Testimony of Mila Kofman, J.D.
Superintendent of Insurance, State of Maine

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Subcommittee on Health
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Good morning. My name is Mila Kofman and I am the Superintendent of Insurance for the State of Maine. Mr. Chairman, I thank you and the Committee for your leadership and willingness to examine the private individual health insurance market and problems consumers experience when forced to obtain insurance through this market.

It is both an honor and a privilege to testify before you on this matter. By way of background, I lead the State of Maine agency which serves and protects the public through its regulation and oversight of the insurance industry. It is my job to ensure that insurance companies keep their promises to their policyholders. We do that through vigilant financial oversight and licensing of insurance companies, examinations of insurers' activities, and our review and approval of premiums and insurance products. It is my job to make sure that claims are paid! I also chair the Consumer Protections & Innovations Working Group (D Committee) of the National Association of Insurance Commissioners. (I am here on behalf of the Bureau of Insurance not the NAIC).

Before becoming the Superintendent of Insurance in Maine, I was an associate research professor at Georgetown University's Health Policy Institute, with a research focus on private health insurance. I studied regulation of health insurance products and companies, state and federal health care and coverage reform initiatives, new products, and market failures. I was the co-editor of the Journal of Insurance Regulation. Before joining the faculty at Georgetown University, I was a federal regulator at the U.S. Department of Labor, where I worked on issues affecting ERISA health plans.

I believe it would be optimal for us to address the health care crisis in America in its entirety and for the federal government to ensure that all Americans have the same basic rights and protections related to health care no matter where one lives or works. All Americans should have access to affordable, adequate and secure health coverage.

Maine and other states have been at the forefront of health care reform, developing innovative new initiatives to help finance medical care, and to restructure the private and public insurance programs to cover more people. In Maine, Governor Baldacci has been a leader in establishing meaningful new health coverage options for individuals – coverage that actually works for people with medical needs.

Maine's Dirigo Health Reform Act of 2003 was intended to deal with system-wide issues of cost, access and quality. The DirigoChoice insurance product -- a public/private partnership between the State of Maine and a private insurance company -- was designed to be a bridge for people who are not eligible for Medicaid and who cannot afford private insurance coverage, and is available to both individuals and small business groups. As of August, 2008, 11,512 people were enrolled (this includes small business workers, individuals, and their families); over 23,000 people have been served since the DirigoChoice program opened for business.[1] With additional funding, many more Mainer's could be covered.

Despite such efforts, there are 47 million Americans without health coverage and millions more with inadequate coverage. We live in the wealthiest and most advanced country in the world, yet we allow 18,000 Americans to die preventable deaths each year because they lack coverage. The uninsured problem is estimated to cost our economy $60 to $130 billion annually.[2] The leading cause of personal bankruptcies in the United States is illness (the majority of those filers were insured).[3] The uninsured problem and the way we finance medical care handicaps American businesses in a global economy. The Big Three automakers spend more on health care than on steel. Our per capita spending on health is higher than Germany, Canada, France, Australia, and the United Kingdom (UK). Although we outspend those nations as a percentage of GDP, we have worse health outcomes: Americans report more problems with access to care than in the UK and Canada; in terms of life expectancy we rank lower than Japan, France, Australia, Canada, Germany, New Zealand, the Netherlands, and the UK.[4]

You've asked me to discuss the individual health insurance market. Health insurance in the individual market is inaccessible for many, unaffordable for many more, and inadequate for many of those who have it. It is not a "free market" where purchasers have meaningful, or in most cases, any choice of products.

BACKGROUND: ACCESS, ADEQUACY AND AFFORDABILITY

Nearly 160 million Americans have health coverage through their employers. However, some workers do not have access to job-based coverage because their employers do not offer coverage, they are not eligible for coverage, they can't afford the premium share, or they are self-employed. Many do not qualify for public insurance programs.

The individual market is like a "residual" market – purchasers do not choose it when other meaningful options are available. The individual market is not a true "free market" in the traditional sense. A free market assumes that every individual who wants to buy a product can choose among sellers competing for his/her business. No one competes to insure sick people.

The reality of the health insurance market is that a carrier's success depends on its ability to minimize the risk it assumes. This means that each company is better off if it only insures people who will not need medical care. This provides incentives to cherry-pick healthy people, and limit the number of unhealthy people covered. While the desire of insurance companies to reduce risk is rational from a free market perspective, it creates a market which many Americans cannot access.

