EXAMINING INNOVATIVE APPROACHES TO COVERING THE UNINSURED THROUGH EMPLOYER-PROVIDED HEALTH BENEFITS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH,
EMPLOYMENT, LABOR AND PENSIONS

COMMITTEE ON
EDUCATION AND LABOR

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C O N T E N T S

EXAMINING INNOVATIVE APPROACHES TO COVERING THE UNINSURED THROUGH EMPLOYER–PROVIDED HEALTH BENEFITS

Thursday, March 15, 2007
U.S. House of Representatives
Subcommittee on Health, Employment, Labor and Pensions
Committee on Education and Labor
Washington, DC

The subcommittee met, pursuant to call, at 10:30 a.m., in room 2175, Rayburn House Office Building, Hon. Robert Andrews [chairman of the subcommittee] presiding.

Present: Representatives Andrews, Kildee, Wu, Sestak, Loebsack, Hare, Clarke, Courtney, Kline, McKeon, Boustany and Walberg.

Staff Present: Tylease Alli, Hearing Clerk; Carlos Fenwick, Policy Advisor for Subcommittee on Health, Employment, Labor and Pensions; Michael Gaffin, Staff Assistant, Labor; Jeffrey Hancuff, Staff Assistant, Labor; Brian Kennedy, General Counsel; Megan O'Reilly, Labor Policy Advisor; Rachel Racusen, Deputy Communications Director; Michele Varnhagen, Labor Policy Director; Robert Borden, Minority General Counsel; Steve Forde, Minority Communications Director; Ed Gilroy, Minority Director of Workforce Policy; Rob Gregg, Minority Legislative Assistant; Jessica Gross, Minority Deputy Press Secretary; Victor Klatt; Minority Staff Director; Jim Paretti, Minority Workforce Policy Counsel; Molly McLaughlin Salmi, Minority Deputy Director of Workforce Policy; and Linda Stevens, Minority Chief Clerk/Assistant to the General Counsel.

Chairman ANDREWS. Good afternoon. The subcommittee will come to order. We would like to thank the witnesses for their participation this morning. We have assembled an excellent panel of people, and we are very happy that you are here.

There are 47 million Americans without health insurance. I believe that it is a foregone conclusion, and it is obvious it is a moral imperative that we do something about that. If you awoke this morning anxious about the fact that if your son or daughter had to go to a pediatrician, and you couldn't pay the bill, that is a serious and urgent and immediate problem that deserves the attention of the Congress and the entire country.

Beyond the moral imperative, though, it is becoming more and more clear to me that the economic burden of having 47 million uninsured is an unsustainable burden for the United States. In global competition, be it in autos, airlines, pharmaceuticals, software, we

will not compete successfully if our entrepreneurs are saddled with a system where they are cross-subsidizing the healthcare of people whom they don't employ, but are paying for either directly or indirectly through premiums and shifted costs and taxes.

I believe there is a strong economic imperative to get as many Americans fully insured and fairly insured as rapidly and as intelligently as we can.

Secondly, I believe there is a growing understanding that people who are insured are suffering and are burdened by the fact that they are cross-subsidizing people who are uninsured; that the problem of uninsurance is not simply an urgent life problem for those without insurance, it is also a family budget problem for those fortunate enough to have insurance.

By no means is reducing the number of uninsured the exclusive remedy for controlling health care costs, and I know Mr. Webber is going to speak to this later, and I want to tell him at the outset that I agree with what he said, that controlling health care costs is a global question, and it requires attention, I believe, to insurance market reform, to malpractice reform, to the use of technology and innovation that would reduce costs in many, many other areas.

It is the purview and jurisdiction of this committee to look at the employer-based health care system, and we have chosen to begin our examination by looking at ways that the employer-based health care system could be utilized to reduce the number of uninsured. Fifty-nine percent of Americans get their insurance through their employer. This is not to denigrate other means of acquiring insurance, but it is to acknowledge that the employer-based system has been successful and meaningful in many people's lives. So our mission, the committee will embark upon a mission to think about ways and creatively examine ways that, through the existing employer-based health care system, we can reduce the number of uninsured people in our country.

In the short run, we are going to examine the possibility of employer-based participation in the children's health insurance program called SCHIP. The Committee on Energy and Commerce is obviously responsible for the reauthorization of that program, and in consultation with the Committee on Energy and Commerce, we are discussing ways in which employers could become involved in extending employer-based health care coverage, building on the SCHIP system to decrease the number of uninsured people.

The committee intends beyond that to look at the interesting experiments that are being done by various State governments across the country. Massachusetts has already adopted some very meaningful reforms. California is considering very meaningful reforms, as is my State, New Jersey. My friend Mr. Kline's State, Minnesota, has already adopted a number of meaningful reforms. So we will be considering ways that the ERISA statute should or could be modified to facilitate those meaningful reforms in a way that we could reduce the number of uninsured and in a way that we could control costs.

Let me say one final point. I am acutely aware of the voluntary nature of the ERISA statute. I am acutely aware of the fact that the 59 percent of Americans who get their insurance through employers, almost all of them did so because the employer decided to,

not because the employer was required to by law. And although I would not, for one, rule out the idea of an employer mandate, I frankly think there are circumstances under which it is appropriate.

I come at this question personally from the starting point that we should be looking at optimizing incentives that would make an employer choose to insure rather than address the question of laws which would mandate an employer, require him or her to do so. This is a vast question and an important question, and I am certain that the Committee on Ways and Means and the Committee on Energy and Commerce, the Committee on Appropriations, many others will consider the consequences of this. So will we.

I look at today being the first in a series of discussions about ways that we can exercise our jurisdiction in a way that will control costs for employers and employees, improve the quality of the health care system in the country, and, most especially, reduce the number of uninsured.

At this time I am going to ask my friend and colleague, the Ranking Member of the committee, Mr. Kline for his opening statement, and I understand that Dr. Boustany would also like to make a statement. And at the conclusion of Mr. Kline's remarks, Dr. Boustany is welcome to do that.

