchanges to help them afford the premiums. If tens of millions more do get coverage through the exchange, generally because they have lost their employer coverage or their employers do not provide health insurance, the cost of providing subsidies would soar, driving the Federal budget deficits even higher.

IMPACT OF PPACA ON THE COST OF HEALTH INSURANCE

Whether the premiums are paid directly by individuals or by taxpayers in the form of subsidies, rising health costs affect us all.

Numerous provisions in PPACA will put upward pressure on health insurance premiums, such as the new taxes on drug companies, device makers, and insurers. When they take effect, these and many other new fees and taxes will be passed along to consumers in the form of higher premiums or reduced services or access to care.

Four health reform provisions that take effect this year are sure to increase health insurance premiums in the short term.⁵

1. *Removal of lifetime and annual limits on health insurance:* Beginning with plan years after Sept. 23, health plans no longer will be allowed to place lifetime limits on new or existing group health plans or individual products. They also will be prohibited from setting annual dollar limits on coverage for “essential benefits” as defined by the Secretary of Health and Human Services. The added cost of these added claims will have to be built into premiums for all policyholders, but it will have secondary effects of causing some employees to lose coverage if their employers cannot afford the higher premiums associated with the no-limit coverage. Self-funded plans will need to purchase additional reinsurance coverage.

2. *Dependent coverage:* Health insurers will be required to allow members to extend coverage to their adult children up to age 26. While this could bring more young and healthy people into the insurance pool, it also has a potential for adverse selection. Privately-purchased health insurance for young people is generally inexpensive; those who have trouble buying coverage in the individual or small group market and who are more likely to take advantage of this new mandate are likely to have higher health risks and therefore higher health costs. Insurers and employers also will be barred from rejecting children under 19 with pre-existing conditions. Insurers are working to determine the actuarial cost and will be adjusting premiums accordingly.

3. *Preventive care:* Newly-written policies will be required to cover not-yet-determined preventive services at no cost to the policyholder. This simply means that copayments and other cost-sharing will now be built into premium costs, causing them to go up.

³PricewaterhouseCoopers, “Potential Impact of Health Reform on the Cost of Private Health Insurance Coverage,” October 2009, at http://www.politico.com/static/PPM116_pwc2.html.

⁴James Capretta of the Ethics and Public Policy Center writes in *Kaiser Health News*, April 8, 2010:

“The risk of cost overruns is even higher at the Federal level than in Massachusetts. The Congressional Budget Office projects just 17 million people will be getting subsidized insurance through the State-based exchanges in 2016. But the population with incomes between 100 and 400 percent of the Federal poverty line—roughly the group targeted for subsidized coverage—is more like 130 million people. CBO assumes the vast majority of low- and moderate-wage families will stay in job-based plans with no additional Federal help. But what if they are wrong? Employers are already looking for ways to shed as much of their health care bill as they possibly can onto taxpayers. If 30 or even 50 million Americans end up in the exchanges, Federal costs will soar.”

⁵Steve Davis, “Four key health reform provisions that will affect health insurers this year,” April 5, 2010. AIS’s Health Business Daily.

4. *Medical loss ratios*: Beginning on January 1, 2011, health insurers will be required to report on the proportion of their premium dollars spent on direct medical care versus administrative costs. If Federal regulators decide that wellness, care coordination, and consumer education programs are considered administrative costs rather than actual care delivery, for example, insurers could be forced to drop programs that actually help reduce costs, as I explain on page 8 of my testimony.

It should be noted that the government is on shaky ground in excessively tight regulation of private health insurance by tightening these loss ratios. The CBO has concluded⁶ that excessive regulation of insurance would mean that premiums paid for private health insurance would have to be reflected in the Federal budget.

Other cost drivers are yet to come. For example, under PPACA, the Secretary of the Department of Health and Human Services will have authority to determine what benefits must be covered in the generous health insurance policies mandated by the Federal Government. Massachusetts' experience shows that mandating generous benefits will increase the costs of health insurance and that political attempts to force premiums down will likely fail.

LESSONS FROM MASSACHUSETTS

One of the promises of Massachusetts' 2006 health reform law was that getting everyone covered would force costs down, but that is far from being realized. One third of State residents polled by Harvard researchers in a study published in "Health Affairs" in 2008 said that their health costs had gone up as a result of the 2006 reforms. A typical family of four today faces total annual health costs of nearly \$13,788, the highest in the country. Per capita spending is 27 percent higher than the national average.⁷

The State's stubbornly high health costs are partly the result of government regulations that stifle competition in the insurance market and mandate what services health insurance must cover. A 2008 study by the Massachusetts Division of Health Care Finance and Policy found that the State's most expensive insurance mandates cost patients more than \$1 billion between July 2004 and July 2005. The Massachusetts health reform law left all of them in place.

Further, insurance companies in Massachusetts are required to sell policies to people, even if they wait until they are sick to buy coverage. The current structure and fines associated with the individual mandate in PPACA are likely to lead to this same consequence.

In addition, there is growing evidence that many people in the Bay State are taking advantage of the guaranteed issue provisions in the law. They are purchasing health insurance when they need surgery or other expensive medical care, then drop it a few months later.

The Boston Globe reported this month,⁸ "Thousands of consumers are gaming Massachusetts' 2006 health insurance law by buying insurance when they need to cover pricey medical care, such as fertility treatments and knee surgery, and then swiftly dropping coverage, a practice that insurance executives say is driving up costs for other people and small businesses.

"The typical monthly premium for these short-term members was \$400, but their average claims exceeded \$2,200 per month. The previous year, the company's data show it had even more high-spending, short-term members. Over those 2 years, the figures suggest the price tag ran into the millions.

"Other insurers could not produce such detailed information for short-term customers but said they have witnessed a similar pattern. And, they said, the phenomenon is likely to be repeated on a grander scale when the new national health care law begins requiring most people to have insurance in 2014, unless Federal regulators craft regulations to avoid the pitfall.

"These consumers come in and get their service, and then they leave because current regulations allow them to do it," said Todd Bailey, vice president of underwriting at Fallon Community Health Plan, the State's fourth-largest insurer.

"The problem is, it is less expensive for consumers—especially young and healthy people—to pay the monthly penalty of as much as \$93 imposed under the State law for not having insurance, than to buy the coverage year-round. This is also the case

⁶ Congressional Budget Office, "The Budgetary Treatment of Proposals to Change the Nation's Health Insurance System," May 2009.

⁷ Robert J. Blendon, Tami Buhr, Tara Sussman, and John M. Benson, "Massachusetts Health Reform: A Public Perspective From Debate Through Implementation," *Health Affairs* 27, no. 6, October 28, 2008, at <http://content.healthaffairs.org/cgi/content/abstract/27/6/w556>.

⁸ Kay Lazar, "Short-term customers boosting health costs," *Boston Globe*, April 4, 2010. http://www.boston.com/news/local/massachusetts/articles/2010/04/04/short_term_customers_boosting_health_costs/.

under the Federal health care overhaul legislation signed by the president, insurers say," *The Globe* reported.

The individual mandate in PPACA likely will lead to the same gaming of the health insurance market that we see in Massachusetts, with people signing up for health insurance when they need it and paying the much-less-expensive fine otherwise. This creates adverse selection and will lead to higher and higher premiums for those who remain in the pool.

In Massachusetts, faced with soaring medical expenses, Gov. Deval Patrick wants to cap insurance rate increases for those in the individual and small group market at 4.8 percent, not the 8 percent to 32 percent increases the companies have requested for the coming premium year.

Last week, two of the State's biggest health insurers were threatened with fines of as much as \$5,000 a day, plus another \$1,000 for each consumer who was unable to buy insurance at approved rates from the insurer, if they did not comply with the governor's directive.

How long will these non-profit insurers be able to stay in business if the government forces them to continue to pay benefits that exceed the premiums they are allowed to collect? Three of the four major health insurers in Massachusetts showed operating losses for 2009. If their rates are capped, they say they'll be forced to cut payments to health providers, putting further pressure on doctors and fragile hospitals.

In their complaint filed against the State last week, the major health insurers in Massachusetts say they could collectively lose more than \$100 million—"losses that will deplete their individual reserves, weaken their financial stability, and in some instances threaten their near-term solvency."

And the law's distortions don't extend just to health insurance: Some Massachusetts safety-net hospitals that treat a disproportionate number of lower-income and uninsured patients are threatening bankruptcy. They still are treating a large number of people without health insurance, but the payments they receive for uncompensated care have been cut under the reform deal.

PRIVATE SECTOR INNOVATION

Many of the problems the country is facing involving health costs could be addressed by encouraging much more competition and empowering consumers to have greater control over decisions involving their care and coverage. In a truly competitive market for insurance where consumers had more power over spending decisions, price transparency and a larger choice of options would drive out insurers who price their products exorbitantly.

Unfortunately, the lack of competition in health insurance in many States limits the options for coverage, over-regulation drives up costs, and our structure of financing health insurance gives consumers little power to make choices.

While health care is different than other sectors of our economy and requires special consideration, there are many areas where consumers can and want to have more control over their health care choices. The evidence I will describe below shows that competition could work if we were truly to engage consumers as partners in getting better value for their health care dollars. The private sector has demonstrated that it can get health costs under control, particularly where companies have provided new structures to allow consumers to become engaged.

Employer Innovations

Many leading employers are working to get better value for spending on health care and health insurance for their employees in order to shape their health insurance offerings to fit their resources and workforces. A few examples:

- Safeway chief executive Steve Burd has become an evangelist for wellness incentives in the company's health insurance arrangements. In the first year after these plans were introduced, the company's health costs went down 11 percent. "If you design a health care plan that rewards good behavior, you will drive costs down," he said.⁹ The company shared its cost savings with employees, cutting their costs by 25 percent or more. Safeway introduced a program called Healthy Measures that encourages employees to get health assessments and provides support and in-

⁹Victoria Colliver, "Preventive health plan may prevent cost increases," *San Francisco Chronicle*, February 11, 2007, at <http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2007/02/11/BUG02020R81.DTL&type=printable>.

Scott Shreeve, "Safeway uses incentives and transparency to improve employee health," *The Health Care Blog*, October 29, 2008, at http://www.thehealthcareblog.com/the_health_care_blog/2008/10/safeway-uses-in.html.

centives for responsible health behaviors. Safeway also covers the full cost of recommended preventive care.¹⁰

- Target offers its employees a range of health insurance choices. One Health Savings Account option costs them as little as \$20 a month, and Target contributes \$400 a year to health spending accounts for individuals and \$800 for families.¹¹ “We’ve seen, and national research supports, that team members make more cost-conscious decisions when they participate in a consumer-based plan,” according to John Mulligan, Target’s vice president for pay and benefits. “These plans engage our team members in a decisionmaking process that gives them greater ownership and control of their health care dollars.” The company offers its 360,000 employees Decision Guides to help them compare price and quality and estimate their costs, plus access to wellness programs, a nurse hotline, and other support tools.¹²

- Wal-Mart offers dozens of health plan options to its employees, one with premiums as low as \$5 a month. For this, employees receive a \$100 health care credit, more than 2,400 generic drugs available for \$4 a month, and major medical coverage with no lifetime maximum that starts at \$2,000—basically the moment they step into a hospital. Employees can choose to pay higher premiums for lower deductibles and more comprehensive coverage.¹³ For \$62 a month, employees can choose a \$500 deductible policy with a \$100 health care credit and no lifetime maximum on their insurance coverage.

- Whole Foods’ CEO John Mackey toured the country talking to employees about health benefits options. Afterward, employees voted to switch to new account-based health plans with higher-deductible insurance coverage. Whole Foods deposits up to \$1,800 a year into a spending account for each employee, with Mackey pointing out that this is not charity but part of the employee’s compensation package. If they don’t spend the money on medical care, it rolls over and the company adds more the next year. Some workers have as much as \$8,000 in their accounts.¹⁴ Whole Foods saves money and still covers 100 percent of its employees’ health insurance premiums.

These companies and many others have worked extraordinarily hard to find the delicate balance between getting health costs under control and continuing to provide coverage that satisfies their workers. There simply is no way that a benefit or cost structure dictated by Washington could achieve these same results. Maintaining ERISA protection is crucial to allowing companies to continue to innovate.

¹⁰ Ibid.

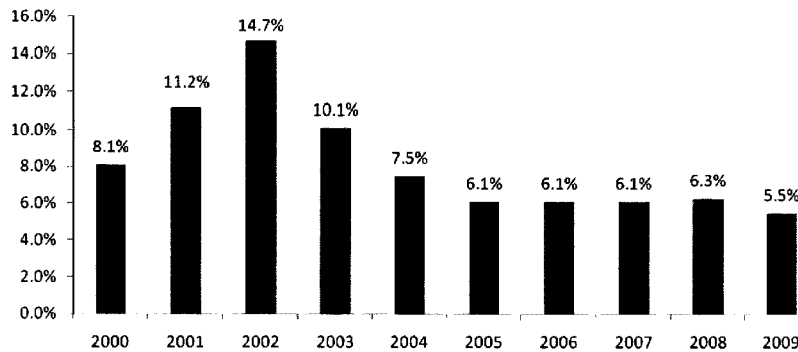
¹¹ “Target Offers Employees Health Savings, Reimbursement Accounts, Plans to Eliminate Traditional Health Plans, USA,” *Medical News Today*, May 18, 2006, at <http://www.medicalnewstoday.com/articles/43453.php>.

¹² “Thought Leaders: John Mulligan, Vice President, Pay & Benefits, Target Corporation,” *hub Magazine*, Summer 2008, at <http://www.hubmagazine.net/printer.php?ID=180>.

¹³ “Wal-Mart Announces Improvements to 2008 Health Benefits Package,” Wal-Mart Stores, Inc., September 18, 2007, at <http://walmartstores.com/PrintContent.aspx?id=6731>.

¹⁴ John Stossel, “Control Your Own Health Care,” *RealClearPolitics*, October 3, 2007, at http://www.realclearpolitics.com/articles/2007/10/control_your_own_health_care.html.

“Whole Foods Market Benefits,” Whole Foods Market, at http://www.wholefoodsmarket.com/careers/benefits_us.php.

Total health benefit cost increases per employee

Source: Mercer's National Survey of Employer-Sponsored Health Plans; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April) 1990-2009; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April) 1990-2009.