Unlike job-based coverage, in the individual market, with few exceptions there are no guaranteed access requirements; insurers are allowed to deny coverage to people with past, present, or perceived future medical needs. In fact, people with relatively minor needs, like hay fever, have had insurance applications rejected.[5] Also in most states, insurers are allowed to charge higher rates for individual market policies based on ones health. Even if a person with less-than-perfect health passes medical underwriting and can afford being surcharged for having past or current medical needs, their conditions may not be covered by the policy (e.g., permanently excluded through a rider or temporarily excluded through a pre-existing condition exclusion period).

Five states – Maine, Vermont, New York, New Jersey, and Massachusetts (merged market) -- protect consumers in the individual market by prohibiting discrimination based on medical needs through guaranteed issue and adjusted community rating requirements.[6] But if a consumer does not live in Maine or one of the other four states, that person may not have access to a private market, leaving them sick and without insurance coverage.

Other characteristics of the individual market make it difficult to conclude that it is truly a free market. Consumers face various hurdles.

First, a free market assumes that the consumer has the information needed to make an informed choice. However, unless required by state law, I have found that insurers do not voluntarily make copies of policies available before a person enrolls. Imagine buying a car and being told you can't see the car, you can only look at the brochure of the car. Americans shopping for insurance must rely on summaries of coverage, which may not provide sufficient details for them to estimate their out-of-pocket costs and in some cases may have incorrect information or be misleading. Even when one has a copy of the full policy, it is not always possible to figure out what one's out-of-pocket liability may be. For example, a study on maternity coverage, which I co-authored, found that for any given plan, anticipating out-of-pocket costs is difficult in the best of circumstances, and even if consumers could accurately forecast their health care needs for the coming year, lack of transparency in contract language makes it hard to know what expenses a plan will cover.[7]

Furthermore, generally an insurance carrier can change its benefits after a policy has been purchased. So unlike buying a car, where you get the tires, the engine, and other parts and you get to keep them, an insurer can change benefits any time. For example, plans can and do change prescription drugs on their formulary list. This means that if you buy one policy over another because your medicine is originally covered, your coverage for the medicine may disappear – and you are paying the same premium price. Imagine, buying a new car and the following month the dealer takes out the engine while you are expected to continue making payments. Maine strives to protect its consumers from such changes by limiting changes in benefits to those which are required by law or those which qualify as minor benefit modifications. In the case of a decrease in benefits, a benefit modification is deemed minor if the insurer can show that the total of any decrease in benefits does not decrease the actuarial value of the total benefit package by more than 5%. This limitation does not apply to changes in formulary, however.

ADEQUACY

Individual market coverage is not adequate and may indeed even be illusory. For example, a case we intervened in involved a child who was hospitalized with a serious mental illness. The insurance company decided that the child no longer required inpatient care, and instead, approved coverage for appropriate level of care provided in a residential setting with a complete educational program equivalent to a regular high school. The problem was the residential setting to which the carrier believed it was discharging the adolescent did not exist in Maine at that time.

In another case, where we successfully assisted the patient, the cost of treatment was high but coverage limits were low. The insurance policy paid a daily maximum of $1,500 for chemotherapy and radiation treatments for cancer. The patient did not realize that this amount would not be nearly sufficient to cover the real cost of these treatments; the cost of the first month of chemotherapy treatments exceeded $17,000; one injection alone cost $5,419.12. Radiation therapy treatments followed chemotherapy for six and a half weeks, five days a week. Paying more than a $500 monthly premium in 2005, the consumer believed the policy would provide meaningful coverage.

AFFORDABILITY

Affordability has been a significant problem nationally and in Maine. Maine's policymakers have not shied away from trying to address it, with recent comprehensive efforts in 2003 (the Dirigo Reform Act).

Nationally, nearly half of people with individual health insurance coverage spend more than 10% of their income on premiums and medical care.[8]

Escalating premiums make coverage unaffordable for many and prompt many others to reduce their coverage by switching to less expensive catastrophic policies and/or policies with reduced benefits. As of 2006, approximately 72% of policies in Maine's individual market had deductibles of $5,000 or higher and the average deductible was approximately $7,000.[9] The community-rated annual family premium for a major medical plan with a $5,000 deductible is $9,919.32;[10] for that particular plan some families pay more depending on their age. This year and last, Maine's policymakers have continued to address this through creative and innovative, incremental reforms which include reinsurance and a demonstration project to attract 25-30 year-olds into the pool.