John?

Mr. KLINE. Thank you, Mr. Chairman, for that concession and the opening remarks, and because of that, in the spirit of listening to our witnesses and not so much to us, I will add in realtime my opening remarks, which as I just told the witnesses, is always dangerous.

I am delighted that we are having this hearing, and I am pleased that the Chairman has decided to have a series of hearings. I think the discussion and the debate across the country in so many different venues and forums about trying to better understand how Americans pay for their health care, how they are insured for their health care, and how we ought to pay for or be insured for our health care is probably at the very pinnacle of important issues that we are going to be addressing, certainly in this Congress. That we are starting with employer-provided health insurance, health benefits is an important place to start, because, as the Chairman said, I think he used a number over 59 percent. I was looking at a report that said over 63 percent of workers who get their insurance through employee-provided insurance and some 15 percent of additional family members. So clearly it is at the core of our system.

I would just like to ask unanimous consent that we include the Employee Benefits Research Institute report earlier this month that discusses in some depth the employer-provided health insurance.

Chairman ANDREWS. Without objection.

[The Employee Benefit Research Institute report, "Employment-Based Health Benefits: Access and Coverage, 1988-2005," dated March 2007, is available at the following Internet address:]

http://www.ebri.org/pdf/briefspdf/EBRI_IB_03-20071.pdf

Mr. KLINE. And with that, let me thank the witnesses for being here and, again, the Chairman for holding this hearing, and I will yield back so Dr. Boustany may have a chance to speak.

[The statement of Mr. Kline follows:]

Prepared Statement of Hon. John Kline, Ranking Republican Member, Subcommittee on Health, Employment, Labor, and Pensions

Good morning. I'd like to thank Chairman Andrews for convening this hearing this morning. I expect this will be the first of many in our Subcommittee dedicated to exploring the current successes—and failures—of our nation's health care system. The delivery of health care is an issue of great importance to every one of our constituents, and I expect that as we take up this issue today and in the weeks beyond, we will find that on both sides of the aisles, we share many of the same concerns and issues. We may even agree on some solutions, while I expect we'll disagree on others. That said, this is a matter of indeed national importance, and I am glad to see that we are undertaking, as legislators, a thoughtful and complete examination of the issue.

I think it particularly fitting that we start the process today by an examination of our employer-based health care system, and the innovations companies are pursuing within that framework. I think sometimes as we look at the problems our health care system faces—be it the fact that there are too many uninsured Americans, or that costs are rising at rates which threaten the ability of businesses and individuals to purchase health insurance—it is too easy to overlook some fundamental successes.

Earlier this month, the nonpartisan and highly respected Employee Benefits Research Institute released a report examining trends in the employer-based health care system over the last twenty-five years. I would ask unanimous consent that a copy of this report be included in the record.

EBRI's report underscores some very important facts. First, we should be mindful that employment-based health benefits are the most common form of health insurance for individuals and workers in the United States. In 2005, 63.1 percent of workers were covered by an employment-based health plan from their own employer, and almost 15 percent had coverage through an employer as a dependent. Indeed, only four percent of workers eligible for health coverage through their employer are uninsured.

As EBRI's study makes clear, and I quote, "While claims of the demise of employment-based health benefits have been made, EBRI research has found that this is simply not the case. Employment-based health benefits have historically [been]—and continue to be—the most common source of insurance in the United States."

I raise this point today because I think it's important and appropriate, as we move forward to pay heed to one of the fundamental tenets of the practice of medicine itself: First, do no harm. As I said earlier, we absolutely face challenges in our current system, ranging from cost to access. But as we explore efforts to expand and build on our employer-based system, we must be certain that we do not take action that will exacerbate, rather than solve, these problems. I trust our witnesses will speak to these issues in greater detail.

I would also be remiss in not bringing to the Subcommittee's attention one bipartisan health care solution on which this Committee has long taken the lead. Of course I am referring to Association Health Plans, or AHPs.

Estimates indicate that 60 percent or more of the working uninsured work for or depend on small employers who simply lack the ability to provide health benefits for their workers. These employers are denied the ability to purchase quality health coverage for their workers that compares with the benefits large, multi-state companies have been offering to their workers for decades.

AHPs address both the access and cost issues at the heart of the health care reform debate, giving uninsured working families new hope for a solution that can give them access to quality health care. By giving small businesses the opportunity to pool their resources and increase their bargaining power, AHPs would help employers reduce their health insurance costs, and equally important, expand access to quality health care for the people for whom it is currently out of reach: uninsured working families.

In the last Congress, the House passed bipartisan legislation authorizing the creation of Association Health Plans with the support of three dozen Democrats. I

would hope that as we take up the health care debate in this Congress, we can look to common-sense, bipartisan solutions like AHPs as an issue upon which many of us can agree—or at least as a starting point as one part of the solution, if not the solution to every problem that our health care system faces.

With that, I welcome our witnesses. Our panel today is a distinguished one, and I look forward to their testimony as to how our current system is working, and how it may be improved.

Chairman ANDREWS. Dr. Boustany, you are recognized for 5 minutes.

Mr. BOUSTANY. Chairman Andrews, thank you so much for allowing me to make an opening statement, and I appreciate your comments and willingness to work on health care reform issues that come under the jurisdiction of this committee. And, Ranking Member Kline, likewise I appreciate you giving me the time to speak here as well.

As we look at health care reform on a broad front, I believe there are three main threadlines that we have to approach it on. One is information technology and all the aspects that go along with that that help reduce duplication, the privacy issues, and also informing the consumer. The second one would be choice, creating a wide range of choices which will bring more competition, open competition, into the marketplace that ultimately will drive down the cost of premiums regardless of who is paying those premiums. And the final piece is control, and I do believe that ultimately decisions should be made by the patient, the patient's family and the physician who treats the patient. And I think if we keep those three principles in mind as we go forward, I think we will follow the right path in health care reform.