As this chart shows, employers held cost growth to 5.5 percent in 2009, the lowest increase in a decade. The use of wellness and health management programs increased as large employers found these tools to be very helpful in holding health costs down.¹⁵ It is crucially important that implementation of the new health reform legislation provide incentives for employers and health plans to continue these innovative approaches to controlling health costs.

New Health Care Financing Options

Several new private sector health coverage options are available to companies and individuals such as Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs).

HSAs permit individuals to combine health insurance with a tax-free health spending and savings account. The account is used to pay for routine health care expenses, such as doctor's visits, for services not covered by insurance, and to create a cushion to pay premiums in lean economic times. The high-deductible insurance policy covers larger medical expenses such as hospitalization and surgeries. Federal law also allows the insurance contract to cover preventive care, such as cancer screenings.

Eight million Americans had health insurance that qualifies holders to open HSAs as of January 2009.¹⁶

The older sisters of HSAs, Health Reimbursement Arrangements, were created via a regulatory interpretation in 2002 to give employers more flexibility in structuring health coverage for their workers. HRAs operate much like HSAs, but can be offered only through the workplace. They are generally account-based plans accompanied by health insurance. While the money in HSAs is truly portable to the employee or individual holder, access to HRA funds is generally restricted after an employee leaves a company. But HRAs give employers more flexibility in shaping their benefit packages, including providing incentives for prevention and wellness activities.

Both products are helping to make health insurance more affordable and are helping companies lower their health costs. Health insurance premiums generally are lower than average because deductibles are higher, and the savings on premiums can help fund the HSA or HRA that people can use to pay for routine health expenses.

Companies that have introduced health plans with new incentives for consumers to be engaged as partners in managing health costs generally have seen lower-than-average health cost increases. Annual premium increases for employment-based coverage averaged about 6 percent for the last 3 years, down from double digits earlier

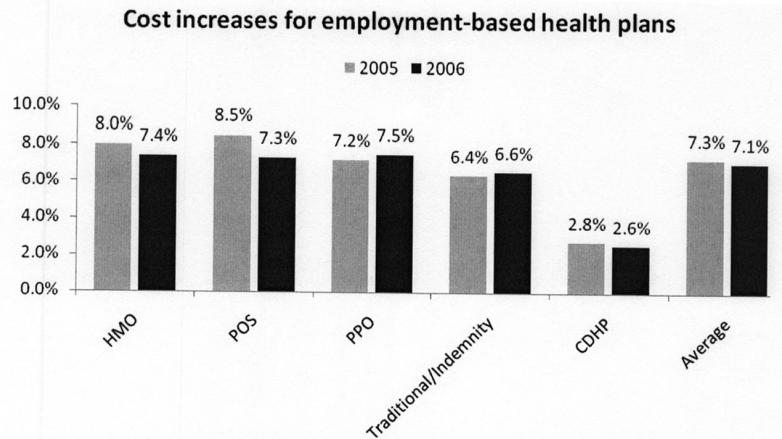
¹⁵ "In a tough year, employers hold the line on health benefit cost increases," Mercer LLC, November 18, 2009, at <http://www.mercer.com/summary.htm?idContent=1364345>.

¹⁶ "January 2009 Census Shows 8 Million People Covered by HSA/High-Deductible Health Plans," America's Health Insurance Plans, May 2009, at <http://www.ahipresearch.org/pdfs/2009hsacensus.pdf>.

in the decade.¹⁷ The most impressive results have come from consumer-directed plans such as HSAs and HRAs.

Enrollment in consumer-directed health plans (CDHP) grew to an estimated 23 million people in 2009, up from 18 million people in 2008—a 27 percent increase. This finding was reported by the American Association of Preferred Provider Organizations and was based upon research from Mercer's 2009 National Survey of Employer Sponsored Health Plans. Small employers led CDHP adoption in 2009, accounting for most of the growth among all employers.¹⁸

Deloitte's Center for Health Solutions found that cost of consumer-directed health plans (CDHPs) increased by only 2.6 percent in 2006 among the 152 major companies it surveyed. This is about a third the rate of increase for traditional plans.¹⁹



Source: "Reducing Corporate Health Care Costs: 2006 Survey," Human Capital Practice of Deloitte Consulting LLP and the Deloitte Center for Health Solutions, 2006.

Lower Costs of Insurance Coverage

Consumer-directed health products have helped to moderate health cost increases overall.

- UnitedHealthcare found that employer health benefit costs were more than 15 percent lower in 2007 for its HRAs than for traditional PPO plans. Importantly, 85 percent of the cost savings were attributable to lower utilization costs, such as avoiding hospitalizations and greater use of generic drugs—and not from cost shifting to employees.²⁰

- A Mercer study found that consumer-directed health plans delivered substantially lower costs per employee than either PPOs or HMOs in 2008. CDHP medical plans averaged \$6,207 per employee, compared to \$7,768 for HMOs and \$7,815 for PPOs.²¹

- In addition, health insurance that people purchase in the individual market is often more affordable than employment-based coverage. eHealthInsurance, the largest online broker for individually-purchased and small-group health insurance,

¹⁷Total U.S. health benefit cost rose by 6.1 percent in 2007. "Mercer National Survey of Employer-Sponsored Health Plans," Mercer LLC, November 19, 2007, at <http://www.mercer.com/summary.jhtml?idContent=1287790>.

¹⁸American Association of Preferred Provider Organizations (AAPPO), "2010 Survey of Consumer-Directed Health Plans," April 14, 2010, at <http://www.aappo.org/fncDownload.cfm?newsID=140>.

¹⁹"Reducing Corporate Health Care Costs: 2006 Survey," Human Capital Practice of Deloitte Consulting LLP and the Deloitte Center for Health Solutions, 2006, at http://www.deloitte.com/dtt/cda/doc/content/us_chs_red_cor_hca_costs_0106.pdf.

²⁰Meredith Baratz and Todd Berkley, "Consumerism in Health: A Conversation with Galen Institute and the Consensus Group," UnitedHealthcare, January 7, 2009.

²¹"Mercer National Survey of Employer-Sponsored Health Plans," Mercer LLC, November 19, 2008, at <http://www.mercer.com/summary.htm?idContent=1328445>.

found that the average yearly health insurance premium in 2009 was \$1,968 for individuals and \$4,656 for a family.²²

Other Benefits

In addition to moderating cost increases, HSAs also are providing new options for the uninsured. Up to 43 percent of those enrolling in HSA-qualifying health insurance were previously uninsured, showing that uninsured Americans in particular have been looking for an affordable alternative to traditional health insurance, according to Assurant Health.²³ Assurant Health's most recent data show that they have broad appeal:

- 66 percent of HSA purchasers are families with children
- 63 percent of HSA purchasers are over age 40
- 52 percent of all HSA purchasers have high school or technical school training as their highest level of education
- 30 percent of HSA purchasers have family incomes of less than \$50,000

UnitedHealthcare found, based upon a survey of 300,000 HSA owners, that the average account holder had household incomes of \$55,500, and 25 percent of those with an HSA had incomes of less than \$39,000.²⁴ Changes in Federal law in 2006 allowing employers to make larger deposits for lower-income workers also are apparently succeeding, since UnitedHealthcare found that they were more likely to have employer contributions in their HSAs than higher-income HSA holders.

Other Private Insurance Options

Many other employers are offering innovative programs to help their employees get and stay healthier and spend health care dollars wisely. They are offering incentive programs to encourage employees to get health assessments to detect problems early and health coaching to help those with chronic illnesses better manage their care. These companies generally work in partnership with health plans to design the consumer-based products, manage the finances, educate employees about using them, and provide wellness programs and support for employees with chronic conditions. Price transparency is an important element in their success.

For example, in 2005, Aetna launched a program that offers a range of consumer-support tools to help patients find physicians, compare costs and quality, and get personalized information about medical conditions and treatment. Its personalized search engine provides health information tailored to patients' individual needs.²⁵

The results show this patient engagement works. Aetna is following health care claims and utilization of 1.6 million members of its Aetna HealthFund consumer-directed plans. Four years of evidence show sustained savings, more patient engagement in managing health, and greater utilization of preventive services. Employers who offered an Aetna HealthFund plan lowered their health care spending trend and saved money through all 4 years with the plan, across all Aetna products they offered.²⁶

Aetna studied its members to identify the keys to successful implementation and found the keys were *greater* spending on preventive care, including wellness programs, focusing on employee communication and education, and carefully structuring benefits packages with appropriate levels of employee responsibility.²⁷

Many companies are offering turnkey solutions to health plans and employers. U.S. Preventive Medicine, for example, offers employers packages of services they can tailor to fit the needs of their workforces for preventive care services.²⁸

In addition, a galaxy of Web sites has evolved to offer everything from treatment information to diet advice. EverydayHealth has just surpassed WebMD as the most-visited site for medical information, and new sites appear every day to help patients

²²"Costs 2010 Spring Cost Report for Individual and Family Policy Holders," eHealth, Inc., March 30, 2010, at http://news.ehealthinsurance.com/pr/ehi/document/Spring_2010_Cost_Update.pdf.

²³"Quick Facts: Health Savings Accounts," Assurant Health, at <http://www.assuranthealth.com/corp/ah/AboutAssurantHealth/HSAFactSheet.htm>.

Maureen E. Sullivan, "Health Plan Initiatives, Trends and Research in Consumer-Driven Care," BlueCross BlueShield Association, October 20, 2008, at <http://www.bcbs.com/news/bluecrossradio/consumerdriven2008/>.

²⁴Meredith Baratz and Todd Berkley, "Consumerism in Health: A Conversation with Galen Institute and the Consensus Group," UnitedHealthcare, January 7, 2009.

²⁵"Aetna and Healthline Networks Announce First Ever Personalized Health and Health Benefits Search Engine—Aetna SmartSource," Aetna Inc., March 12, 2008, at <http://www.aetna.com/news/newsReleases/2008/0312.html>.

²⁶"Aetna Research Identifies Four Keys to Success for Consumer-Directed Health Plans," Aetna Inc., January 31, 2008, at <http://www.aetna.com/news/2008/0131.htm>.

²⁷Ibid.

²⁸U.S. Preventive Medicine, <http://www.uspreventivemedicine.com/>.

find the best doctors, the lowest cost medicines, and the most cost-effective diagnostics.

Lower Drug Costs

Competition, primarily from greater use of generic drugs, helped to moderate prescription drug spending. Drug prices increased 2.5 percent in 2008, compared to 1.4 percent in 2007. This is slower than the 4.1 percent average annual rate of growth between 1997 and 2007 and less than the overall rate of medical inflation.²⁹ Part of the reason is increased use of lower-cost generic drugs, but private competition over drug pricing in the Medicare Part D program also contributed. And retail establishments also have engaged in private price wars. In 2006, Wal-Mart began offering 30-day supplies of several hundred generic drugs for just \$4. Competitors quickly followed suit, with some even offering to fill prescriptions for antibiotics for free.

There also has been active engagement by pharmaceutical companies in creating programs for low-income and uninsured people to obtain their products at little or no cost. Pharmaceutical companies have made significant investments to develop, expand, and promote patient assistance programs like Together Rx Access, Pfizer Helpful Answers, Partnership for Prescription Assistance, and many others. New private partnerships, like the Asheville Project and the Ten Cities Challenge, also have been created to help patients with chronic illnesses, including diabetes, get the medicines and counseling they need to manage their diseases.³⁰

Care Delivery

Private health care firms have responded to consumer demand for more convenient, accessible medical care. For example:

- TelaDoc offers its customers telephone consultations with physicians from wherever they are, anytime of day, 365 days a year. The average patient gets a call returned by a doctor in less than 40 minutes, and the cost per call is just \$35—a fraction of the cost of an emergency room visit. TelaDoc physicians also use electronic prescribing to minimize errors and keep a record of patients' medications.³¹
- There also has been an increase in the number of low-cost walk-in medical clinics like RediClinic, Take Care, and MinuteClinic. There are now more than 1,180 retail clinics nationwide.³² They are usually located in malls or chain stores and are typically staffed by nurse practitioners working in conjunction with local doctors and hospitals to diagnose and treat common illnesses. They are open 7 days a week, before and after work, and prices are a fraction of emergency room charges. These clinics use Mayo Clinic and Cleveland Clinic protocols to diagnose and treat a range of routine health problems, from allergies and bronchitis to poison ivy, ear and bladder infections, and strep throat, usually for a fraction of the cost of hospital emergency rooms. Wal-Mart found that about half of the people visiting its in-store clinics were uninsured and did not have other sources of care. Wal-Mart partners with local hospitals and doctors' groups to create the clinics in many areas, but it insists that all of them create electronic health records for every patient that are accessible at any other clinic in the chain.
- Specialty hospitals owned by physicians are showing the value of focused care in delivering high-quality, efficient care with greater patient satisfaction and better health outcomes.
- Physician practices also are innovating to become more consumer-friendly. Some are freeing up an hour or more a day for same-day appointments. Others are

²⁹ Micah Hartman, Anne Martin, Olivia Nuccio, Aaron Catlin, "Health Spending Growth At A Historic Low in 2008," *Health Affairs Web Exclusive*, January 5, 2010, at <http://content.healthaffairs.org/cgi/reprint/29/1/147>.

³⁰ Grace-Marie Turner, "Gold Standard," *Health Policy Matters Newsletter*, Galen Institute, March 14, 2008, at http://www.galen.org/component,8/action,show_content/id,14/blog_id,1030/category_id,0/type,33/.

Carole W. Cranor, Barry A. Bunting, and Dale B. Christensen, "The Asheville Project: Long-Term Clinical and Economic Outcomes of a Community Pharmacy Diabetes Care Program," *Journal of the American Pharmaceutical Association*, Vol. 43, No. 2, March/April 2003, at http://www.aphafoundation.org/searchable_files/filemanager/JAPhA_Long%20term.pdf.

Toni Fera, Benjamin M. Bluml, William M. Ellis, Cynthia W. Schaller, and Daniel G. Garrett, "The Diabetes Ten City Challenge: Interim Clinical and Humanistic Outcomes of a Multisite Community Pharmacy Diabetes Care Program," *Journal of the American Pharmaceutical Association*, Vol. 28, No. 2, March/April 2008, at <http://www.diabetestencitychallenge.com/pdf/DTCCInterimReport.pdf>.

