United States Senate
Committee on Finance

Sen. Chuck Grassley · Iowa
Ranking Member

http://finance.senate.gov
Press_Office@finance-rep.senate.gov

Opening Statement of Sen. Chuck Grassley, Ranking Member
Hearing, Covering the Uninsured: Making Health Insurance Markets Work
Tuesday, September 23, 2008

This has been a good series of hearings. We started off with two former Secretaries of HHS. We've examined why costs are rising but quality does not appear to be improving at the same rate. We've looked at who is uninsured and why. We explored how the tax code impacts health care coverage and what changes could be made that would increase coverage. We've considered delivery system and payment system reform.

In this last hearing in our current series, we're going to look at health insurance markets. It seems as though they don't work very well. It varies widely depending upon what state you happen to be in. The price difference for health insurance between New Jersey and Pennsylvania, two bordering states, is typically cited as an example of the impact of state regulations on a market. And while such criticisms are sometimes warranted, the issue is much more complex. States govern small group plans and individual plans. Those are the most expensive policies to sell and that has nothing to do with state regulation. Those policies are expensive because the cost to sell and administer them is higher – when you sell to one person at a time it costs more than when you sell to a group of hundreds or more. It is expensive because people getting coverage that way often tend to be sicker.
It is expensive because there is virtually no tax subsidy for an individual who is buying coverage in the individual market.

And yet if we simply require insurers to take everyone who applies, people will wait until they are sick to get coverage. Massachusetts has addressed this by requiring everyone to have health insurance. That state's experiment is in its second year. Our witness from Blue Cross will tell us how it's going. Time will tell whether having a law requiring people to buy health insurance means that people actually buy it. Many states require drivers to have car insurance. Most find enforcement to be difficult. So we will hear about how it's going in Massachusetts.

I am also interested in how insurers determine the rates they charge small businesses and the rates they charge individuals. The National Association of Insurance Commissioners has two model acts that address rating in the small group market. One limits variation in premiums based on health status – it uses "rate bands." Another allows for variation based only on age, geography and family composition. More states have adopted the first model than the second model. I will be interested

in what their experiences have been.

States are experimenting with different ideas in regulating health insurance. Oklahoma, where Commissioner Holland oversees the insurance market, has a functioning high-risk pool. I'm looking forward to hearing from her how it is working. Other states are thinking about trying reinsurance to help with the very expensive cases. All are ideas that have merit should be examined as we consider health care reform ideas.

In 1974, the federal government used the Employee Retirement Income Security Act or ERISA to limit the ability of states to regulate pensions and health insurance provided by employers. To the extent an employer provides coverage, it can't discriminate against the sick people. Everyone who takes group coverage must be charged the same rate, regardless of age or health status. That is essentially guaranteed issue and community rating. Every big business in America that offers health insurance lives under those rules. But when a state talks about imposing those same rules on the products it regulates, the state insurance market could disintegrate right before our eyes. As we look at health reform, we need to understand what works and what doesn't work in developing rules for the insurance market.

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