As a heart and lung surgeon in a State, Louisiana, that has a very low insurance coverage level, I can tell you from personal experience I have seen many uninsured patients delay treatment, and I believe Congress has a moral and ethical duty to expand affordable coverage. Millions who lack insurance forgo needed care, making them sicker, and requiring more costly and invasive treatments down the road. In fact, a recent CBS poll found that 60 percent of uninsured adults said a family member had not sought care due to cost. A 2005 health affairs study found that half of all bankruptcies were due to medical debt.

We must expand coverage because it is fiscally responsible, and it is humane. Our coverage problem threatens every American's access to excellent medical care. Seven out of ten Americans want Congress to act this year. The trade-offs of solutions must be explored, but shame on us if we wait until 2008 to do anything to protect and expand coverage.

Americans overwhelmingly demand freedom to make health care choices that meet their individual needs, similar to the range of choices that Members of Congress enjoy through the Federal Employee Health Benefit Plan. They also want Congress to find ways to encourage employers to maintain and improve the health care insurance coverage they have agreed to provide to workers. Millions of Americans have worked their entire careers for health care benefits they now enjoy.

And with that in mind, lawmakers who champion single-payer proposals should consider that 70 percent of Americans who would

have to drop their existing coverage and trust Washington not to ration medically necessary care when a family member needs it most. Consider access problems in Canada's single-payer system. Two years ago that country's Supreme Court fittingly noted that, quote, access to a waiting list is not access to health care. Instead, Congress must customize coverage solutions for the diverse groups who lack insurance beginning with the low- to moderate-income American, older workers who don't qualify for Medicare, and smaller-business employees. Furthermore, more than half of uninsured have incomes below 200 percent of the Federal poverty level. In Louisiana, many families at this income level currently qualify, but are not enrolled in Medicaid or SCHIP.

Americans overwhelmingly support expanding SCHIP to cover more kids this year, and I am hopeful this will happen. Many families that make too much to qualify for government programs simply cannot afford premiums without some form of assistance, and I do believe changes to the Tax Code could bear fruit in expanding insurance coverage for these workers.

More than 6 out of 10 uninsured Americans are small-business employees, and I was pleased recently to see that Chairman Baucus in the Senate Finance Committee said he intends to create purchasing pools for individuals in small businesses so that they can take advantage of group rates for coverage, and I am hopeful that this committee won't rule this out. I believe we have to look at all options.

We also need to do more to make coverage portable between jobs because there really isn't true portability. Looming health care labor shortages and a shrinking pool of working taxpayers will exacerbate the problem. That is another issue I think this committee should look at.

Arbitrary cuts produce false savings. We need to look past government accounting gimmicks and address the real long-term problems that exist. As I mentioned earlier, we must invest in health IT to discourage waste, encourage wellness and help patients manage chronic conditions; and we must give timely, useful and valid information on cost and quality to providers and consumers. Medical societies must help to develop these quality measures, and publicly reported data must be risk-adjusted. I won't get into personal experiences with that.

I look forward to working closely with the members of this committee to expand access to affordable coverage and excellent medical care, and I look forward to your testimony.

Chairman ANDREWS. Thank you, Dr. Boustany. We look forward to your sharing of your experiences both as a legislator and as a physician in this process.

Without objection, any Member who wishes to enter an opening statement on the record will be able to do so.

Also the Medicare prescription drug law required the President to establish a Citizens' Health Care Commission to make recommendations about the uninsured. It also required the committees of jurisdiction to consider these recommendations. As part of today's hearing record, we will include the Commission report, a very small document, and the President's response in the hearing record as well.

[The report, "Health Care That Works for All Americans," dated September 29, 2006, may be viewed at the following Internet address:]

http://www.citizenshealthcare.gov/recommendations/finalrecommendations—print.pdf

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[The President's response follows:]

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

The Honorable Nancy Pelosi
Speaker
House of Representatives
Washington, DC 20515

MAR 13 2007

Dear Ms. Pelosi:

There have been several health system reform proposals over the past few months including the Citizens' Health Care Working Group (Working Group) report and the report of the Medicaid Commission.

This transmittal contains the Administration's position on these proposals.

The Working Group report was submitted to the President and the Congress on September 29, 2006. The report is required by section 1014 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173.

I appreciate the efforts of the Working Group in compiling their report and thank them for taking part in this effort. However, while we share many of the Working Group's goals for the U.S. health care sector, the Administration disagrees with the Working Group's recommendations on how these shared aspirations should be achieved.

The Medicaid Commission submitted their report to me on December 29, 2006 as required by directive. I appreciate the efforts of the Commission and thank them for their efforts and their report.

The Administration's proposals to expand access to affordable quality health insurance were put forward by the President in the State of the Union address and in his FY 2008 Budget. This approach to health care reform is based on making affordable health insurance available to every American through the power of individual choice, competitive markets and state-based innovation.

I look forward to continuing discussion with the Congress as to how we can work together to advance common goals of improving access, quality, and affordability of health care.

Sincerely,

Michael O. Leavitt

MICHAEL O. LEAVITT

The Administration's Response to the Recommendations of the Citizens' Health Care Working Group and the Recommendations of the Medicaid Commission

Background

- The Citizens' Health Care Working Group (Working Group) was created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, Sec. 1014.
- The Working Group was created to "engage in an informed national public debate to make choices about the services [Americans] want covered, what health care coverage they want, and how they are willing to pay for coverage."
- The result of the Working Group's community meetings and other activities were released in a June 1, 2006 report entitled *Interim Recommendations of the Citizens' Health Care Working Group*. Comments on the interim recommendations were accepted until September 1, 2006.
- The Working Group submitted its final recommendations in a report to the President on September 29, 2006.
- Part I of this Report to Congress provides the Administration's views and comments on the Working Group's recommendations.
- Part II of this Report to Congress contains the Administration's response to the Secretary's Medicaid Commission which was formed in May 2005 by Secretarial directive and reported to the Secretary on December 29, 2006.
- We also discuss details of the President's initiatives to make access to basic, affordable health insurance available to every American.