³¹ TelaDoc, <http://www.teladoc.com>.

³² "The Retail Clinic Market in 2009," *Merchant Medicine*, at <http://www.merchantmedicine.com/News.cfm?view=74>.

working with employers to staff on-site clinics so employees can see a doctor without taking time off work.

- Hospitals are experimenting with new ways to ease crowding in their emergency rooms, visited by an estimated 119 million patients in 2006. There are more than 8,000 walk-in urgent care facilities nationwide staffed by practicing physicians. Inova Health System and Shady Grove Adventist in the Washington, DC, area and dozens of other hospitals nationwide are opening free-standing emergency facilities to treat everything from lacerations to heart attacks and gunshot wounds. Patients are seen faster, and if they need to be admitted, they are transported by ambulance to nearby hospitals.³³

- A growing number of physicians are experimenting with innovative medical practice design,³⁴ including direct medical practices. Physicians, generally internists or family practitioners, contract directly with their patients to offer a medical home, providing medical care, consultation, and coordination with specialists for a fixed fee. The fees range from \$60 to \$15,000 in some practices, but generally cost about \$1,500 a year.³⁵ Other physicians are bypassing insurance and simply posting prices for medical services. They find they can charge patients much less because they save on the administrative overhead of insurance billing.

- Health Advocate, a Pennsylvania-based company, helps consumers find the right doctor for their ailments, work with insurance companies on coverage, and manage other administrative headaches. This service helps consumers, via call centers, who are being given more responsibility to navigate the world of health care and health coverage.³⁶

UNFINISHED AGENDAS

I commend you and the many other members of Congress for working toward the goal of expanding access to health coverage for the uninsured, modernizing our health care delivery system, and trying to provide relief for private and public payers to rising health costs.

The challenges are enormous. Millions of Baby Boomers are aging into Medicare, putting new pressures on the system. The costs of public programs threaten to squeeze out other public services provided by Federal and State governments. Millions of people continue to lose their health insurance when they lose or change jobs (and I believe the coverage of many workers is actually threatened by PPACA.) But the cost of health care and insurance coverage continue to be at the center of the health reform debate. I think the evidence shows that private sector initiatives and genuine competition offer the best hope of helping consumers and taxpayers with health costs.

The Path Forward

Addressing the needs of 300 million Americans for better quality care at more affordable prices requires modernizing our health sector to become more efficient and innovative. It is not possible to expect that one piece of legislation could be written carefully enough to accommodate these needs and also continue to provide a platform for future innovation to enhance the quality of medical care in the future.

The medical profession is moving toward patient-centered medicine, with micro-targeting of treatments tailored to the individual genetic code of individual patients. Advances in medical science demand that progress must continue without being blocked by regulatory obstacles and restrictive payment systems. This continued innovation is vital to progress in health care.

While we face major problems with cost and access to coverage, the evidence shows that careful reform which respects the diverse needs of our population is crucial. As the examples I have offered here show, competition can work in public and private programs and force the system to be more responsive to consumers. By properly structuring incentives and creating a climate friendly to this innovation, Congress could put us on a path to uniquely American health care solutions. As I believe the evidence shows, competition works, even in health care, and offers the best solution for the future.

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

³³ "ER Care, Stat!," Sandra G. Boodman, *The Washington Post*, September 16, 2008.

³⁴ Society for Innovative Medical Practice Design at <http://www.simpd.org/>.

³⁵ David Albenberg, MD, "Concierge Medicine: The Pitfalls and the Pendulum," Fall 2008, at http://pri-med.com/DigitalAssets/Shared%20Files/Syllabus%20Files_Fall08/C&E/Mid-Atlantic/Practice%20Solutions/Session11-Concierge%20Medicine%20Part%201FNL.pdf.

³⁶ Mike Stobbe, "Booming Business Helps Patients Navigate Medicine," Associated Press, July 25, 2008.

Thank you all very much for being here and for your testimonies. We'll start a round of 5-minute questions.

First, Ms. Menke, thank you for telling us your story. I do feel your frustration. I just listened to Ms. Turner talk about employers, how they're keeping their rates down. That might be OK, but that doesn't answer your problem, and the problem of so many small towns in my State, our State, that don't have 50 or 100 or more employees.

The State insurance commissioner in Iowa, as you said, modified your premium increase from 31 percent to 25 percent. We have that authority under State law. I assume you agree, that's probably a pretty good thing to have, considering your testimony.

Ms. MENKE. Yes, I absolutely do think it's a good thing to have. I'm glad that Iowa had that. And I would support other States having an insurance commission or insurance division that would regulate insurance premiums.

The CHAIRMAN. I just want to point out one thing. You mentioned they were found to be justified, after an independent review. So, I started looking into that; had my staff look into it. And the independent review was done by INS. I'm not certain where INS is from. But, I was reading here, from a press statement here—INS Consultants, a Philadelphia actuary. They found the insurance division's rate review process acceptable and reasonable using INS's methodology. But, as was pointed out in a newspaper article, it said that, while INS is technically independent, there's no way the firm would contradict and embarrass the agency which hired the firm. If INS were to contradict the insurance division, it would likely not be hired in the future by the Iowa insurance division or any other insurance regulator. So, you wonder about that independence. And I wonder about that, myself, in terms of these rate reviews.

You know, with your story, I've heard so much across the State of Iowa. And, as I pointed out, two companies have 80 percent market share. So, when you went out for bids to find another company, you said they all came in considerably higher.

Ms. MENKE. Right.

The CHAIRMAN. And I'd point out that your insurance rates went up 131 percent in 5 years. Medical inflation over that same time would have been about 50 percent, maybe, something like that, if you figure about 10 percent per year. So, again, that's what raises the questions about just how much is being taken out by profits and other things in these companies. And as was pointed out by Senator Feinstein, a lot of these companies have bought other companies, and now we're in these huge, huge for-profit companies—insurance companies in the country that, basically, in many States—Illinois, Mr. McRaith—they really don't have that kind of rate review.

In 2014, we'll have a big change in that. Anticipating that change, would you think there's a potential for insurance companies to charge unjustified premium increases before then, Mr. McRaith?

Ms. MENKE. Well, I believe that Blue Cross/Blue Shield did hedge their bets by going for these increases now.

The CHAIRMAN. Yes.

Ms. MENKE. And I read that same article that you did, about the independent reviewer, so yes.

The CHAIRMAN. Mr. McRaith, what do you think? Do you think there's a possibility that insurance companies, anticipating that 2014, would be out there trying to game the system?

Mr. McRAITH. Well, Mr. Chairman, first of all, let me assure you that the insurance commissioner in Iowa, Susan Voss, is an exceptionally talented regulator. I'm sure that conflict of interest is not one she would ever reconcile against the consumer.

In terms of the companies and potential for abuse between now and 2014, I do think there's a distinct possibility that less responsible companies are going to attempt to price out people who might be sick or injured, or might become sick or injured between now and 2014. We have seen some evidence that in Illinois already. Although we had dramatic, explosive rate increases over the last couple years, small groups, with just one or two sick employees, have seen rate increases of 50 percent or more. Those are unprecedented levels for us.

The CHAIRMAN. Ms. Ignagni, before my time runs out, as Commissioner McRaith said, he has no idea what premium rates are for small businesses in his State. I was kind of shocked when I heard that. I understand the health plans that you represent have agreed to provide more transparency—

Ms. IGNAGNI. Yes, sir.

The CHAIRMAN [continuing]. For premium rates. As you know, the Affordable Care Act provides for public disclosure of how premium rates are determined. But, this requirement only applies to new health plans, not existing ones. So, in the interest of transparency, do the health plans you represent support a legislative change to ensure that this requirement for public disclosure applies to existing health plans, as well?

Ms. IGNAGNI. We are working with the NAIC and individual insurance commissioners, and are in the process, now, of reaching out to consumers, to undergo a very comprehensive—as we said in our testimony, you're quite right—transparency effort. And that means information on Web sites. And we're working with the NAIC, in terms of how the actuarial justifications can be done in consistent ways across the country. We believe it's important for consumers and businesses to have a line of sight into what is going on, and we think that that will spark, in fact, a broader discussion about how we deal with this issue and the underlying costs that are fueling the premiums.

The CHAIRMAN. So, you're not prepared, right now, to say whether or not this should apply to existing plans.

Ms. IGNAGNI. I think, that, Senator, we have—every page of the legislation, as you know—virtually every page—affects our members in a variety of ways. And we submitted a chart which shows the full breadth of that. I think the first thing to do is to let the department, which is now moving very quickly to develop the standards that will be required in all States. We think that that's an important change, and we think that it will provide the kind of transparency that's necessary so that folks can get their hands around what's going on. We think that will draw them to the un-

derlying factors that are—that is, in fact, fueling the growth in premium.

The CHAIRMAN. I've gone over my time.

Senator Alexander.

Senator ALEXANDER. Thanks, Mr. Chairman.

And thanks, to all the witnesses, for coming.

Ms. Menke, the story of those increases is really terrifying, I'm sure, for many, many Americans who've suffered the same thing.

Let me suggest a couple of solutions that have been talked about here in the Congress. One, you alluded to. There's the idea of a small business health insurance plan, which generally would say that small businesses, including a small town—you might join up with other smaller entities, and, by creating a larger pool, you might be able to offer insurance to your employees at a more reasonable or lower cost. Would that be helpful in your case, do you think?

Ms. MENKE. Yes, it would be.

Senator ALEXANDER. Another idea was to broaden the ability of individuals in Iowa or Tennessee to shop across State lines for insurance, so they might compare prices and maybe have more choices. Do you think that might be helpful in your case?

Ms. MENKE. I don't know the answer to that, but the more competition that's out there, I think, the more competitive the prices would be.

Senator ALEXANDER. Thank you very much.

Both of those ideas were offered and rejected by Republican Senators in the health care debate. And, in fact, the health care bill makes it—law makes it more difficult for people to shop across State lines.

Ms. Ignagni.

Ms. IGNAGNI. Yes, sir.

Senator ALEXANDER. I'm told by staff that they called Iowa Blue Cross/Blue Shield, who said that the Blue Cross Transition policy, that had such high rates, that Ms. Menke talked about, pays \$1.81 in claims for every dollar they collect in premiums. How can an insurance company afford to do that?

Ms. IGNAGNI. Well, you can't maintain your operations if that continues.

Senator ALEXANDER. So, what do you do?

Ms. IGNAGNI. Well, you have to increase rates.

Senator ALEXANDER. Or?

Ms. IGNAGNI. Or you go out of business. And then consumers lose choices. And it's a tremendously disruptive situation.

Senator ALEXANDER. I'm a little confused, too, by some of the talk. What percent of Americans are covered by insurance companies that are not for-profit?

Ms. IGNAGNI. About 50 percent, sir.

Senator ALEXANDER. About half.

Well, so, those companies don't have profits?

Ms. IGNAGNI. No, you can't—if—you have to be in black to be in business—

Senator ALEXANDER. Yes.

Ms. IGNAGNI [continuing]. Versus the red.

Senator ALEXANDER. Well, what if you're—

Ms. IGNAGNI. Any for-profit——

Senator ALEXANDER. What happens to the money that puts you into the black? Where does that go? Does that go to some greedy person?

Ms. IGNAGNI. No. Well——

Senator ALEXANDER. Well, I mean, that's the insinuation.

Ms. IGNAGNI. As level-setting, we have, on average now, last year, 3.2 percent average profits.

Senator ALEXANDER. But, what happens to the black? I mean, where does the money go? It goes to salaries, right?

Ms. IGNAGNI. It goes to salaries and administrative operations.

Senator ALEXANDER. Could it go to reserves?

Ms. IGNAGNI. It goes to reserves.

Quite a lot of those administrative operations are designed to improve health care. Disease management, for example.

Senator ALEXANDER. Can it be used to reduce premiums or otherwise for the benefit of the members?

Ms. IGNAGNI. Yes.

Senator ALEXANDER. All right. So, when Senator Feinstein says that, in Michigan, Blue Cross/Blue Shield raised prices at a heavy rate—Blue Cross/Blue Shield is not for-profit. Is that not right?

Ms. IGNAGNI. Yes, it is. And, in fact, I know about that situation. They paid out a \$1.50 for every dollar they took in, roughly, in their individual product.

Senator ALEXANDER. OK. And in Iowa, the Blue Cross/Blue Shield, is that not-for-profit?

Ms. IGNAGNI. It's a not-for-profit plan, yes, sir.

Senator ALEXANDER. So, what we're talking about is pretending that we're going to control the rising cost of premiums by taking away profits from companies, half of which don't make profits, because they're not-for-profit.

Ms. IGNAGNI. Well, I think there's been tremendous amount of misinformation in the debate. And I think this is an important opportunity to really shine a spotlight on the real data.

Senator ALEXANDER. What happens, then, under the Feinstein bill, with insolvency? If I remember from my days as Governor, the State's responsible, is it not, for determining whether an insurance company might go broke? And if it goes broke, then, if I have its insurance, I don't get paid.

Ms. IGNAGNI. Yes.

Senator ALEXANDER. But, under this bill, the Federal Government might decide what the premium might be. So, the Federal Government might put an insurance company out of business. That would be all right, I suppose. But, it wouldn't be all right for all the people who had premiums with that insurance company, because they might not get paid.

Ms. IGNAGNI. I think Commissioner McRaith said this very well. I think it's dangerous to separate review of rates from solvency. You have to keep them together, and we think the State is the best place to do that. They're closer to the ground, and the insurance commissioners do a very good job.

Senator ALEXANDER. Commissioner McRaith, this is my last question; my time is up—but, what should we do, on this legislation, with the solvency question—should the solvency issue be sep-

arated from the decision about what the premium rates should be? I can foresee, under the bill, the possibility that you might decide that a rate is reasonable, but the Federal Secretary might overrule you and decide it's unreasonable, putting an Illinois company—making it insolvent and perhaps having customers lose their insurance. Do you see any concern there?

Mr. MCRAITH. Senator, solvency is the first priority for insurance regulators in every State. The Massachusetts example, I think, is extremely misleading. All of those companies, even with the decline of those proposed rates, would remain financially strong.