Some argue that coverage would be more affordable without guaranteed issue and adjusted community rating requirements. However, states without these consumer protections have much higher percentages of the population without health insurance. In Maine -- a state with guaranteed issue and adjusted community rating -- 10% percent of the population is uninsured; in Texas, New Mexico, and Oklahoma – states without these consumer protections – at least 20% of the population is uninsured.[11]

High-risk pools have also been discussed as a way to address cost. In reality, many high-risk pools have had significant funding problems. In addition, "uninsurable" people – that is people who were denied coverage in the private market because of existing medical needs -- have had a variety of problems with high-risk pool coverage. These problems include: premiums that are too expensive, waiting lists in some states, limits on eligibility, inadequate insurance coverage (e.g., an annual limit of $75,000 on benefits, no or low coverage for prescription drugs), exclusions from coverage for existing medical conditions, and high out-of-pocket obligations (e.g., annual deductible of $10,000).

Because of the funding issues and barriers to consumers, only a small percentage of people the high-risk pools are intended to assist are enrolled. Although thirty-four states have high-risk pools,[12] all these pools together cover less than 200,000 people.[13] A nationwide study of 900 diabetic people with insurance problems identified 344 people who lived in high-risk pool states, yet only 7 signed up for the risk pool.[14] In Maine, a high-risk pool established in 1988 was closed in the early 1990s due to funding problems; its enrollment never exceeded 450 people.

Health coverage is expensive because medical care is expensive. Many factors contribute to the price of coverage. The price reflects the cost of medical care, administrative costs, and profits.

- In Maine, between 1997 and 2007, per member medical expenses paid by HMOs each month increased from $125 to over $300; nearly $250 of the 2007 cost is for hospital/medical care.[15] Anthem Health Plans of Maine, the state's largest health carrier, saw its non-HMO per member per month medical expenses increase from $160 in 2001 (the earliest year that data is available) to $221 in 2007.[16]
- Administrative expenses among Maine's HMOs increased from approximately $22 per member per month in 1997 to $26 per member per month in 2007.[17] Anthem's non-HMO administrative expenses rose from $8 per member per month in 2001 to $20 per member per month in 2007.[18]
- Since 2006, Anthem has declared nearly $152 million in dividends (reflecting profits for all their business in Maine -- individual, small group, and large group markets).[19]

Nationally, almost all major health insurance companies saw their profits rise from 2003 to 2007; by the end of 2007, the companies had combined profits of $12.6 billion, an increase of 170% from 2003.[20]

Profits of the health insurance industry have been subject to public scrutiny. While the number of uninsured continued to increase and American families struggled and made sacrifices to stay insured,

paying double-digit premium increases, it was reported that the CEO of United Health Care received a bonus of $1.6 billion dollars worth of stock options (in addition to his salary).[21]

NEXT STEPS

There is a strong and appropriate role for federal policymakers. Americans need and demand meaningful health insurance coverage options to access and pay for necessary -- in many cases lifesaving -- medical care and services. Working with the states, together we can address the health care crisis facing our nation's employers, workers, and families.

I encourage you to build upon the foundation that you established in 1996 through the Health Insurance Portability and Accountability Act (HIPAA). HIPAA established a floor of consumer protections including guaranteed access requirements for small business, nondiscrimination protections and portability for workers and their families. Those same consumer protections should be extended to the individual market. All Americans deserve the same rights and protections, whether they have health insurance coverage through their employer or buy it themselves in the individual market. Federal reforms should be modeled on HIPAA – a federal floor recognizing that states have and should be allowed to create and enforce higher levels of consumer protections as their populations demand. The federal government could:

- Establish standards for individual "health insurance" – the label of "health insurance" is applied to policies that cover little and leave people exposed to significant financial out of pocket expenses, as well as limited or no access to needed medical care.
- Prohibit discrimination against people with medical needs. Guaranteed access and adjusted community rating must be basic consumer protections for all Americans, no matter where they live.
- Help people pay for meaningful health insurance coverage.
- Make a federal financial commitment to states to help fund expansion programs and develop strategies for system-wide changes to address medical cost drivers.

Thank you for your consideration of this important issue. I look forward to assisting you as you look for ways to address the ever growing problem faced by millions of Americans without adequate health insurance and the rising costs of coverage for all Americans. I hope that you will create new meaningful options to provide access to affordable, adequate and secure health insurance coverage for all Americans.

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[1] Information provided at meeting of the Dirigo Health Agency Board of Trustees, September 15, 2008, and the Governor's Office of Health Policy and Finance.

[2] For highlights see, Press Release, January 14, 2004, "IOM Report Calls for Universal Health Coverage by 2010; Offers Principles to Judge, Compare Proposed Solutions" available at www.nationalacademies.org/onpinews/newsitem.aspx?RecordID=10874.

[3] See David Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, "Illness and Injury as Contributors to Bankruptcy" Health Affairs Web Exclusive February 2005. Many insured debtors blamed high copayments and deductibles for their financial ruin.

