

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

**Before the
U.S. House of Representatives
Committee on Energy and Commerce Subcommittee on Health
March 17, 2009**

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 health insurance 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 regulation and oversight of the insurance industry. My views about reforms and the private market have also been informed by my experience as a federal regulator at the U.S. Department of Labor (EBSA - ERISA health plans) and through my research on private health insurance as an associate professor at Georgetown University.

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 every American has the same basic rights and protections related to health care no matter where one lives or works. 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 small groups and individuals – coverage that actually works for people when they are sick.

Maine's Dirigo Health Reform Act of 2003 was intended to deal with systemwide 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 it is for both individuals and small businesses.

Despite such efforts by Maine and other states, 47 million Americans have no health coverage and millions more have inadequate coverage. The leading cause of personal bankruptcies in the United States is illness (the majority of those filing for bankruptcy were insured).¹

Moreover, the uninsured problem and the way we finance medical care handicaps American businesses in a global economy. The widespread lack of adequate health coverage is estimated to cost our economy \$60 billion to \$130 billion annually.² Even though our spending on health care is higher than Germany, Canada, France, Australia, and the United Kingdom (UK), both per person and 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.³

A great deal of national attention has been focused on our current health insurance system in this time of economic crisis. This morning, I will discuss the types of problems I am not seeing because of the insurance reforms we have in Maine. I will also describe one of the biggest problems I am seeing with the private health insurance market – affordability.

Guaranteed Issue and Adjusted Community Rating

The reality of the health insurance market is that a carrier's success depends on its ability to minimize its risk. 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. An estimated 20% of people account for 80% of health care spending.⁴ Avoiding even a small number of high cost individuals can substantially reduce an insurer's losses.⁵ 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. No one competes to insure sick people.

In the private health insurance market, insurers adopt practices that seek to minimize their risk of loss, including denying coverage for applicants who have health conditions or a history of health problems. People have had insurance applications rejected for such commonplace ailments as hay fever.⁶ In most states, insurers are allowed to charge higher rates for individual market policies based on one's health.⁷ 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 (e.g., permanently excluded through a rider or temporarily excluded through a pre-existing condition exclusion period).

Furthermore, although state and federal laws give individuals the right to renew coverage once they have bought it, guaranteed renewability provides no protection against rate increases – people who want to go out and shop other companies need to go through the full underwriting process all over again. In the group insurance market, state and federal laws require coverage to be available to all small businesses, but in many states, insurers are allowed to charge higher rates to small businesses whose workers have medical needs.

Since 1993, Maine has prohibited these practices. Insurers are required to sell coverage to any individual or small business that wants to purchase it. Called "guaranteed issue," this consumer protection law prohibits insurers from denying coverage because a person has a medical condition, now or in the past.

In Maine we also have adjusted community rating.⁸ Adjusted community rating is the requirement that insurers set prices for policies based on the collective claims experience of everyone with such a policy. In other words, insurers are not allowed to discriminate against individuals with past or current medical needs. They are not allowed to charge sicker people higher rates. Rate variations are allowed for such factors as age and geography within limits. These protections also apply to small groups. Businesses with sicker workers are not penalized by higher rates because they employ workers with health needs.

In addition to allowing people with medical needs into the private health insurance market, the combination of guaranteed access and adjusted community rating laws has protected Maine consumers from some of the problems experienced by consumers and small businesses in other

states. For instance, we do not have “rescissions” – the problem Chairman Waxman examined extensively as Chairman of the Oversight Committee. In Maine a consumer does not fear losing his or her insurance because he or she may have accidentally completed the application form improperly. People in other states have reported losing their insurance as a result of failing to remember and to indicate on the application such events as: seeing a marriage counselor years before, having been prescribed anti-depression medications after having a child, and for misinterpreting the question “have you had a headache” as meaning having serious on-going headaches. In Maine, because insurers are not allowed to consider this information in the first place when selling or pricing a policy, we have not had this problem.