We do share the concern about the solvency priority and that protection for consumers. There's nothing in the bill, as I read it, that says the Secretary can overrule a decision by a State insurance regulator, regarding a rate approval or denial.

Senator ALEXANDER. But, doesn't it say, if the rate increase is unreasonable, the Secretary may review it, and your decision might be unreasonable, in the Secretary's opinion.

Mr. MCRAITH. What it says is that the Secretary shall defer to those States that have rate approval or denial authority. In many cases, as you know, States have that authority.

Tennessee is a great example, where you have the—among the lowest rates for small groups and in the individual market, as well; some would argue, because of that rate approval authority. So, the concern about solvency is important. Secretary Sebelius, of course, as a former insurance commissioner, understands that. We're confident we can work, as States, independently, to protect consumers from the possibility of an insolvency.

Senator ALEXANDER. Thank you, Mr. Chairman.

Mr. MCRAITH. Thank you.

The CHAIRMAN. Senator Casey.

STATEMENT OF SENATOR CASEY

Senator CASEY. Mr. Chairman, thank you very much. And I know that I missed some of the testimony. I wanted to review a couple of questions, which may plow through some ground you've already covered, but I wanted to make sure that we explored some aspects of the issue itself, but also the legislation that Senator Feinstein has introduced.

I guess I wanted to begin with Ms. Ignagni. With regard to the bill itself, that she spoke about today, and that I know you and others have provided commentary and testimony. I guess, I'm not sure I understand. Let me just get—for the record, you don't support the Feinstein—

Ms. IGNAGNI. No, sir.

Senator CASEY [continuing]. Legislation. OK.

And I know it's a, I guess, about a 12-page bill. It is not all that complicated, but having a health insurance rate authority in place, I think, makes a good bit of sense.

But, I wanted to ask you, in particular with regard to the corrective action section of the bill, where the Secretary or the relevant State insurance commissioner would review a proposed increase and then review the justifications for a rate increase and then make a determination about the reasonableness of that. Why don't you support that part of the bill?

Ms. IGNAGNI. A number of States, as you know, Senator, have the ability to do that—the overwhelming majority, No. 1. No. 2, in the legislation already—not the Feinstein legislation, but the existing legislation that was just passed—there are three changes, four actually, that we think are very important, and it explains why we believe what we do.

First, in the legislation for the first time, profits and administrative costs are capped through MLR provisions. Two, there—

Senator CASEY. Medical loss—

Ms. IGNAGNI [continuing]. Medical loss ratio—I'm sorry.

Also, No. 2, there's a new process where there will be guidelines, developed by the Secretary, that the States will implement, to assess the reasonableness of rates.

Senator CASEY. Right.

Ms. IGNAGNI. No. 3, there will be requirements about actuarial justification. And, No. 4, there will be requirements that the States receive resources to help with the person power necessary to support all that.

We think it's important to, one, let all of this proceed. It's going to proceed very, very quickly. We think it will provide the kind of public discussion that is important that will really shed light on the overall issues of rising health care costs. So, we've been very concerned about the prospect of new legislation in a context where, just a month ago, legislation was passed, number one, and where, in Massachusetts—I want to go back to that—we're very concerned about what's going on there.

Commissioner McRaith made the point that no plan would be close to insolvency. That, in fact, isn't correct in Massachusetts. There are a couple plans there that are very concerned about the impact of the arbitrary cap that's now been imposed. It has nothing to do with underlying costs.

Senator CASEY. OK. I just want to make sure I understand your position on this part of the bill. Let me ask you, hypothetically: Absent these changes that we just passed a couple weeks ago—would you be opposed to this policy, absent those changes?

Ms. IGNAGNI. I think, absent those changes, we'd really have to assess—thoughtfully assess your question. But, with the changes, I think it's a different environment.

Senator CASEY. So, you—

Ms. IGNAGNI. And we think the changes should be allowed to work, to see where we are. And we hope that there will be more of a discussion in States—

Senator CASEY. So, you—

Ms. IGNAGNI [continuing]. About the underlying—

Senator CASEY [continuing]. Agree with the policy behind this section of the bill, you just don't think it's necessary. You think the changes in place now will be sufficient.

Ms. IGNAGNI. We think the changes that are in place, coupled with what is already going on at the State level across the country, will allow the kind of discussion that you're looking for.

Senator CASEY. But, here's the problem for a lot of Americans. They feel as if they have no control, or no ability to impact the control, of rising costs. And, second, it seems like every time they pick up the paper, there's a health care executive who's making a lot of

money—millions and millions, if not tens of millions. And they scratch their head and say, “My rates went up, and this person’s making a lot of money.” I mean, do you understand that basic problem that people have?

Ms. IGNAGNI. Yes, most definitely. And I understand, also, that people are frustrated about the symptom, which is premiums. That’s what they see. They see a bill. But, that’s a reflection of the underlying—it’s not just cost, it’s utilization, as you know. It’s adverse selection.

Senator CASEY. Yes.

Ms. IGNAGNI. It’s a range of other factors.

Senator CASEY. What I can’t understand is, Why has your industry, for years, so aggressively—spending lots of money doing it, not just using your voice, but using your dollars—to oppose efforts to do just what you and I have just had a discussion about? I mean, why did we need legislation to say that you can only spend a certain percentage of your overall dollar on administration? Why did we need to even put these in place? Why couldn’t you do it on your own? Why couldn’t you be more transparent about profits and about pay—about what these executives have been paid? Why did we have to legislate at all, and why do we even have to have a discussion about additional legislative remedies?

Ms. IGNAGNI. Senator, I think this is a very fair question, and let me give you a very frank answer, in the spirit of your question. What I think is important for the country, as we talk about health care costs, is assessment of profits all the way down the line. Fortune magazine says, on average, we have 3.2 percent—on average. In the pharmaceutical industry, it’s 25 percent. In the device industry, it’s 11 percent. And we can go on and on about different stakeholder groups. This is not to castigate those groups, but just to say that, unfortunately, we’ve had an entire debate about health care insurance reform about the insurance industry, which is 4 percent of health care expenditures, and not enough about the other 96, which is, in fact, driving the premiums where they are.

The recent articles today in the Wall Street Journal, Sacramento Bee over the weekend, article after article, talking about rising health care costs. Politically, it’s difficult to take that on. I understand that. But, in terms of getting our hands around where we’re going as a country, we need to take the next step. So, we’re happy to be very—we want to participate. We’ve offered a number of remedies. Our industry stood in the front of the line, saying that we have to have insurance market reforms. We strongly supported that. Administrative simplification requirements, we strongly supported that. But, the next step is important to get our hands around rising health care costs.

Senator CASEY. I know I’m way over time. I’ll stop. But, it’s my sense you’ve been pretty reluctant to join these reforms. But, maybe we’ve made some progress.

Thank you.

The CHAIRMAN. Senator Coburn.

STATEMENT OF SENATOR COBURN

Senator COBURN. Thank you, Mr. Chairman.

I'd like to put into the record the article from the Sacramento Bee, because I think it raises an issue which the health care bill missed.

[The information referred to follows:]

[The Sacramento Bee, April 18, 2010]

CALIFORNIA'S HIGHER HOSPITAL COSTS ADD TO HEALTH INSURANCE HIKES

(bcalvan@sacbee.com)

This report is part of an ongoing series examining the factors driving up the cost of health care.

Behind every public uproar are some hidden facts. Here's one about rising health insurance rates in California: Sharp jumps in hospital costs are a big part of the story.

A Bee analysis of financial data from 300 hospitals statewide shows they collected \$25 billion from insurance companies between September 2008 and October 2009—an increase of more than a third since 2005.

Hospitals are charging insurance companies, and by extension their customers, billions of dollars for expenses not directly related to care. These include new hospital wings, new technology and services for the uninsured.

Some providers, including Sutter Health in Sacramento, have negotiated reimbursement rates with “markups” more than double what it costs them to provide services.

“It's become *en vogue* to crucify the insurance companies. . . . It's the hospitals that hold insurance companies hostage,” said Will Fox, a principal and consulting actuary for Milliman, a Seattle-based firm that has extensive experience studying hospital finances in California. Fox has done work for insurance companies, government agencies and business groups.

Hospitals say their charges to insurers are justified and necessary. But their byzantine pricing policies make it difficult to understand why costs are rising so quickly.

Under State law, hospitals have to report the total amount of money they spend to provide services to insured patients each year, how much they bill insurance companies and how much they wind up collecting.

Based on those numbers, *The Bee* found that California hospitals charged insurers an average of 53 percent more than what they told the State it cost them to provide services. In 2005, the gap was 40 percent.

For this story, *The Bee* obtained data submitted to the Office of Statewide Health Planning and Development by hospitals across California between October 2008 and September 2009, the latest available period.

INSURED CARRY HEAVY BURDEN

Rising hospital costs reflect billions of dollars in spending on items that don't directly relate to caring for individual patients with insurance, but are nonetheless charged to their insurance companies. These costs get passed along in the form of higher premiums.

For example, hospitals charge insurance companies to recoup lost profits from meager Medi-Cal reimbursements and to provide care to the poor and uninsured.

The cost of caring for the uninsured and covering unpaid debts has risen substantially in recent years as the economic downturn leaves more people without income or coverage.

California hospitals are also facing costs of at least \$110 billion for construction to comply with State earthquake safety codes.

No one doubts the economic strains hospitals are under, said David Hopkins, director of quality measurement at the Pacific Business Group on Health. The group is a coalition of some of the State's largest employers, including the University of California, Wells Fargo and Chevron.

Still, Hopkins is not entirely sympathetic.

“They're collecting and making all this money for other reasons—and because they can,” he said.

Hospitals in the Sacramento area, for example, have expanded considerably in recent years. New wings, investment in medical technology and expansion of services may give hospitals a competitive edge on their rivals, but also add to their costs.

Rising salaries for nurses, pharmacists, imaging professionals, as well as compensation for administrators and staff, are some of the variables that go into a hospital's cost equation.

The prices insurance companies pay to hospitals result from intense negotiations, with providers pushing for the highest prices for their services and health plans pushing for deep discounts.

In northern California, most hospitals now belong to large chains with the market power to largely dictate prices, according to researchers hired by the California HealthCare Foundation.

According to *The Bee's* analysis, Sutter hospitals have obtained better reimbursement rates from insurance companies than any other provider in the region.

As one of the region's largest systems, Sutter Health is a "must have" provider in an insurer's network because of its reputation among consumers, said William Sandberg, executive director of the Sierra Sacramento Valley Medical Society. Sutter Health leverages that power during negotiations, he said.

HOSPITALS' PRICE-COST GAP VARIES

Sutter Medical Center, for instance, received about \$420 million in payments for medical services from insurers between October 2008 and September 2009—127 percent more than it spent to provide those services, *The Bee* found.

At the other end of the spectrum is Kindred Hospital in Folsom, a small 39-bed facility that belongs to a national chain. It charged insurance companies 35 percent over cost.

Catholic Healthcare West, which operates the chain of Mercy hospitals in the Sacramento area, charged insurance companies anywhere from 40 percent to 80 percent above cost at its various capital hospitals, according to *The Bee's* analysis.

The UC Davis Medical Center received payments from insurers that were 57 percent above the hospital's costs. As with many other teaching hospitals, UCD's operating costs are significantly higher than those of Sutter or Mercy.

Sutter Health has faced scrutiny for its pricing practices before. Five years ago, CalPERS, the State's largest buyer of health services, forced one of its key insurers to drop 13 Sutter Health hospitals from its stable of providers because CalPERS deemed the Sutter facilities too expensive.

Sutter officials did not offer a direct rebuttal to *Bee's* findings about its pricing rates, but said the nonprofit health system, based in Sacramento, should not be judged on price alone.

Patrick Fry, the health system's chief executive officer, said the CalPERS action proves Sutter doesn't have the kind of market-controlling clout some of its critics describe.

Consumers, he said, should also consider value.

"When you go to a clothing store, do you know how much it cost to make? We buy things because we think the price is fair," Fry said.

Bill Gleason, a spokesman for Sutter Health, said the hospital system has kept price increases for insurance companies in the "single-digits" in recent years, but declined to elaborate.

"That's hugely important because of certain allegations by health plans who are pointing their fingers at health care providers," Gleason said.

He contrasted the "single-digit" rise in Sutter prices to the 39 percent increase in premiums announced earlier this year by Anthem Blue Cross on thousands of Californians with individual policies. The Blue Cross rate hike ignited a national debate over the rising cost of health care.

Gleason said the high quality of services provided at Sutter Health facilities saves on costs in the long run by reducing expensive follow-up care.

"We still have work to do to make our services even more affordable to patients, and we think we're making good progress," Gleason said.

RISING COSTS "A MYSTERY" TO EXPERTS

Researchers for the California HealthCare Foundation call rising hospital costs "something of a mystery."

Writing in the February issue of *Health Affairs*, a policy journal, researchers for the foundation said expenses for hospital care rose an average of 10.6 percent a year from 1999 to 2005, far outpacing inflation.

Insurers and hospitals negotiate discounted rates, and hospitals have different price structures for each insurance network they decide to join.

In some cases, hospitals have blocked efforts to shed more light on their pricing policies. Revealing the information, they say, could reduce competition in the industry.

Jan Emerson, a spokeswoman for the California Hospital Association, said hospitals are up front with their costs, as required by law. She noted that hospitals

must provide a price quote to anyone who asks, and file menus of procedures and prices with the State.

"The health plans are trying to shift the blame because they are under attack," Emerson said. "It's outrageous that they are trying to shift blame. They should be looking at themselves."

Still, the State's accountability requirements for hospitals have been criticized as weak by some business groups, consumer advocates and others. The prices filed with the State, for instance, rarely reflect what consumers actually pay.

While existing law doesn't prohibit insurers from disclosing cost information, some hospitals explicitly prevent insurers from releasing it.

Sutter Health, for example, does not allow Aetna to publicize its negotiated prices with Sutter hospitals on the insurer's Web site. Aetna said the information would allow subscribers to comparison shop.

Cedars-Sinai hospital in Los Angeles, considered one of the State's priciest because of its popularity with the rich and famous, was the only other California hospital to prohibit use of its pricing data on Aetna's Web site, the insurer said.