[4] See Commonwealth Fund charts, Spending on Health, 1980–2004 (Data source: OECD Health Data 2005 and 2006) and Access Problems Because of Costs in Five Countries, 2004, available at www.cmwf.org.

[5] A Georgetown University study on the individual market in 8 locations around the country found that applicants were rejected 37% of the time, and when they were offered coverage, 85% of the time the coverage had benefit restrictions, 20% of the time it had premium surcharges, and nearly 20% of the time had both. This does not take into account the people who were discouraged from applying, so the number of people squeezed out of the private market is likely to be much greater, absent guaranteed access requirements. See Karen Pollitz, Richard Sorian, and Kathy Thomas, "How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?" a

report for the Henry J. Kaiser Family Foundation, Menlo Park, California, June 2001. Furthermore, with few exceptions, insurers are allowed to charge people with medical needs higher premiums. A GAO study on HIPAA implementation found that carrier pricing of HIPAA guaranteed access products could result in substantially higher rates, ranging from 140 to 600 percent of the standard rate. See United States General Accounting Office, "Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators", Report to the Chairman, Committee on Labor and Human Resources, U.S. Senate, February 1998, GAO/HEHS-98-67.

[6] "Guaranteed issue" laws prohibit insurers from denying coverage to applicants based on health status. "Community rating" means that insurers must set prices for policies based on the collective claims experience of everyone with such a policy, and are not allowed to vary rates based on health or claims of a business or a person. Mila Kofman, Karen Pollitz, "Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change," Journal of Insurance Regulation, National Association of Insurance Commissioners, Summer 2006, Vol. 24, No. 4.

[7] Karen Pollitz, Mila Kofman, Alina Salganicoff, Usha Ranji, "Maternity Care and Consumer-driven Health Plans", a report for the for the Henry J. Kaiser Family Foundation, Menlo Park, California, June 2007.

[8] Additionally, one in every four insured Americans (insured all year with group coverage) spend 10% or more of their income on premiums and out of pocket expenses for medical care. Sara Collins, et al, "Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families," September 14, 2006, The Commonwealth Fund.

[9] See Bela Gorman, Don Gorman, Elizabeth Kilbreth, Taryn Bowe, Gino Nalli, Richard Diamond, "Reform Options for Maine's Individual Health Insurance Market: An Analysis Prepared for the Bureau of Insurance", May 30, 2007.

[10] Maine Bureau of Insurance, "Consumer Guide to Individual Health Insurance", last updated: September 2, 2008.

[11] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements). Henry J. Kaiser Family Foundation, statehealthfacts.org.

[12] Academy Health, "High-Risk Pools", State Coverage Initiatives, an Initiative of The Robert Wood Johnson Foundation, Washington, DC, www.statecoverage.net/matrix/highriskpools.htm.

[13] Laura Meckler, Anna Wilde Mathews, "McCain's Free-Market Health Plan Would Boost Role of High-Risk Pools", The Wall Street Journal, June 2, 2008.

[14] Karen Pollitz, Eliza Bangit, Kevin Lucia, Mila Kofman, Kelly Montgomery, Holly Whelan, "Falling Through the Cracks: Stories of How Health Insurance Can Fail People with Diabetes", Georgetown University Health Policy Institute and the American Diabetes Association, 2005.

[15] Maine Bureau of Insurance, "Maine HMO Aggregate Data – 2008 Quarter 2", last updated: September 12, 2008.

[16] Annual Statements made by Anthem Health Plans of Maine, Inc. to the Maine Bureau of Insurance; available upon request from the Bureau.

[17] Maine Bureau of Insurance, "Maine HMO Aggregate Data – 2008 Quarter 2", last updated: September 12, 2008. Anthem Health Plans of Maine for 2004 through 2007.

[18] Annual Statements made by Anthem Health Plans of Maine, Inc. to the Maine Bureau of Insurance; available upon request from the Bureau.

[19] Annual Statements made by Anthem Health Plans of Maine, Inc. to the Maine Bureau of Insurance; available upon request from the Bureau.

[20] Northwest Federation of Community Organizations, "Insuring Health or Ensuring Profit? A Snapshot of the Health Insurance Industry in the United States," July 2008.

[21] In order to settle a federal securities class action suit, William McGuire, former CEO and Chairman of UnitedHealth Group Corporation, returned 3.675 million shares of these stock options – originally brought to light in 2006 -- in early September. See Bob Chlopak, "Dr. William McGuire Joins Settlement of UnitedHealth Group Federal Security Class Action," PRNewswire-USNewswire, September 10, 2008.