Affordability

Premiums in both the individual and group markets have escalated rapidly, far outpacing increases in wages. Many individuals and businesses can no longer afford the prices charged. Those with insurance choose higher deductible policies in order to keep their premiums lower. 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 annual family premium for a major medical plan in the individual market with a \$5,000 deductible is \$9,919.32.¹⁰

Health insurance premiums are expensive because medical care is expensive. The private health care financing system has not effectively switched its focus and incentives from paying for sick-care to promoting wellness. The current system rewards inefficiency. Carriers have not been able to negotiate effectively enough with providers to keep costs contained.

Many factors contribute to the price of coverage. The price for private health insurance generally reflects the cost of medical care, administrative costs, and profits.

- In Maine, between 1997 and 2007, medical expenses paid by HMOs each month increased from \$125 per member to over \$300; nearly \$250 of the 2007 cost is for hospital/medical care.¹¹ 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 2007.¹²
- Administrative expenses among Maine’s HMOs increased from approximately \$22 per member per month in 1997 to \$26 in 2007.¹³ Anthem’s non-HMO administrative expenses rose from \$8 per member per month in 2001 to \$20 in 2007.
- Since 2006, Anthem has declared nearly \$152 million in dividends (reflecting profits for all its business in Maine -- individual, small group, and large group markets).¹⁴

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 employers 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:

- 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. Rate protections should also be extended to small group coverage.
- 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.
- 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.

It is equally important to have watchdogs in place to ensure that consumer protections are being enforced. State regulators already have the people and infrastructure to serve as effective watchdogs. States routinely police insurance companies through market conduct exams and rate and form filing reviews. State insurance investigators provide critical intelligence, identifying areas in which carriers are not complying with the law. I encourage you not to duplicate or replace the existing, effective state-based insurance oversight.

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

¹ 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.

^{2[2]} 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/opinews/newsitem.aspx?RecordID=10874.

³ Commonwealth Fund charts, “Spending on Health, 1980-2004” (Data source: OECD Health Data 2005 and 2006) and “Access Problems Because of Care in Five Countries, 2004”, available at www.cmwf.org.

⁴ Marc Berk and Alan Monheit, “The Concentration of Health Care Expenditures, Revisited,” Health Affairs, Vol. 20, No. 2, March/April 2001.

⁵ The private health insurance market is largely for-profit, with some of the largest companies publicly traded on Wall Street. These companies have an obligation to their shareholders to operate in ways that maximize profits, which means avoiding the risk of loss. Not-for-profit insurers must also avoid losses, since: (1) they cannot insure only sick people and stay in business absent government subsidies and; (2) they must compete with for-profit companies for “good” risks.

⁶ A Georgetown University study on the individual market in eight locations around the country found that applicants were rejected 37% of the time, and when 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 Soriano, 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.

⁷ 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 U.S. GAO, “Health

Insurance Standards: New Federal Law Created Challenges for Consumers, Insurers, Regulators”, Report to the Chairman, Committee on Labor and Human Resources, U.S. Senate, February 1998, GAO/HEHS-98-67.

⁸ Maine’s small group rating rules: no rate variation allowed based on gender, health status or claims experience; variations based on age, industry, and geography are limited to no more than 20% above or below the community rate; additional variation allowed for smoking status, group size, family structure, and participation in wellness programs. Maine’s individual rating rules: same as the small group rules, except that variation for industry, group size, and wellness programs do not apply.

⁹ 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 Maine Bureau of Insurance, “Maine HMO Aggregate Data – 2008 Quarter 2”, last updated: September 12, 2008.

¹² Annual Statements made by Anthem Health Plans of Maine, Inc. to the Maine Bureau of Insurance; available upon request from the Bureau.

¹³ 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.

¹⁴ Annual Statements made by Anthem Health Plans of Maine, Inc. to the Maine Bureau of Insurance; available upon request from the Bureau.