Last year, the California Medical Association and the California Hospital Association helped defeat Senate bill 196, which was aimed at giving consumers access to more information. The bill would have barred hospitals and doctors from refusing to allow insurers to reveal their pricing information to subscribers.

The legislation was supported by consumer groups and the insurance industry. They resurrected the issue last month in a new bill, Assembly bill 2389. The Assembly Health Committee plans to hear it in May.

Senator COBURN. The reason why we need another bill is because we don't have competition in the health care industry, and we're still not going to have it, after the reform bill that we've just passed. And this report shows that the average California hospital charges 53 percent more than it costs to care for the patients that they care for. So, when you talk about costs—the insurance industry—there's no question, there's been abuses and that they're not my friend when I'm practicing medicine, because they're not any different than the government bureaucrat that's getting ready to get in between me and my patient, as well.

But, we continue to treat the symptoms, and not the disease. The disease is cost. We did nothing in the new health law about \$250 billion worth of medical tests that nobody needs, but we were going to continue to order them in this country, because the trial lawyers are so strong. We did nothing about the fraud and waste, essentially coming to \$150 billion a year, of which all is paid for through insurance premiums.

If we don't attack the real problem, and if we refuse to use competitive markets—in the State of Oklahoma, we have an insurance commissioner, and she does a great job for our State, but she can't lower the costs. All she can do is control the rate premiums to where there is a viable insurance product being offered in our State.

I believe there are 30 States that have rate review. Is that correct?

Mr. McRAITH. That's right. In the individual market, it's—depending on how you interpret it—27 to 30 States.

Senator COBURN. Thirty States. What would keep the other States from having individual rate review in their States?

Mr. McRAITH. It's a function of State law.

Senator COBURN. Right. So, we're going to say—a State has chosen not to do that, so we're going to say that they're going to have to do that, and then—if they don't do it well enough, then we, in Washington, are going to sit down and say, "We don't agree with what you've done."

Mr. MCRAITH. Well, I think the concerns about solvency that were raised here today are—illustrate exactly why the States will take action. States do not want to segregate or separate solvency concerns from rate review. And for that reason, if this bill were to pass—and it would be an improvement for the State of Illinois—it's my expectation that States would pass rate approval authority to retain the connection between solvency and rate review.

Senator COBURN. But, they can do that already. They can pass—

Mr. MCRAITH. That's right.

Senator COBURN. They can do that already. And they have chosen not to do that. Yet, we're going to sit and tell them, "You have to." I mean, you know, it's pretty arrogant on our part, to say, to Illinois, "You're not doing it right, and here—you're going to have to do it. And if you don't do it, we're going to do it for you." I mean, that's, in essence, what we're saying. And we're fixing the symptom.

There's no question there's abuse in the insurance industry. There's no question there's excess salaries in the insurance industry. But, that's not fixing the problem. That is a symptom of the problem. The problem, as Ms. Menke finds, is that the costs aren't controlled, and therefore, experience and ratings come about to cover that loss ratio.

And so, with the adverse selection that's getting ready to come, in the next few years with the bill that the President has signed, those problems are going to get worse if we don't attack costs. So, why wouldn't we want to attack costs, rather than attack regulation of insurance firms?

Mr. MCRAITH. Senator, if that is true, the rate review process will only substantiate that as true. The rate review process, in fact, will be an opportunity to learn to gather information. What we know is, in fact, health insurer profits are significantly greater than 3.2 percent.

We do know, also, on that same list prepared by Forbes, public utilities were ranked 12th. Public utilities are the most highly regulated industry in the country. So, it's not rate regulation that has an effect on viability or profitability. We're confident that the rate review process will further inform the public discussion and policy-makers like you.

Senator COBURN. And the total profits in the insurance industry last year were?

Mr. MCRAITH. I think it depends on who you ask, and—

Senator COBURN. Well—

Mr. MCRAITH. That's the reason why the—

Senator COBURN [continuing]. Give me the range. Give me the range.

Mr. MCRAITH. It's in the billions of dollars, to give you an answer.

Senator COBURN. OK. And the total—

Mr. MCRAITH. Because the definition of "profit"—

Senator COBURN [continuing]. Waste—the cost of health care—

Mr. MCRAITH. Is unclear.

Senator COBURN. According to Thompson Reuters, the total wasted dollars in health care is \$700 billion. We're working on the

wrong problem. The problem is costs. And we're looking out here at this little symptom of the costs, and we're saying, "That's excessive." And I don't know whether it is or not; I don't know the inside workings of insurance companies. But, what I know is, we can do all we want out here; until we go fix the costs, we're not going to address the problem.

Ms. Turner, what's an alternative to what's been offered today that we have before in the Feinstein bill? What's another way of getting at the same problem?

Ms. TURNER. Well, it's a really different view of the world. And I think an opportunity has been missed to really engage an army of consumers in evaluating the best value for the health care dollar. If you had transparency of where those costs go, consumers could—and consumers had power to make decisions, which they don't now—we do not have a properly functioning market in the health sector—then you could have flexibility of offerings, you could have competition, and you could have transparency of price, leading consumers to find those companies that say, "You know, this one is really giving me the best value for the dollar. They're not paying their CEO an exorbitant amount. They do a good job of making sure fraud and abuse are monitored. They're giving me good value for my dollar." But, consumers don't have that authority. And I, frankly, think that's one of their great frustrations. And I'm concerned that this is going to perpetuate that—

Senator COBURN. And there's no connection with the purchase of health care and the payment.

Ms. TURNER. Exactly.

Senator COBURN. So, we don't—

Ms. TURNER. That's right.

Senator COBURN. I'm over time, Mr. Chairman. Thank you. Pardon me for going over.

The CHAIRMAN. I know Senator Franken has a committee he's got to get to, and he's been here a long time, so I recognize Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Well, thank you, Mr. Chairman.

I'm proud that over 90 percent of insured Minnesotans get their coverage from a nonprofit health insurer. The average medical loss ratio of those companies in Minnesota is about 91 percent.

I'm also pleased to have worked successfully with Senator Rockefeller to author the medical loss ratio provisions that are included in the health reform law and are inspired by Minnesota law. And I think that, along with these rate reviews that Senator Feinstein is proposing, minimum loss ratio is an important element in holding health insurance companies accountable.

From 2000 to 2007, American families saw their premiums almost double. During that time, we saw more than 6 million Americans become uninsured. And during that time, insurance company profits rose 428 percent. That's not good for consumers.

Ms. Turner, I read your testimony last night, and I appreciate your description of Safeway, which does a good job, their policy to provide wellness incentives and preventive care for their employ-

ees. You mentioned that this brings down costs. So, how does that do that?

Ms. TURNER. Companies have found, in a number of ways, that they can engage employees with incentives to get health assessments so they can find out in advance if they're pre-diabetic or if they may have—be at risk of heart disease. And then, in use—

Senator FRANKEN. That's like preventive care, then.

Ms. TURNER. Preventive care. And also, it allows coordinated care for people who are diabetic, so that they can have more tools to help manage their disease.

They also provide incentives for people to get preventive care—screening tests. And those kinds of incentives—

Senator FRANKEN. You write in it that they're provided free.

Ms. TURNER. They find that there's value for the dollar to provide those, free. But, of course, they're built in. I mean, it's part of the compensation.

Senator FRANKEN. But, that's what I find interesting. Because, in your testimony, you write that that's a great cost-saver—providing preventive medicine, free. But, also in your testimony, you say that—in the health reform law, you list coverage of preventive care as a factor that will result in increased premiums. So, this is actually kind of puzzling to me, because it seems to me that what you describe when a private corporation provides preventive care, free, it's an innovation—a cost-saving innovation, but that when we write that into the bill, that suddenly it's a burden. So, the same thing, providing—I mean, to me, I had to laugh. I am sorry, because it seemed like a bias, almost. A bias against the Federal Government doing something. The Federal Government does something, it's bad, and it's good if private innovation does it.

Ms. IGNAGNI, I wanted to talk to you. You wrote in here—you have a thing that says that, in California, a similar effort was made to cap prices charged by energy distributors and ignore supplier costs, leading to brownouts and reduced service for consumers. What year was that?

Ms. IGNAGNI. That was back in the 1990s, sir. I'll have to go back and check.

Senator FRANKEN. Are you aware that there was manipulation during that period.

Ms. IGNAGNI. Yes, sir.

Senator FRANKEN. And that the cause of these brownouts and the extra charges to the State of California was not caused by regulation, but was caused by companies like Enron ripping Granny off?

Ms. IGNAGNI. I am well aware of the Enron situation, sir. I'm also well aware of discussions that have been going on in California about lessons, with respect to arbitrary caps, and not taking into account, in the true sense of the word, supplier costs. It would be sort of—what we're seeing in Massachusetts, for example, is that there has been an arbitrary standard chosen. This is what's of significant concern. That relates to the medical—

Senator FRANKEN. Well, but the example you cited, actually, was a case—not of over-regulation—but a case of exploitation, deliberately cutting off supply of electricity to drive up the price. So, ac-

tually, your example is almost a perfect example of why we need regulation, not why we were suffering from too much regulation.

I'm sorry, and I apologize, because I only have so much time.

In a recent report from the Senate Commerce Committee, we see that the medical loss ratio for Anthem, of Maine, is 95 percent in the individual market, while just across the border, in Anthem, in New Hampshire, the loss ratio is 63 percent for the same product. Now, this amazes me, that you could literally step across the border and the efficiency of your health plan would decrease by 32 percent. Do you think that's fair and that something else may be going on there?

Ms. IGNAGNI. Yes, I do, sir, in fact. I think that a year-to-year analysis of loss ratios actually indicates that there are significant costs that go into the first-, second-, and third-year transaction costs in the individual market. First, broker compensation: it's the highest, as you know, in the first year. Second, all of the costs that go into assessing an individual—

Senator FRANKEN. And what year—

Ms. IGNAGNI [continuing]. This will all go—

Senator FRANKEN [continuing]. What year is Massachusetts—

Ms. IGNAGNI [continuing]. In 2014.

Senator FRANKEN [continuing]. Is New Hampshire in?

Ms. IGNAGNI. Pardon?

Senator FRANKEN. What year was New Hampshire in?

Ms. IGNAGNI. I have to go back and look at Senator Rockefeller's report, but I'll be happy to do that. But, usually, when you see those very low costs, they are reflective of first, second, and third year of—

Senator FRANKEN. Low costs or low ratio?

Ms. IGNAGNI. Low ratios. I'm sorry. I mis-spoke.

Senator FRANKEN. OK.

Ms. IGNAGNI. Low ratios. They're reflective of the earlier years of an individual, which is why the NAIC proposals, and why the NAIC practices, is to look at the entire life of a policy, as opposed to those first several years. I do think the individual loss ratio is an important issue, that I know we're talking to the committee about. Small companies, in particular in the individual market, very reliant on brokers, are going to find very, very difficult—not in 2014, but between now and 2014, because they have no other distribution mechanism to actually meet those 80-percent requirements. And so, it's—we think it's a serious concern that is quite legitimate, because there's no other distribution now. In 2014, there'll be the exchanges, and that will be a very different marketplace than it is now. But, if we want to preserve competition, we think, respectfully, that that should be looked at very carefully.

Senator FRANKEN. OK. Thank you.

Ms. IGNAGNI. Thank you, sir.

Senator FRANKEN. I am certainly out of time.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Hagan.

STATEMENT OF SENATOR HAGAN

Senator HAGAN. Thank you, Mr. Chairman. Thank you for holding this hearing today.

I wanted to talk a little bit more about transparency, and I know Senator Coburn had mentioned it in some of the discussion—where we were talking about the actual health care costs and the transparency or nontransparency of it. With health insurers arguing that the rising health care costs and increased utilization is driving up premiums, and patient advocacy groups saying that the health insurers' profits are too large, it's clear that the only way to get at the truth here is, I think, to increase the transparency, particularly the transparency of health care costs and the transparency of what health insurers and customers are paying for health care services.

I've been advocating for increased transparency throughout this debate on health care reform, and I'm pleased that our final bill contains some language to improve our understanding of health care cost and help better inform customers about their out-of-network cost. But, I think more needs to be done. And I think consumers and businesses need to know what they are getting, and for what price.

I know—in California—I think, Ms. Ignagni, you talked about this in your written testimony, too—that there's been studies—I believe Safeway did a study—

Ms. IGNAGNI. Yes.

Senator HAGAN [continuing]. Of colonoscopies in the San Francisco Bay area, and they found variation in ranges from 800-and-some-odd dollars to over \$8,000 for that procedure, and then gallbladder surgeries in that same region ranging from about \$4,200 all the way up to \$21,000. And the problem is, as a consumer, nobody knows what it is that they're paying for.

So, I'd be interested to hear what you have to say—any of you—on this issue and any thoughts that you might have for actually improving price and health care transparency.

Ms. IGNAGNI. Senator, I think, actually—and we've worked very closely with the insurance commissioners, and I'm sure Commissioner McRaith wants to say something about this—it's become evident, in their activities, that there needs to be the kind of transparency that you're talking about.

We're very supportive of this. We've done a very large survey about out-of-network charges. And it's shocking to see the wide variation in charges across the country. I'd be delighted to provide that for the record.

Ms. IGNAGNI. We think that there's important necessity for capturing more data. There is a provision in the legislation, where States will be collecting these kinds of data. And we think that's very, very important for both the legislature, as well as advocates and all entities within a State, because you have to take a State-by-State look, as you know, at what is going on, and we think that's an important provision. It's been a little-noticed provision, but I think it's an important part of the legislation, to provide that kind of consumer sense that they have a better tracking system than they do now on what providers are actually charging.

Ms. TURNER. Can I say, also—I think that, in order for the transparency to be effective, that consumers really need to have an incentive and the ability to make decisions based upon the information they have. If they feel that, "Well, it'll be interesting to know what that test is." But, as long as somebody else is paying for it—

to Senator Coburn's point—then there's no incentive for them to change their behavior and to seek that \$4,500 treatment, rather than the \$21,000. So, I think that getting to the point of consumer incentives and giving them the power and the ability to seek out that more affordable care is really a crucial part of reform.

Senator HAGAN. But, Mr. McRaith, some States are saying that this is proprietary information—not States—some insurance companies are saying that's proprietary information. Can you shed light on that issue? And with—Ms. Ignagni, would the insurance companies be willing to work together to make this more transparent?