Part I. General Comments on the Citizen's Health Care Working Group Report

The Working Group chose an approach based on mandates and government intervention rather than an approach emphasizing consumer choice and options. In reviewing the Working Group's report, we have major concerns with some of the recommendations.

- The Administration agrees in principle with many of the Working Group's aspirations for the U.S. health care sector. However, the Administration disagrees with the Working Group's specific recommendations with regard to how these shared aspirations should be achieved.

- The Administration agrees with the Working Group that increasing affordability and expanding access to health insurance is an important goal.. We believe that the President's health initiatives (including health savings accounts, the implementation of Medicare part D, proposals related to association health plans, implementation of benefit flexibility in Medicaid under the Deficit Reduction Act, and, most recently, the President's Affordable Choices Initiative and his proposal to equalize the tax treatment between employer-provided health insurance and insurance purchased in the nongroup market) offer the best way to achieve that goal. We are engaged in an active agenda designed to achieve many of the goals identified by the Working Group including:
  - ✓ Improving efficiency and quality by emphasizing Value-Driven Health Care and health information technology standards; and,
  - ✓ Fostering community health networks through the President's Health Centers Initiative.
- Major areas of disagreement include:
  - ✓ The establishment of a national commission to define a core health benefit—an idea that the Federal Government can choose the best set of benefits for all Americans;
  - ✓ Limits on patient choice through the development of a national core health benefit; and,
  - ✓ The lack of consideration of, or specific recommendations on, cost control and affordability.

Improving Quality of Care and Efficiency

The President and Secretary Leavitt share a strong interest to promote quality of care and efficiency (Recommendation 5).

- A goal of the Administration is to shape the American health care sector into a system where doctors and hospitals succeed in delivering high value patient care.
- Presently, individuals often do not have the information they need to measure the value of the health care they receive. They do not know the price of their medical treatments, nor can they evaluate the quality of the providers who deliver their medical care.
- On August 22, 2006, President Bush signed an Executive Order (EO) to help increase the transparency of America's health care system - empowering Americans

to find better value and better care. This EO directs, to the extent permitted by law, Federal agencies that administer or sponsor Federal health insurance programs to:

- ✓ Adopt and implement interoperable health information technology as systems are upgraded;
- ✓ Increase transparency in the quality of health care;
- ✓ Increase transparency in the price of health care; and,
- ✓ Give consumers and providers incentives to care why all of these things are important.

- The Administration is promoting Value Driven Health Care (VDHC)—an initiative designed to improve the quality and affordability of health care. VDHC includes four cornerstones (health information technology standards, quality standards, price standards, and incentives) based on the following principles.
  - ✓ Consumers deserve to know the quality and cost of their health care. Health care transparency provides consumers with the information necessary, and the incentive, to choose health care providers based on value.
  - ✓ Providing reliable cost and quality information empowers consumer choice. Consumer choice creates incentives at all levels, and motivates the entire system to provide better care for less money. Improvements will come as providers can see how their practice compares to others.
  - ✓ To date, over 600 employers, governments, and other purchasers of health care goods and services representing 85 million Americans have agreed to adopt the President's VDHC Initiative.
  - ✓ Eighty of America's largest 200 corporations have signed on to VDHC. Twelve states' governors have signed VDHC Executive Orders. Eight State health plans for employees have signed on to VDHC.
- The Administration launched a health information technology initiative with the establishment of the Office of the National Coordinator for Health Information Technology in 2004.
  - ✓ This initiative lays the groundwork to provide electronic health records for Americans, while protecting their right to privacy.
  - ✓ This initiative supports the adoption of e-prescribing and electronic health records to facilitate adoption of interoperable health information technologies by hospitals, physicians, and other health care providers for improving quality and safety for all Americans.
  - ✓ Public-private collaboration is already beginning to show results. Accomplishments include: (1) recommendations on interoperability specifications between software systems; (2) encouraging adoption of health IT through certification of outpatient electronic health record (EHR) products meeting base-line criteria for functionality, security, and interoperability; (3) increased market focus on integrating health IT with value-drive health care; (4) changes in regulation to allow donation of health IT and training services between providers; and, (5) recommendations presented to the Secretary of Health and Human Services on how to move toward an electronic environment in the areas of consumer empowerment, chronic care, electronic health records, and bio-surveillance.

- ✓ Fifty-five office-based electronic health record products have now been certified by the Certification Commission for Health Information Technology seal. This is the main public-private body for certification of electronic health record products that meet specific criteria and standards.

- Through agencies such as the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services (HHS) has initiated efforts to improve the quality, safety, efficiency, and effectiveness of health care for all Americans.
  - ✓ AHRQ has promoted evidence-based practice in everyday care through establishment of Evidence-based Practice Centers (EPCs).
  - ✓ In 2001, CMS began the Quality Initiative to assure quality health care for all Americans through accountability and public disclosure. This initiative has included quality initiatives for nursing homes, hospitals, home health, and physicians' offices.
  - ✓ CMS has instituted and expanded a program of incentives utilizing differential payment updates for hospitals and home health agencies that report data to CMS for specific patient quality measures. This program was authorized under the Medicare Modernization Act of 2003 (MMA) starting with a hospital reporting requirement for 10 quality measures. The Deficit Reduction Act of 2005 (DRA), has allowed CMS to expand the hospital program to 21 measures for FY 2007. HHS is also developing a plan to implement a value-based purchasing program for Medicare hospital payments beginning with FY 2009.

National Core Benefits

The Administration does not support the establishment of a public/private Commission to define a set of national core benefits and services, nor does it agree that core benefits or services should be defined for all Americans (Recommendation 4). Rather, the Administration believes that every American should have access to a basic, affordable, private health insurance plan. Market competition among private plans is proving to provide affordable health care that meets consumer needs better than mandated benefits.