Mr. MCRAITH. Senator, first of all, one of the great realities and incessant conflicts in many States around the country and in Illinois is the conflict between providers and payers. And it's interesting to hear the payers talk about the increase in cost, and we're not dealing with increased costs. Provider reimbursement rates, if you talk to the providers, have declined. Obstetricians used to be paid \$3,000 per birth. They're now paid less than \$2,000 per birth. So, the question is, Where is that savings being passed on to consumers? Our discussion today about rate approval and denial—rate review authority enhances that information, enhances the transparency. One of the kind of perverse realities of transparency, though, is: I'm not sure any of us would choose the cheapest doctor. I'm not sure, if we had a child who needed surgery, we want to send that child to the doctor who charges the least. So, that's going to be an interesting point—data point for us to track as we move forward.

I did want to emphasize, again, rate review is not necessarily a punitive tool. It is an informative tool, at a minimum, to help policymakers like you understand where our health care dollar is being spent.

Senator HAGAN. Actually, I had a neurosurgeon from North Carolina tell me that he needed a hip replacement. And, as a physician, he was looking for, obviously, quality care, but wanted to know what it would cost and contacted numerous physicians and couldn't get a good feel. So, it's not so much, you know, the cheapest. I think we obviously want quality, but I think people would go to the cheapest, knowing, too, that there was quality product—

Mr. MCRAITH. That's right. I agree with that, completely, yes.

Senator HAGAN. Ms. Ignagni, what about cooperation within the industry? And the proprietary point.

Ms. IGNAGNI. Two points. No. 1, the Secretary asked our industry to work together to undertake a very comprehensive transparency initiative, which we are well on the way with in—we've been conferring with the NAIC, and we're going to be, actually, very close to wrapping up that project. So, I think people will find that not only responsible, but a useful exercise, for health plans to be posting on their Web sites the kind of detailed information that's important for consumers to know.

No. 2, we've been talking, with a range of health care provider groups across the country, about how to do transparency in a better way, so that consumers can get the kind of information that you're talking about. We think the data systems that were added to the legislation—the data centers—that that's a very good start. We

think we can add to that, and rather than give you a specific “how” right now, I will tell you, we are conferring with a range of health care clinician groups, and we’ll have something to say—more to say about this in the future. But, I think there’s a lot we can all do together to be responsible and provide that kind of look that you’re inviting us to comment on. You’re right about it.

Senator HAGAN. Thank you.

Looks like my time has run out. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. I’ve just got this in—9:02 a.m., “United Health First Quarter Profit Climbs.” I’m interested in that, since they’re one of the two in Iowa that control most of the market.

“United health insurer, United Health Group, Incorporated, raised its 2010 profit outlook, Tuesday, and reported better-than-expected first-quarter earnings. The Minnetonka, Minnesota, insurer said it now anticipates a 2010 profit of 3.15 to 3.35 per share, up from the 2.90 to 3.10 share it projected earlier this year. The largest publicly traded health insurer, based on revenues, said it earned \$1.19 billion, or \$1.03 per share, for the 3 months that ended March 31. That’s better than the \$984 million, or 81 cents per share, reported a year ago. Revenue climbed 5 percent, to \$23.19 billion, from \$22 billion.”

Well, again, that just came in.

Ms. IGNAGNI. And sir, I’d be happy to submit for the record, the question that Dr. Coburn asked about aggregate profits in the industry. It’s about \$12 to \$15 billion, and we’re spending \$2.5 trillion. So, if you took all of the profits away—I believe it was Senator Alexander that made the point earlier—it’s about 2 days of health care expenditures. We’ll be happy to submit all of that, plus the other industries, for the record.

Ms. IGNAGNI. I, of course, hadn’t seen the United announcement, because we were here.

Mr. MCRAITH. Mr. Chairman, I’ve heard the discussion about health insurer profits, and I think there’s some clarity that should be added to this discussion. We regulate insurance companies at the low end of their capital levels. We do not regulate what is too much capital or surplus. A company can decide that, “surplus is not profit.” So, when a company tells you that it makes 2.2 percent profit, what it’s telling you is a discretionary decision that’s been made about how to report that number. It is not a reflection of capital received or the financial strength of that individual company, necessarily.

Ms. MENKE. I have a question.

The CHAIRMAN. I’m trying to get to Senator Reed, but go ahead, Ms. Menke, I’m sorry.

Ms. MENKE. I have a friend that does not have insurance, but the provider that he went to reduced his cost by 40 percent, versus someone that did have insurance. And I know Blue Cross/Blue Shield, if you’re a provider, you have to sign a contract, or you have to enter in a contract with Blue Cross/Blue Shield, right? And then you accept the rates that they will pay you—

Ms. IGNAGNI. Yes.

Ms. MENKE [continuing]. As a provider. So, for a person that doesn’t have insurance—goes to that same provider—my insurance

company is billed \$100 and he was billed \$60. I don't understand that.

Ms. IGNAGNI. Senator, do you want me to say—I think that a number of physicians are just very aware of the hardship, now, in our country, with the recession, and I think they're trying to do their part. And that is probably what explains that. A physician, knowing that an individual doesn't have any coverage, is trying to do his or her part to help out. I think that's a very noble thing, and I admire that.

The CHAIRMAN. But, isn't that also part of the cost-shifting that's going on, too?

Ms. IGNAGNI. Yes, sir, it is. It is part of the cost-shifting. There are two kinds of cost-shifting. One is uncompensated care. But, not to say that that physician wouldn't necessarily do that. I mean, we just don't know, until we see, at the end of the year—we can see trends. The other is the underfunding that a physician or hospital will receive from Medicare or Medicaid, because they're not paying 100 percent of the cost. So, you're quite right about that.

The CHAIRMAN. Thank you.

Senator Reed. I know Senator Reed has to go.

STATEMENT OF SENATOR REED

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

Mr. McRaith, you have the opportunity to view the filings of those insurance companies. In terms of the calculation of what they spend on medical care, that they submit to you as a regulator, and consequently profit in reserves, is that the same thing they show Wall Street, in your view?

Mr. MCRAITH. I think that the financial statements we receive are different, often, from—and contain different information from the—I think it's a 10(k) that gets filed, quarterly, with the SEC.

Senator REED. So, at least it is possible that they could come in to you, or to HHS, with the claim that they're committing 80-plus percent to medical care, and then turn around and go to the investment community and say that their profits are 30 percent; i.e., they've got two books.

Mr. MCRAITH. In fact, we've seen, historically, that publicly traded insurers will say, to stock analysts, they intend to continue to deliver value to shareholders by holding the line on claims payment and increasing premiums above medical inflation. Publicly traded companies, as you well know, Senator, have fiduciary duties to their shareholders.

Senator REED. No, I agree with that point. But, I think, going forward, we have to be careful not only about reviewing the ratings, but we also have to be very careful about having a consistent set of reports between regulators and financial statements, because otherwise they're going to be making, you know, 30 percent profit, yet they're spending 90 percent on health care cost.

Mr. MCRAITH. Well, I think again, what's important—not to repeat myself—is that the rate review process is not necessarily some punitive contentious exercise.

Senator REED. Right.

Mr. MCRAITH. I think you're absolutely right; it can be an informative tool for policymakers, like yourself and State legisla-

tures, to understand what is happening in the health insurance marketplace. Does it need to be refined?

Senator REED. Ms. Ignagni, when you talk about aggregate profits of the health care industry, do you measure that across the board, or just for-profit health providers?

Ms. IGNAGNI. Actually, Fortune magazine, Senator, measures it. We don't do it ourselves.

Senator REED. Well, what's the base?

Ms. IGNAGNI. It's the for-profits, which is why I said to the Chairman that the base for the for-profits is 12, and that's why I told the Senator that it was 12 to 15. With the not-for-profits put in, it's roughly 15 in the industry total.

Senator REED. All right.

Mr. McRaith, do you have a calculation of what the return on equity would be—or which profits, as you point out, could be a little disingenuous, because you can have as—Blue Cross of Rhode Island has \$400 million in reserves, and yet, they don't make a profit. But, they keep piling up the reserves.

Mr. McRAITH. And that is a concern. I know of one Blue Cross plan in another State—major State—where it was technically a nonprofit but had accumulated so much excess surplus that the insurance commissioner entered an order requiring it to either lower premiums or return money to policyholders. The required capital levels—surplus levels for an insurance company—a health insurance company—are somewhere above 200 percent. Insolvency, though, doesn't arrive until 70 percent. These companies are often above 600 percent of risk-based capital, which, for us, is the sign of a strong company, but it also is a sign that profitability, maybe, is more than the 2.2 percent some would lead you to believe.

Ms. IGNAGNI. Senator, may I just add, for the record—I'd be delighted to give you a longer answer; I know there's no time right now—but, I would note that with the discussion, in the middle of health reform, about insurance company profits, that once the data were provided and articles were written about how low they were, relative to the rest of the sectors, that some groups actually started talking about return on equity, because the data was very clear, the profits were low compared to pharmaceuticals, compared to device, etc, etc. I think that is, as you know, a reflection of, How you do on the investing of your reserves, which you have to keep capital—make sure that you're able to pay claims if something that you can't foresee today—H1N1, etc.—happens. But, I did note that there was a shifting of focus from the issue of profits, once the data were reported, and they were found to be very, very low, relative to the other sectors, to this issue of return on equity.

But, I'd be delighted to provide that information.

Senator REED. Fine. Profit is one measure, but return on equity is another measure. You can compare them to as—not only device makers and other parts, but you can—you know, if you compare them to manufacturing sector, insurance is doing pretty good, I think. So, it's all the point at which you're comparing.

Ms. IGNAGNI. And, Senator, this is our whole—the focus of our testimony is to send a strong message that we want to not only participate in the conversation, we want to help the committee assess what's really going on and how to address the issues—it's very

difficult, politically, to take on—which is the rising cost of health care. There hasn't been a real appetite to take that on in a significant way that would—

Senator REED. How has the industry taken on the rising costs?

Ms. IGNAGNI. Actually, there's a number of things that we've been doing. First, we made a strong commitment, in the context of health reform, to do administrative simplification. We have developed the language and the standards to allow that to proceed. That will allow doctors and hospitals to spend more time with patients. Millions of dollars have been invested to accomplish that, just the big banks, with ATM technology. And now we're bringing out portals, in New Jersey and Ohio, to test how to deliver the administrative simplification to physicians in a very simple way, so every physician can contact every health plan in one very simple Internet connection. That's one set of things.

A whole range of other things that we're doing about hospital re-admissions. We have data now, government data, that shows that we are doing a much better job than the traditional Medicare program, for example, on hospital re-admissions, which people are very concerned about. That's about coordinating—

Senator REED. My time has expired, but how do you respond to Mr. McRaith's point, that publicly-traded health care companies essentially described to Wall Street their strategies, denying claims and raising premiums above the cost of inflation? That doesn't seem to be a cost-saving strategy.

Ms. IGNAGNI. Sir, I don't—our members are organized to provide the highest quality care for the lowest price, to consumers and to business purchasers. Our members are very, very clear, both about their fiduciary responsibilities, their issues, with respect to maintaining solvency and maintaining responsibility for consumers. I don't know—

Senator REED. So, they have no responsibility to their shareholders?

Ms. IGNAGNI. I said that they have fiduciary responsibility. They have responsibilities, with respect to solvency, because we don't want hundreds of AIGs around the country that would be—that would increase significant volatility and create a situation that would be untenable. We found that situation—

Senator REED. But, what's their primary responsibility? Their fiduciary responsibility is to their shareholders.

Ms. IGNAGNI. Their primary responsibility is to—in a going concern is, whether you're for-profit or not-for-profit—to do the job that you have been asked to do by people who purchase your product. The people who purchase our products are consumers and businesses, and they expect that you're going to offer coverage to them. That's job one, to actually provide that. A part of that, also, is maintaining a going concern, whether you're for-profit or not-for-profit. So, all of these issues are very important, and we take them very seriously.

Senator REED. So, there's no distinction between a for-profit insurance company and a not-for-profit insurance company in the way they operate.

Ms. IGNAGNI. Both types of insurance companies have to have a profit, to be able to maintain operations, as you know. And I think

that, unfortunately, we're having a discussion about profits that are——

Senator REED. Well, frankly——

Ms. IGNAGNI [continuing]. Relatively small——

Senator REED [continuing]. We're having a discussion about firms that go to the Street and say, "Our strategy is, we're going to deny claims and raise premiums above medical inflation.

Ms. IGNAGNI. Sir, I thought I had said this, and I apologize if I didn't say it, but I don't know of any company that has gone to Wall Street that says that it is in business to deny claims.

Senator REED. Mr. McRaith, do you have any——

Mr. MCRAITH. I'd be happy to—well, let me, first of all, be clear——

Senator REED. Sure.

Mr. MCRAITH. In no way—going forward——

Senator REED. You're not, in any way, insinuating the operations of these companies——

Mr. MCRAITH. No. No, but, to be clear, there are companies, operating in States around the country, that have loss ratios of 50 percent; in some cases, less. All I would submit is that, if what Ms. Ignagni is saying is true—and I have no reason to doubt her, of course—then rate review will only enhance that and support that position.

I do want to clarify, AIG was not an insurance company problem. By the way, I know, Senator Reed, you're familiar with that discussion.

Senator REED. Yes.

Mr. MCRAITH. But, on the health insurance side, there are companies that have submitted, to stock analysts and others, exactly that statement. They will deliver value by holding the line on claims and increasing premiums above the medical inflation.

Senator REED. Well, I've got to yield my time. But, it seems to me that——

The CHAIRMAN. Move on.

Senator REED. I'll move on. But, everything I hear from doctors, hospitals, and everything else is, insurance companies deny claims and raise premiums.

So, thank you.

The CHAIRMAN. Thanks, Senator.

Senator Murray, thank you for your patience.

STATEMENT OF SENATOR MURRAY

Senator MURRAY. Sure. Thank you very much, Mr. Chairman, for having this hearing.

You know, when we were debating health care reform, thousands and thousands of my constituents wrote to me about their health care stories. And I remember one in particular, a guy by the name of Mark Peters. He owned a small technology company in Port Townsend, WA, my home State. And he told me that he offered health insurance to cover his employees. He was doing the right thing. He wanted to keep doing that, but he'd just received a letter from his insurance company raising his rates by 25 percent, and he just said that, "My business cannot sustain increases like that. No business can."