- The Administration believes it would be impossible for a federally appointed board to define a single benefit package that is able to address the diverse needs of Americans in their different income, family, geography, and health circumstances.
- Attempts to constrain consumer choice, such as defining a standardized benefits package, are counter to the market-based solutions supported by the Administration.
- A nationally determined set of core health benefits would place important decision-making about a person's health care in the control of Federal appointees, rather than allowing the consumer to choose the benefits that best meet their needs.
- As we saw with the successful implementation of Medicare part D, a government-run "one size fits all" benefit design is neither necessary nor preferred by consumers. For example, more than 90% of part D enrollees chose a plan other than the standard part D benefit.

Expanding Access

The Administration agrees with the need to expand access to basic, affordable health care, but proposes to do so through market-based approaches that have been a key part of the Administration's health care proposals over the past six years (Recommendation 1).

- The President's Affordable Choices Initiative will help make basic private health insurance available in a budget neutral manner. The Initiative would redirect institutional subsidies to help states make basic private health insurance available to low-income and hard-to-insure Americans to help them purchase health insurance.
- The President proposes a standard tax deduction for health insurance—similar to the standard tax deduction for dependents—equal to $15,000 for families and $7,500 for individuals. The deduction would be available to anyone who purchases insurance coverage – in the employment setting or in the non-group market. This proposal provides for equitable and fair tax treatment of insurance; an immediate incentive to all Americans to purchase coverage, particularly for those Americans who do not receive insurance coverage through their jobs.
- Health Savings Accounts have significantly expanded access to previously uninsured Americans. At least three million Americans take advantage of HSA's by enrolling in HSA-eligible health coverage; recent improvements made in the Tax Relief and Health Care Act may increase the number of Americans with an HSA.
- Expanding access can best be achieved by harnessing market forces to reduce health care prices, such as through Association Health Plan legislation, and at the same time preserve America's international leadership in medical innovation.
- The Administration is transforming health care through incentives, improved information for consumers on health care price and quality, and health information technology. Keeping medical costs competitive by improving health care price and quality transparency is critical to increasing access to health care services and insurance.
- The addition of a Medicare prescription drug benefit has provided access to prescription drugs for Medicare beneficiaries, and 39 million Medicare beneficiaries now have access to prescription drug coverage through Medicare part D or another source.
- The Administration proposes medical liability reforms to limit costly and frivolous lawsuits. These lawsuits waste scarce health care resources, increase health care costs, and drive doctors out of business.

Community Health Networks

The Administration agrees with this recommendation and is leading the way in developing and expanding integrated public/private community networks of health care providers (Recommendation 3).

- The Administration is leading an initiative (the President's Health Centers Initiative) to increase health care access in the nation's most needy communities. Through health centers, affordable primary and preventative health care will be made available to over 16 million uninsured and underserved people in FY 2008.
- Begun in 2001, this initiative will improve health care access for 1,200 communities through the support of new or expanded health centers. This expansion complements the President's efforts to increase health insurance coverage in private and public insurance programs.

Guarantee Financial Protection Against High Costs

The Administration supports the principle of taking care of our most vulnerable citizens while encouraging individuals to take financial responsibility for their health care costs (Recommendation 2).

- Society has already made the decision that sick or injured persons will be treated and that if a person is elderly, poor and disabled, pregnant, or a child needing protection, government has developed means of assuring access to and payment for health care.
- The Administration believes that costs can and should be kept down, and this can be better achieved through defined contributions rather than through defined benefits.
- One example of the Administration's approach to keeping costs down is the Medicare Prescription Drug benefit. Relying on private sector price negotiation, this benefit has lowered enrollee costs dramatically through a market based approach and consumer choice. The average monthly premium for a Medicare part D plan in 2007 is $22, far less than the $37 per month estimated at the time that the MMA was enacted.

Restructure End-of-life Services

This Administration recognizes the need to identify the best way to provide end-of-life care as more Americans live longer lives (Recommendation 6).

- HHS has undertaken a review of the advance care planning process, including advance directives, which enables an ongoing dialogue among providers, patients, and families, and promotes flexible policies that are accessible to everyone.
- The Department of Veterans Affairs (DVA) has made a significant effort to improve the provision of palliative and end-of-life care to our nation's veterans in the DVA's clinical settings.

Part II. General Comments on the Medicaid Commission's Final Report and Recommendations

The Administration supports many of the themes and recommendations of the Medicaid Commission's final report. The President's Affordable Choices initiative is consistent with the Commission's recommendations to provide access to health insurance to the uninsured, which will ensure that those individuals do not default into Medicaid.

- The Administration agrees wholeheartedly with the Medicaid Commission's core assumption, that "fundamental reform is needed in order to ensure the long-term sustainability of the Medicaid program." States now spend more on Medicaid than on education, and states are asking for the flexibility to develop reforms that meet the needs of their citizens.
- Underlying the Commission's recommendations are the following core principles:
  - ✓ States need flexibility to address the unique challenges in each state;
  - ✓ Investing in quality will yield returns in positive health outcomes;
  - ✓ Focusing on personal responsibility and rewarding healthy behaviors will lead to a more efficient program; and,
  - ✓ Encouraging beneficiary participation to ensure that health care decision-making is in the best hands—the individual receiving care.
- These are principles that the Administration fully supports and that are at the core of Administration policy and initiatives, such as the President's Affordable Choices Initiative, and the Secretary's Value-Driven Health Care Initiative.
- The Commission has clearly laid out recommendations to reform the Medicaid program, preserving the safety-net for low-income and disabled individuals, while allowing states to better control Medicaid spending.