And the gall that rubs everybody is, at the same time as working families and people like Mark are struggling with these rising health care costs in this recession, the five largest health insurance companies took in a combined profit of 12.2 billion, which was up 50 percent—56 percent—over 2008.

In your testimony, Mr. McRaith, you talk about how the Illinois Department of Insurance can regulate health insurance premiums if the rates that are charged by health insurance are not adequate for what they're paying out. But, in this time when Americans are finding it so hard to pay for coverage, there seems to be no one determining if premiums being charged will result in extreme profit for the insurer, at the cost of those who desperately need coverage. So, I think that's really where the rub is, and it's kind of where the conversation has been going, whether or not we can regulate that. And I think it's a really important debate to be having.

We've gone over that, but, Mr. McRaith, I do want to ask you a question, because you also talk about how State insurance regulators and insurance commissioners have been regulating insurance companies for years, and a lot of people believe that States have better knowledge on their individual situations and are well-equipped to handle the rate regulation at the State level. But, having said that, there really is a large spectrum of premium increases requested to be approved throughout the country—some 13 percent increase, some 56 percent in another. And I wanted to ask you if you believe there's a role for the Federal Government to standardize base regulations across States.

Mr. McRAITH. I think that the State regulators, working with industry, working with HHS and others, can and will develop appropriate standards for all of the issues—loss ratio, expectations, premium rate reviews, the definition of an “unreasonable rate increase.”

I do want to clarify: Some of this conversation implies outright hostility between the industry and the regulators. And the truth is that we, I think, are very much in partnership in trying to implement the reform in a responsible and professional way, as you would like us to do.

But, I don't think that we need the Federal Government to set a standard. I believe the States can develop and implement the standard.

Senator MURRAY. OK. I want to come back to a question Senator Franken asked, and that is, on this committee, we have heard, over and over again, that prevention is not only good health policy, it's good economic policy. Private companies, like Safeway—Ms. Turner, you were talking about—have driven down health care costs by encouraging employees to focus on preventive care. And we know it's important. We know that if we want to lower the cost of health care—and Senator Harkin's been a champion on this—we have to focus people on getting insurance coverage for preventive services. And, really, the impetus behind requiring coverage of preventive services was to encourage people to see their physician before they got so sick that their problems were very grave and very expensive, resulting in more expensive care.

I'm going to ask you, Ms. Turner, If we want to make sure all Americans can access preventive services, why shouldn't we require coverage of those services?

Ms. TURNER. Thank you, Senator Murray, very much for your question.

Preventive services aren't free. Obviously, somebody is going to pay for them.

Senator MURRAY. Right.

Ms. TURNER. So, employers have made the decision—and many employers have—to build those into the cost of their benefit programs. It is a longer-term investment, in most cases. Very seldom do you get a short-term return from preventive care services, especially chronic care management. The problem with having the government get involved in this is that the benefits are often longer term, but the costs are more visible in the short term. And that's where, I think, intrusion into rate authority—you know, whether or not these are built into the costs—absolutely, they're valuable—but, I want people to make those decisions themselves about the value of the preventive care. Do they want to pay out-of-pocket? Do they want to have that built into the cost of their premium? You find, actually, with consumer-directed plans, when consumers have more visibility of the costs of their overall health plan, as well as the costs of those preventive services, that they actually increase the use of preventive services. So, consumers do this on their own, when given the authority to do that.

Senator MURRAY. I would say that a lot of the testimony that we've had, and a lot of the discussion we've had, is exactly the opposite, that people don't get preventive coverage. If it's an out-of-pocket expense, they wait too long, and they end up being a lot more expensive, which costs everybody, in the long run. There is some long-term preventive—diabetes coverage, that you mentioned. But, there's some short-term preventive care that saves dollars in the short term, as well. And having insurance companies cover that preventive care, it seems to me that the insurance companies will save money. Certainly, our hospitals and doctors, and certainly all of us who are paying premiums, will have lower costs by covering preventive care.

Ms. TURNER. Well, I will send you the studies by McKinsey and others that have shown that engaging consumers as active partners really does incentivize them to get preventive care, assuming that you arrange the finances in a way that makes this work for them. And that is possible, and that's why many companies have succeeded with these programs.

But, I think that simply adding the cost of a mammogram—the full cost—to a health insurance policy, where, before, the person was going to pay some part of that copayment, that cost then simply gets built into the cost of the insurance premium. And those aggregate costs then, over time, will increase the cost of health insurance, with everything else and all the other mandates that are included.

Also, employers now are making their own decisions about what they want to be included in that preventive package. And when those decisions are being made on a political basis, many more things actually wind up getting included.

Senator MURRAY. I'll let Senator Harkin debate with you, too.

But, I'm for people having personal responsibility. I think that's an extremely important part of health care coverage. But, I also think a lot of families today make decisions based on whether or not they have coverage. And if it's a matter of going to see a doctor, or not, because it's not covered, they'll choose not to, because money's too tight right now. So, having that insurance cover that allows them to make a cheaper choice for all of us, in the long run. And that's just how I see it.

Senator Harkin.

The CHAIRMAN. Just a couple things, then I'll turn to Senator Alexander for any last things that he has.

Senator Alexander, on your point, earlier, about going across States lines. I've never had a problem with going across State lines. In fact, we built into the health care plan—the bill that we have—the ability for regional compacts for States to act together. The only difference is that if somebody wants to come into Iowa to sell a health insurance product, I want them to clear it with the Iowa State Insurance Commissioner, to meet the standards of the State, so there's not this kind of race-to-the-bottom. So, I don't mind going across State lines, as long as there are some standards that the States agree upon. And that's what we put in the health care bill, that, as long as the States agree upon it, fine. I don't have any problem with that.

Second—and I said this to Senator Coburn when he left. I think, to a large extent, he's right about the fact. I think Ms. Ignagni said that, too. We're going after some of the symptoms, here. But, sometimes, I said to him, if a patient came to you, and said, "I've got a lot of problems," the doctor might say, "Well, what's your symptoms?" And if you said, "Well, I don't know. Guess," you'd say, "Well, how can I treat you if don't know your symptoms?"

That's getting to what Mr. McRaith is saying, that all we're trying to do here is to get transparency and to take a look at this. Yes, maybe it's the symptoms, but what does this mean? Perhaps the better we understand and know how the insurance companies are adjusting their rates, and how much is going to profits and how much is going to actual medical loss ratio, we'll get a better handle on the underlying problems.

Sorry that you have to be on the firing line, Ms. Ignagni, but that's where—you know, the rubber hits the road, is when people buy their health insurance policies. And when businesses and when—Ms. Menke, when it comes to her small town, I mean, that's what they see. They don't have any contact with the device manufacturer or what's happening to the pharmaceutical companies and things like that, but they do with the insurance companies.

So, I think it's very important for us to have this openness and to have that kind of review so that we can better understand it. That's all we're talking about, here, is to better understand it. And that way to maybe better understand the whole system.

Third, it was mentioned that the Iowa program, Wellmark, is a nonprofit. It's actually a for-profit company. It's an interesting for-profit company; it's a for-profit mutual company. And that's how they classify themselves.

Ms. IGNAGNI. Actually, sir, they're a not-for-profit Blue plan, but they pay taxes, as all Blue Cross/Blue Shield plans pay taxes. They aren't mutual—

The CHAIRMAN. Well, I just asked my staff to check with them, and they said—they, themselves, said that they were a for-profit company. They're listed as a for-profit mutual company. Not a stockholding company. But, they are a for-profit that returns the profits to their shareholders—well, what's the—

Ms. IGNAGNI. No, they don't have—

The CHAIRMAN [continuing]. Policyholders.

Ms. IGNAGNI [continuing]. Shareholders, actually, sir.

The CHAIRMAN. Policyholders.

Ms. IGNAGNI. Yes. It is organized as a mutual. They do pay taxes. All the Blue Cross/Blue Shield plans pay taxes. But, it's different than an investor-owned company, there's no doubt, which has shareholders, etc. So, that's very different structure, financially.

The CHAIRMAN. Well, it is a different structure, I can guarantee you, but they just list themselves as a for-profit.

On prevention, I have to take issue with Ms. Turner. We have a plethora of information that's come in to us, studies done, that the payback is not that long. The Trust for America's Health did quite an extensive survey on this, and found that certain investments—I don't have the data in front of me—pay back as early as 12 months—in the next year—in terms of certain intervention and prevention programs. So, there are short-term benefits. I think Steve Burg would also tell you that from Safeway and also—what's the other one—Pitney Bowes, they found that they had immediate savings within the next year or 2, right after that. So, it's not necessarily a long-term payback thing.

The other thing that I'd just say, is that on this prevention—is that, like a lot of things, we have studies that show that for mammograms, if you have a copay or deductible, even as low as \$10, it decreases the number of women over age 40, by 8 to 10 percent, who seek a mammogram. It's just one of those things, you know, "Well, if I'm feeling good and I've got a lot of bills to pay and times are tough—I feel OK, I don't need that."

Ms. TURNER. Well, the companies that have actually had the best success with getting utilization of preventive services are the ones that have created account-based consumer-directed plans, where they have insurance coverage, but for a higher deductible. And then they put those premium savings into an account that the employee then has control over. And so, it encourages them not only to seek better value for their care, but there's, really, a wonderful quote in this McKinsey study asking people, "Why do you use this preventive service?" And they said, "You know, I figured out that if I take better care of myself, I will save money in the long run." But, they provide the resources for people to do that by basically rearranging the premium dollars.

The CHAIRMAN. Well, I'd like to see that study, because I have other studies that show that health savings accounts are just the opposite. People bill the money—put the money in the health savings accounts. They don't want to spend it when they feel good. They say, I've got to save that in case—when I really get sick. And

so, they don't go in for early types of diagnosis and prevention, because they don't want to spend that money, because they feel good.

Ms. TURNER. Well, I'll be happy to send you these studies. But, it's really important, in the structuring of the plan, to build those incentives in for people to both have the resources, the information, and the ability to make the decisions to take care of themselves.

The CHAIRMAN. Well, in our health reform bill, we built that in by doing away with co-pays and deductibles for certain preventative measures. That's a kind of incentive—I hope, anyway.

Mr. MCRAITH. Mr. Chairman, just to illustrate your point, many of—if not all—Ms. Ignagni's members or AHIPs members agreed to waive the administration cost for the H1N1 immunization, a great public service. We think, in Illinois at least, that's one reason why the infection rate was more contained and compressed than many people had predicted. It was the lack of a copay or charge for patients to receive that vaccine—or that immunization.

Ms. IGNAGNI. And, Senator, Mr. McRaith is right about that. We worked with the Department on that. We thought it was an important intervention. We also are very supportive of this concept of “essential benefits,” including prevention. You and your staff worked very hard on that and we think that makes a great deal of sense, because—

The CHAIRMAN. And I want to thank you for working with us on that.

Ms. IGNAGNI [continuing]. And, for the reasons Commissioner McRaith said, that the data show, as Grace-Marie indicated, that we see very significant results, from a positive perspective—both the cost reduction, as well as quality improvement—when people do get into the system as early as possible. That's the reason that we're seeing, in the Medicare Advantage arena, for example, reductions in re-admissions, because of this full-bore health care coordination. One part of it is early intervention.

The CHAIRMAN. Senator Alexander.

Senator ALEXANDER. Thanks, Mr. Chairman. And thanks for having the hearing.

I think the witnesses have been very helpful, and I thank each of you for coming and being so forthright with your positions. And I know I've learned a lot from you, and I thank you for that.

Mr. Chairman, Senator Enzi and other members would like to submit statements and questions for the record, if we could do that after the hearing is over.

Senator ALEXANDER. Thank you. Thank you very much.

And just to summarize some of what my concerns are, I was thinking, as I was listening, this reminds me of the earmark debate. Senator Harkin and I are both on the Appropriations Committee, and every now and then somebody shows up and says, “OK, we're going to solve the Federal budget problem by getting rid of earmarks,” which are specific appropriations that Members of Congress request, and then have to be approved through Congress. And some people say, “Well, there have been some abuses, and this is the problem.”

The problem we will say, is that among other things, it's only about 1 percent of the spending, and it won't really do anything about the deficit.

That's the problem with this debate, and really with the new health care law. The new health care law, its fundamental mistake is to expand the health care delivery system that's already too expensive, and not focus on reducing cost. And what this hearing, as well-intentioned as it does, and Senator Feinstein's bill, is, it focuses on just a tiny piece of the health care issue, and doesn't really do anything about reducing health care costs. I mean, we've heard testimony today that the profits of insurance companies amount to about 2 days of the health care spending of the United States. Well, what are we going to do about the health care spending for the other 363 days? That's why we have big increases in premiums. And if we want smaller increases in premiums, or lower increases in premiums, or lower premiums, then we need to work together to try to find ways to reduce costs.

Senator Harkin and I have both talked about buying insurance across State lines, and I think our comments reflect different points of view we have. He said that he would be for that, but only if you met certain standards. Well, if I'm telling you what the right standard is, then the policy is not likely to be any cheaper. It might be more expensive, such as in the health care law, which has the minimum credible coverage provision, which, in effect, raises the cost of individual policies by 10 to 13 percent more than they otherwise would raise, according to the Congressional Budget Office.

Now, it is true that a number of people have subsidies to help them pay for that, but that's only 50 or 60 percent of the people. That's paid for by tax dollars. And the others have higher policies.

So, I would hope that, at some point, we could get to the rest of the issue; as Paul Harvey would say, "the rest of the story." Whatever insurance companies are doing right or wrong, that's 1 or 2 percent of the problem, in terms of their profits. What if we took it all away? We'd still have 98 percent of the problem, which is the health care delivery system.

And then, second, as a former Governor, I resist the idea of Washington telling Illinois or Tennessee what to do about this. I mean, Tennessee has decided it wants to regulate insurance premium increases. Fine. Illinois has decided it doesn't. I don't think we should be telling Illinois it should or shouldn't. So, to me, this is another Washington takeover of responsibility, and it's a focus on the wrong problem. It's barking up the wrong tree.