Long-Term Care Recommendations:

- The Commission focused on two major components to the challenge of making sure that all Americans have access to long-term care services:
  - ✓ Ensuring that individuals adequately plan and prepare for their long-term care and retirement needs, and
  - ✓ Ensuring that Medicaid policy provides that individuals are served in the least restrictive setting possible.
- The Administration has been promoting long-term care planning and preparation though the Long-Term Care Consumer Awareness Campaign as well as the Long-Term Care Partnership Program.

- The Administration has been working to ensure that Medicaid long-term care services are provided in the least restrictive setting possible. The sustained focus on the President's New Freedom Initiative and the Money Follows the Person Initiative continually move us closer to that goal. Additionally, the Deficit Reduction Act (DRA) now allows states to offer Home and Community Based Services without a waiver. This is a multi-pronged strategy to ensure that individuals' preferences are respected and to reduce any "institutional bias".

Benefit Design Recommendations:

- The Administration agrees with the Commission's recommendation to support greater state flexibility to design benefit packages to meet the needs of specific populations. Additionally, the Administration supports the recommendation to reward beneficiaries who make prudent purchasing, resource-utilization, and lifestyle decisions. This is in the spirit of the Secretary's Value-Driven Health Care Initiative, which seeks to make price and quality more transparent for the consumer and to align incentives to reward prudent purchasing of health care.
- The Deficit Reduction Act of 2005 (DRA) gives states flexibility to improve their Medicaid programs. States now have the ability to use cost sharing, benefit flexibility through benchmark plans, and other tools to modernize Medicaid. The DRA enables states to increase affordability while expanding health insurance coverage for the uninsured. It also preserves EPSDT services for children under the age of 21 enrolled in the Medicaid program.

Eligibility Recommendations:

- Among the Commission's recommendations on eligibility is a recommendation to provide new options for the uninsured to obtain private health insurance. The Administration strongly supports this concept in a manner that is budget neutral to the Federal Government.
- The report also includes a recommendation to allow states to "*consolidate and/or redefine eligibility categories without a waiver, provided it is cost-neutral to the federal government.*" The recommendation makes clear that no mandatory eligibility categories should lose coverage. While the Administration supports state innovation, adequate safeguards would need to be in place to ensure that no mandatory eligibility groups lose coverage. In addition, cost neutrality will need to be consistent with the Administration's current principles.

Health Information Technology Recommendations:

- The Commission had a number of recommendations to promote investment in interoperable health information technology including the adoption of electronic health records for Medicaid beneficiaries. The Administration continues to support the adoption of Health Information Technology as a normal cost of doing business to ensure that patients receive high-quality care while protecting their privacy.

- The Secretary fully supports encouraging private investment in and adoption of, interoperable health information technology, including electronic health records-- a cornerstone of the Value-Driven Health Care Initiative. The Office of the National Coordinator for Health Information Technology continues to lead the Department's efforts to identify and adopt standards to promote interoperability.
- As a result of Section 6081 of the Deficit Reduction Act, Congress authorized $150,000,000 in new grant funds to States for the adoption of innovative methods to improve effectiveness and efficiency in providing medical assistance under Medicaid. Twenty-seven states have been awarded $103 million for 33 proposal concepts. Many of the grants awarded support States in their movement to Health IT transformation.

Quality and Care Coordination Recommendations:

- The Commission had a number of recommendations to improve the quality of care provided to Medicaid beneficiaries, as well as strategies for improving care for beneficiaries who are dually eligible for Medicaid and Medicare. The Administration supports developing further quality initiatives, and ensuring that individuals who are dually eligible for Medicare and Medicaid have coordinated acute and long-term care.
- Many of the Commission's quality improvement recommendations are consistent with the Secretary's Value-Driven Health Care Initiative and the spirit of the President's August 22, 2006 Executive Order. In order to create a more efficient system the Administration believes that transparency in pricing and quality will encourage beneficiaries and other consumers to seek out the best value in the health care they receive.

Addressing the Challenge of the Uninsured

While the Commission focused its recommendations on the Medicaid program and Medicaid beneficiaries, the report included recommendations to reduce the number of uninsured, thus diverting individuals who might have become eligible for Medicaid in the future.

Specifically the Commission recommended:

> *" ...allow states the option to offer premium assistance to allow buy-in to job-based coverage or to purchase other private insurance"* and *"The federal government should provide new options for the uninsured to obtain private health insurance through refundable tax credits or other targeted subsidies so they do not default into Medicaid."*

These recommendations are generally consistent with the spirit of the President's Affordable Choices Initiative and his proposed standard deduction for health insurance; the interaction between both proposals helps make basic private health insurance readily available, and provides subsidies to individuals who cannot afford insurance.

- ✓ The Affordable Choice Initiative provides help for states to make available basic private health insurance for all Americans by redirection institutional subsidies to help low-income and hard-to-insure Americans to help them purchase health insurance.
- ✓ The President also proposes a standard tax deduction for health insurance that will level the playing field between employer-sponsored health insurance and the individual market – allowing more individuals to be able to afford health insurance.

By ensuring that private health insurance is readily available and affordable, we may reduce the number of individuals who might otherwise become Medicaid beneficiaries. This will preserve the Medicaid program as a sustainable safety net for those who are most vulnerable, namely disabled and elderly individuals.

11

Chairman ANDREWS. A vote has just been called on the floor. With the indulgences of the witnesses, the members of the committee will go cast their votes. The committee stands in recess.

[Recess.]

Chairman ANDREWS. Ladies and gentlemen, we will reconvene. We thank the witnesses for their indulgence.

We are very much looking forward to hearing from the witnesses this morning. We are going to hear from them in the following order. Our first witness will be Ms. Joan Alker. She is the deputy executive director of the Georgetown Center for Children and Families, and a senior researcher at the Health Policy Institute of

Georgetown University. For the last 12 years her work has focused primarily on public coverage for low-income families through Medicaid and the SCHIP program. Dr. Alker holds a master's in philosophy and politics from St. Anthony's College, Oxford University, and an A.B. With honors in political science from Bryn Mawr College. Welcome. It is great to have you with us.

Our second witness will be Mr. Brian England. Mr. England is a small-business owner in Columbia, Maryland. He has owned an independent auto repair shop called British-American Auto Care in Columbia, Maryland, since 1978. His auto shop is made up of 20 employees, which includes part- and full-time workers. He will be giving us some advice on repairing our carburetors as well, I'm sure, if we have a problem. He is a member of the Howard County Chamber of Commerce, and we welcome him.

Our third witness is Mr. Andrew Webber, who joined the National Business Coalition on Health, which is NBCH, as president and CBO in June 2003. NBCH is a national not-for-profit membership organization of 90 local and regional business coalitions on health, dedicated to health system reform through value-based purchasing. Mr. Webber was a vice president for external relations and public policy at the National Committee for Quality Assurance. Welcome, Mr. Webber.

And finally, the last witness will be Dr. Linda Blumberg. She is an economist and principal research associate at the Urban Institute. Dr. Blumberg has focused her career and research interests on issues of health care policy and economics. She has been at the Urban Institute since 1992. From August 1993 through October of 1994, she served as health policy advisor to the Clinton administration during its initial health care reform effort. Some of her works include a variety of projects related to private health insurance and health care financing, building a roadmap to universal coverage in the State of Massachusetts, and effects of the implementation of the SCHIP program on the insurance coverage of children.

We are delighted to have each of you with us. In front of you, you will notice a box with three lights. Each witness is given 5 minutes to summarize his or her written testimony. Your written testimony will be included in full in the record of the hearing. We would encourage to you summarize your written testimony within the 5 minutes that is given. When you are 1 minute away from your time expiring, a yellow light will go on, and when your time has expired, a red light will go on, and we would ask you to try to stay within the guidelines to the extent that that is possible.

Again, to reiterate, the complete statements of the witnesses will be included in the record of the hearing.

So, Ms. Alker, we would like to start with you. Welcome to the committee.

STATEMENT OF JOAN ALKER, DEPUTY EXECUTIVE DIRECTOR/ SENIOR RESEARCHER, CENTER FOR CHILDREN AND FAMILIES/HEALTH POLICY INSTITUTE, GEORGETOWN UNIVERSITY

Ms. ALKER. Thank you very much, Chairman Andrews, Representative Kline. Thank you for the invitation to testify at today's hearing. As you mentioned, Congress this year will be reauthor-

izing the State Children's Health Insurance Program, we call it SCHIP, and as Members consider SCHIP, they will naturally start thinking about the issue of integrating public and private coverage, which is some of what I am going to talk about here today. And over the years some States have used their SCHIP and Medicaid programs to explore ways to use employers' contribution to reduce public costs. This has been one of the primary motivations to establish what are commonly known as premium assistance programs. And premium assistance programs use Medicaid and SCHIP dollars to subsidize the purchase of private coverage, typically employer-based coverage.

So let me talk briefly about what we have learned from these programs so far. With some exceptions, premium assistance programs have not been terribly successful in terms of enrollment. In New Jersey, for example, which runs a highly regarded premium assistance program, and I am not just saying that because it is your committee, they have only had about 700 to 800 family members enrolled in that program over the years.

There are certain logistical challenges that States face, but the primary reason for low enrollment is simply that employer-sponsored coverage is not widely available to low-wage workers. When private insurance is available to low-wage workers, it is often very expensive. In 2004, for example, the average cost of covering a family through Medicaid was $7,418, whereas the cost of covering that same family through employer-sponsored coverage was almost $10,000, 34 percent higher, and this annual cost of almost $10,000, we have to remember, for private coverage doesn't include significant additional costs that families themselves will incur, such as copayments, deductibles and other coinsurance.

As a result, there are two principles that I believe should be given primary consideration when considering premium assistance approaches. First, participating families should not receive fewer benefits or face higher cost sharing than they would in Medicaid or SCHIP. Some States have received waivers of the so-called wraparound rules which ensure this. In particular, as I mentioned, cost sharing for private policies can be very high, and a lot of studies have shown that this could inhibit access to needed services for low-income families.

The second important principle is that public subsidization of private coverage should occur only when it is a cost-effective use of public funds. Taxpayer dollars should not be wasted by spending the same amount or in some cases even more in buying fewer services or imposing higher costs on families.

So let me turn now to some recommendations, and I know, Chairman Andrews, you are in the process of developing a proposal that looks at some of these issues. I believe that Federal policies should encourage and facilitate the ability of States to follow the example of New Jersey and Rhode Island, another State that has run a very good premium assistance program.

Some States have reported that it can be difficult to obtain information from employers on their benefits package in order to assess the so-called wraparound services. A change to the ERISA statute would help States by allowing them to acquire this information from employers, and that would make this easier.

Another needed change is to define the loss of Medicaid and SCHIP eligibility as a qualifying event for purposes of eligibility for employer-sponsored coverage. This could help to prevent periods of uninsurance for children and in some cases parents, when a parent receives a raise and the child becomes ineligible for public coverage because they are over income. For example, a parent could receive a raise in April. The child becomes ineligible for SCHIP, but the family has to wait for the employer's annual open enrollment period in October, and the child is uninsured in the interim.

And finally, creative State approaches should be encouraged. A few States such as Maine, New Mexico and Oklahoma have recently started to offer a public product to small businesses and individuals who are otherwise unable to afford the growing cost of purchasing private coverage. These programs are relatively new, so it is hard to assess their success, and it is often difficult to induce participation without substantial subsidies, but there is little doubt that public coverage is less expensive than private coverage. So I think creating these kinds of opportunities for families and employers to buy in to public coverage is an intriguing new direction and one that should be explored.

In conclusion, I just want to say it is important to remember that covering children and their families is a critical public policy objective and one that enjoys widespread public support. We look forward to working with the members of the committee on this effort.