But, I think it's been very helpful to have the hearing, and I appreciate the chance to attend and participate.

The CHAIRMAN. Senator Alexander, thank you very much.

Anybody have any closing comments they wanted to say, before we leave here?

Ms. IGNAGNI. Senator, I would say that if the committee is interested in a specific set of proposals that could help bring costs under control, we'd be delighted to provide some ideas about that.

The CHAIRMAN. Well, we're always open for that.

Ms. IGNAGNI. Because that is what's driving premiums, in addition to all the issues now in the economy with adverse selection, which affects both the individual market, as well as small employers, as you know.

The CHAIRMAN. I still want to know the answer to the question I asked you earlier about bringing that transparency stuff to exist-

ing plans, rather than just new plans, and I don't know if I got a clear answer on that.

Ms. IGNAGNI. And we'll provide a very detailed response for the record, if that would be of use.

The CHAIRMAN. That would be fine.

Ms. IGNAGNI. Thank you, sir.

The CHAIRMAN. Fine.

Mr. MCRAITH. Mr. Chairman, first of all, thank you for the opportunity to appear before the committee.

I did want to emphasize that we, in Illinois and through the NAIC, intend to implement national health reform in a professional and responsible, collaborative manner. We'll work with AHIP and other groups, consumer advocacy groups, and we'll get it done. We have an obligation to the country and to our individual States to do that.

Ms. IGNAGNI. And sir, my commitment to that, we are working with the NAIC and the insurance commissioners. We will continue that work. I think you'll be pleased in seeing the direction of that work.

The CHAIRMAN. Thank you, Ms. Ignagni.

Ms. MENKE. I also want to thank you for having us here.

The CHAIRMAN. Yes.

Ms. MENKE. Earlier today, I thought I heard that, in Iowa, Blue Cross/Blue Shield recorded \$1.15 for every dollar of premium. In the letter that I have from the Insurance Commissioner, it said 90 cents from every dollar went out. So, I wanted to make that correction.

Ms. IGNAGNI. I think that was the broad loss ratio. We would be happy to provide, for the record, some very detailed—on the specific product, I think it was \$1.80 paid out for every dollar taken in. But, we would be delighted to provide that information for the record.

The CHAIRMAN. Thank you.

Ms. TURNER. Senator, thank you, again, for this hearing. I really appreciate your engagement in this important issue. I think that, going forward, it will be important—looking at the symptoms rather than causes issue—to continue to track the tax increases that were built into health costs, and how those do impact premiums over the long-term, not only in the short term, with some of the changes that go into effect this year; but many of the taxes on the industry itself, as a driver of health insurance premiums. I think it's just really going to be important to watch that, because consumers will be impacted greatly.

The CHAIRMAN. Thank—

Mr. MCRAITH. I'm very sorry, Mr. Chairman, but it occurs to me one thing I'd recommend or suggest to include in the record is some of the Massachusetts materials. There's been a lot of discussion about that today. There are actuaries that I think support the position I express, which is, these are not threatening the solvency of the companies. It's been a point of contention. I'd like to suggest that be included in the record.

The CHAIRMAN. I appreciate that. We have looked at it very closely, and we're very much aware of the different viewpoints and contentions that have been made about the Massachusetts system.

I request unanimous consent to keep the record open for 10 days so Senators can submit statements and questions for the record.

Again, thank you all very much for being here. I thought it was a very enlightening session. Thank you.

Ms. IGNAGNI. Thank you.

Mr. MCRAITH. Thank you.

Ms. TURNER. Thank you.

The CHAIRMAN. The committee will stand adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF SENATOR ENZI

Mr. Chairman, today's hearing is supposed to explore how to provide "protection from unjustified premiums."

Unfortunately, just weeks ago, Congress passed and the President signed a massive new law that will impose unjustified premium increases on millions of Americans. We know the new law will actually drive up premiums—according to the Congressional Budget Office estimates, average premiums for families will go up by \$2,100 because of the new law. This represents a 10 to 13 percent increase in premiums, because of the new law.

No one should be able to claim that this is any surprise. The Joint Committee on Taxation has repeatedly told us that the taxes in the new law will be passed on to consumers in the form of higher premiums.

This means the \$60 billion new tax on health plans, the \$20 billion new tax on medical devices (including hearing aids, crutches, pacemakers, insulin pumps for kids, etc.) and the \$27 billion new tax on prescription drugs will all ultimately be passed on to consumers. All of these new taxes will drive up the cost of health care in this country and result in higher insurance premiums.

Yet, we are here today examining how to protect consumers against unjustified premiums. This seems to be another classic congressional effort to close that barn door, long after the horse has already bolted.

If protecting consumers from unjustified premium increases is such a high priority, why was it not addressed anywhere in the 2,800 pages of new health insurance reform law? Senator Feinstein introduced the bill which is the subject of today's hearing on March 4, 2010, and the President advocated for creation of a health insurance rate authority as part of the proposal he published on February 22, 2010—a full month before the health care reform bill was signed into law. Why then was this proposal not included among the 2,800 pages of new law?

Unfortunately, the new law was never about lowering health insurance premiums—despite comments to the contrary from its supporters. A dozen studies and reports, published months ago, confirmed that the ultimate effect of this bill would be to increase health care costs and premiums. I suspect this will likely be the first of many hearings in which Members of Congress express their outrage over events that anyone with even a basic understanding of simple economics could have predicted.

I regret that we have ended up where we are today. I wanted to pass a bill that focused on decreasing the overall cost of health care—because you can't decrease the cost of premiums without decreasing the cost of health care. We know American families can't afford to pay ever increasing health insurance premiums. Small businesses can't afford premiums that increase twice as fast as inflation.

Three years ago, I proposed a bill that would have actually driven down health care costs for the Federal Government and small businesses. In 2006 I tried to pass a bill that CBO said would slash premiums for small businesses by 3 to 6 percent. The bill would

have allowed small businesses to pool their purchasing power and cross State lines to buy less expensive coverage.

Unfortunately, the bill was filibustered and as a result, we were not able to give America's small businesses the cost relief they desperately needed.

President Obama said premiums for American families would decrease by \$2,500 if we enacted health care reform. He said the status quo is unacceptable. Yet CBO has said the new law will INCREASE premiums for families buying coverage by \$2,100 a year. History will show that he and the supporters of the new law spent \$2.5 trillion to enact legislation that will actually drive up health insurance premiums for many Americans.

We can and should do better. I intend to focus on ways to eliminate the provisions in this new law that will increase costs and in their place enact reforms that will actually make insurance more affordable, both for consumers and the Federal taxpayer.

GALEN INSTITUTE,
ALEXANDRIA, VA 22320,
April 30, 2010.

Hon. TOM HARKIN, *Chairman,*
Committee on Health, Education, Labor, & Pensions,
428 Dirksen Senate Office Building,
Washington, DC 20510.

DEAR MR. CHAIRMAN: Thank you again for the opportunity to testify before your committee last week during your hearing on "Protection from Unjustified Premiums." I very much appreciated being able to discuss our concerns about Senator Feinstein's proposal to give the Federal Government authority to review health insurance premiums and impose penalties if they are deemed "unreasonable." I also was pleased to have a chance to talk about the many successful innovations in the private sector that are demonstrating success in holding down health costs and insurance premiums.

In this letter, I want to follow up on our discussion concerning preventive care. I don't think there is any question that preventive care, wellness programs, and early diagnosis and treatment are valuable and that our system needs to move much more in this direction than in continuing to pay more and more to treat people after they become acutely ill.

But preventive care costs money, too. If health plans provide coverage for 100 percent of the costs of colonoscopies and mammograms, for example, the added expense will be built into the cost of the premium. This increase in costs will be passed along to the consumer or the employer in the form of higher premiums.

I want to emphasize that I believe that investments in preventive care are valuable and humane. They save lives and can enhance productivity by treating patients early so they can get back to their jobs and families. But even the Congressional Budget Office questions whether preventive care will lead to savings for our health sector.

In an August 7, 2009, letter¹ CBO Director Douglas Elmendorf said:

Although different types of preventive care have different effects on spending, the evidence suggests that for most preventive services, expanded utilization leads to higher, not lower, medical spending overall.

That result may seem counterintuitive. For example, many observers point to cases in which a simple medical test, if given early enough, can reveal a condition that is treatable at a fraction of the cost of treating that same illness after it has progressed. In such cases, an ounce of prevention improves health and reduces spending—for that individual. But when analyzing the effects of preventive care on total spending for health care, it is important to recognize that doctors do not know beforehand which patients are going to develop costly illnesses. To avert one case of acute illness, it is usually necessary to provide pre-

¹Douglas W. Elmendorf, "The Budgetary Effects of Expanding Governmental Support for Preventive Care and Wellness Services," Letter to the Honorable Nathan Deal, August 7, 2009, at <http://www.cbo.gov/ftpdocs/104xx/doc10492/08-07-Prevention.pdf>.

ventive care to many patients, most of whom would not have suffered that illness anyway.

He continues:

Researchers who have examined the effects of preventive care generally find that the added costs of widespread use of preventive services tend to exceed the savings from averted illness. An article published last year in the *New England Journal of Medicine* provides a good summary of the available evidence on how preventive care affects costs. After reviewing hundreds of previous studies of preventive care, the authors report that slightly fewer than 20 percent of the services that were examined save money, while the rest add to costs.

According to a recent column by Dr. Charles Krauthammer, “A study in the journal *Circulation* found that for cardiovascular diseases and diabetes, ‘if all the recommended prevention activities were applied with 100 percent success,’ the prevention would cost almost *10 times* as much as the savings, increasing the country’s total medical bill by 162 percent.”

Preventive care is most likely to be successful when it is integrated into coordinated care programs that engage patients as partners in their health spending and health care.

Several studies from health plans that provide these coordinated care settings have demonstrated positive results.

Aetna does an annual study² of members in its HealthFund consumer-directed plans. The study of 2 million members shows that members with a Health Savings Account (HSA) had more than 15 percent lower primary care physician use for non-routine visits and more than 10 percent lower overall medical costs than members in a preferred provider plan.

The HealthFund plans employ a number of tools to allow patients to become more active partners in managing their health care and health costs, including HSAs and Health Reimbursement Arrangements (HRAs). They also have an incentive to get the best value for their health care dollars and to seek out information on quality and price. The Aetna study found that:

- HSA members are more involved in their health care: They are two and a half times more likely to use online tools and three times more likely to take a health assessment than their PPO counterparts.
- For full replacement HRA and HSA plans, employers saved \$118 million per 10,000 members over 5 years.
- Members in Aetna HealthFund plans spent more on preventive care and accessed higher levels of screenings for breast and cervical cancer as compared to members in traditional PPO plans; visited the emergency room less than their PPO counterparts; used the prescription drugs necessary to treat chronic conditions such as diabetes and heart failure at rates similar to PPO members; and used generic drugs at higher rates than members in a PPO plan.

These savings came from an integrated health plan that doesn’t simply tack on preventive care to traditional health policies but rather provides a battery of tools for consumers to become engaged in managing their health, including joining smoking cessation programs, exercise and weight loss plans, and other preventive and wellness measures.

Safeway’s Steve Burd is, as I wrote in my testimony, an evangelist for wellness programs, saying “If you design a health care plan that rewards good behavior, you will drive costs down.”³ Safeway covers the cost of recommended preventive care under its Healthy Measures program and then goes on to provide support programs and incentives for healthy behaviors. The operable issue is that the preventive care is part of an integrated system of care that includes incentives for healthy behavior.

I mentioned during the hearing a study by McKinsey⁴ analyzing the early impact of consumer-directed health plans. McKinsey surveyed more than 2,500 adult Americans with widely varying types of commercial health coverage. The study included more than 1,000 consumers with employer-based, full-replacement CDHPs, as well

²“Aetna HealthFund Consistently Delivering Meaningful Savings and Engaged Members,” Aetna Inc., April 1, 2010, at http://www.aetna.com/news/AHF_study.pdf.

³Victoria Colliver, “Preventive health plan may prevent cost increases,” *San Francisco Chronicle*, February 11, 2007, at <http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2007/02/11/BUG02020R81.DTL&type=printable>.

⁴“Consumer-Directed Health Plan Report—Early Evidence is Promising,” McKinsey & Company, June 2005, at http://mckinsey.com/clientervice/payorprovider/Health_Plan_Report.asp.

as a control group of traditionally insured consumers in 2005 and found that in CDHC plans:

- Consumers were more attentive to wellness and prevention: They were 25 percent more likely to engage in healthy behaviors and 30 percent more likely to get an annual physical. Why? Fifty-one percent of CDHC consumers agreed “If I catch an issue early, I will save money in the long run.”
- Consumers are more attentive to cost control and to behavior changes that could result in better health outcomes and cost savings over the long term. CDHC consumers were more likely to perform independent research to identify treatment options, for example, even when insurance was paying, and they were 20 percent more likely to comply with treatment regimens for chronic conditions.
- CDHC consumers were more value-conscious: They were 50 percent more likely to ask about costs and three times more likely to have chosen a less extensive, less expensive treatment option. They also were much more likely to visit an urgent care center than a hospital emergency room.

Prevention can be valuable and can produce savings, but to save money, it must be part of an integrated health program. Smoking cessation medications are most successful if integrated into educational and support programs. Some companies provide diabetics with supplies and medications at no cost if they make monthly visits to care coordinators who can detect early signs of the progression of their illness. Treatment must go beyond providing the medicines to include treatment for secondary issues such as pain and cardiovascular disease in a system of care. Cholesterol-lowering drugs are most likely to be effective when they are combined with a program of diet and exercise. Many private employers and health plans provide incentives for this integrated, coordinated care.

My concern with the Patient Protection and Affordable Care Act is that many of these programs will be lost as employers focus more on following the rules set by Washington than in continuing to develop and enhance programs with demonstrated success in coordinated and integrated care, including prevention. Just tacking screening tests onto an insurance policy will not get us to the goal of a more efficient health sector that engages patients as partners in managing their health care.

You indicated that the hearing record would be kept open for 10 days, and I hope that these comments could be included in the record.

I would very much welcome the opportunity to continue this discussion with you, and thank you again for the opportunity to testify.

Sincerely,

GRACE-MARIE TURNER.

[Whereupon, at 11:40 a.m., the hearing was adjourned.]