Chairman ANDREWS. Ms. Alker, thank you very, very much.

[The statement of Ms. Alker follows:]

Prepared Statement of Joan C. Alker, M.Phil, Deputy Executive Director, Georgetown University Center for Children and Families

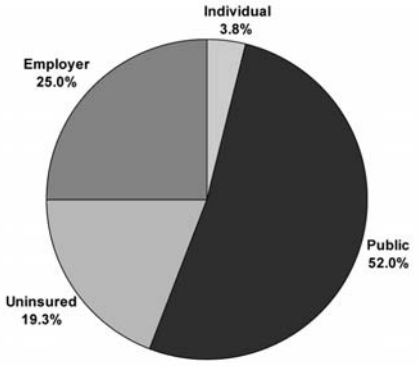
Chairman Andrews, Representative Kline and Members of the Committee: Thank you for the invitation to testify at this morning's hearing on integrating employer-sponsored coverage with the State Children's Health Insurance Program (SCHIP) and Medicaid. My name is Joan Alker, and I am the Deputy Executive Director of the Center for Children and Families, a research and policy center at Georgetown University's Health Policy Institute. I am also a Senior Researcher at the Health Policy Institute. Much of my recent work has focused on the intersection of public and private coverage—including two reports on premium assistance and public coverage that I authored for the Kaiser Commission on Medicaid and the Uninsured. I would like to share some lessons learned from states' experience with premium assistance programs and the best way to integrate public and private coverage for low-income families.

As you know, this year Congress will be reauthorizing the State Children's Health Insurance Program—known as SCHIP. Created in 1997, SCHIP, along with its larger companion program Medicaid, has succeeded in lowering the rate of uninsurance among low-income children by one-third between 1997 and 2005. In 2005, more than one in four children received their health insurance through Medicaid and SCHIP—the vast majority through the Medicaid program. Because Medicaid is by far the larger program, it is important in any discussion of improving coverage for low-income families to consider both Medicaid and SCHIP. In both programs, the majority of children live in families with at least one employed parent.

For children in low-income families (defined as those with incomes below twice the poverty level, or $41,300 for a family of four in 2007) these public programs are the largest single source of health coverage—covering half of all children (See Figure 1). Unfortunately public coverage for parents is typically far less generous—the median income level at which a working parent is eligible for Medicaid is 65% FPL ($13,423 for a family of four in 2007), although some states like New Jersey cover parents at higher income levels. Rates of uninsurance for adults are higher than for children as a result of this less generous public coverage.

Figure 1

Low-Income Children's Sources of Health Care Coverage, 2004-2005



33.3 million low-income children under 19

Source: K. Schwartz, C. Hoffman, & A. Cook, *Health Insurance Coverage of America's Children,* Kaiser Commission on Medicaid and the Uninsured (January 2007).

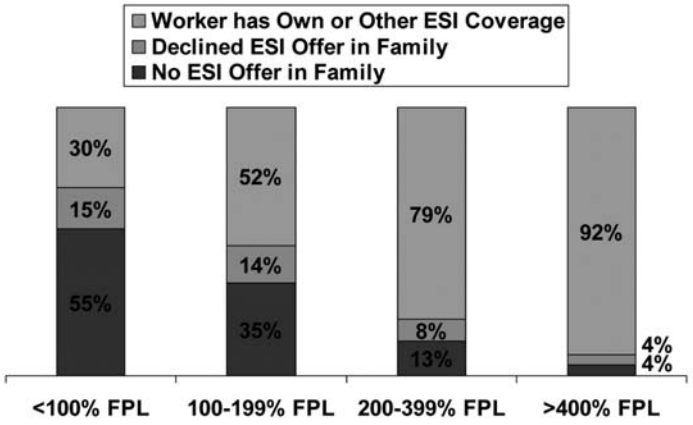
As the expansion of public programs for children, and in some cases parents, has occurred, the question of integration with employer-sponsored coverage has arisen. States, especially during challenging budget times, have explored ways to capture employers' contributions as a source of financing for eligible families. This legitimate desire to reduce public costs has been one of the primary motivations to establish premium assistance programs. Other arguments for premium assistance have been offered as well including the need to support the employer-based system of insurance and prevent the substitution of public coverage for private coverage (or "crowd-out "); the ability to cover all family members in the same health care plan; and the possibility of providing families with better access to providers .

Premium assistance programs use Medicaid and SCHIP dollars to subsidize the purchase of private coverage—typically, but not exclusively, employer-based coverage. Premium assistance is an idea that preceded the SCHIP program. Section 1906 of the Medicaid statute permits states to pay premiums for group health plans on behalf of both Medicaid eligible beneficiaries and other family members if it is cost-effective to do so. A few states such as Iowa and Pennsylvania have pursued this option aggressively. Under the Medicaid statute, the state must provide a "benefits wraparound" to ensure that families do not lose access to any needed benefits that are otherwise available through Medicaid or incur higher cost-sharing as a result of enrolling in private coverage. For example, an employer's coverage may not offer pediatric dental benefits. Other states, including Florida, Illinois, New Jersey, Oregon, Rhode Island and Utah have implemented premium assistance programs for their Medicaid and SCHIP populations through Section 1115 Medicaid and/or SCHIP waivers—in some cases in conjunction with managed care initiatives and other changes. Some of these states have sought and received a waiver of the benefits wraparound required by Medicaid and SCHIP.

What have we learned from state experience so far? With some exceptions, premium assistance programs have not been terribly successful in terms of enrollment. In New Jersey, for example, which runs an exemplary premium assistance program in many ways, enrollment has hovered around 700-800 family members. While there are certain logistical challenges that states face, the primary reason for low enrollment is simply that employer-sponsored coverage is not widely available for low-income families. As shown in Figure 2, only 14-15 percent of low-income working families have an offer of employer-sponsored insurance that they are not picking up.

Figure 2

Offers of Coverage by Income, 2005

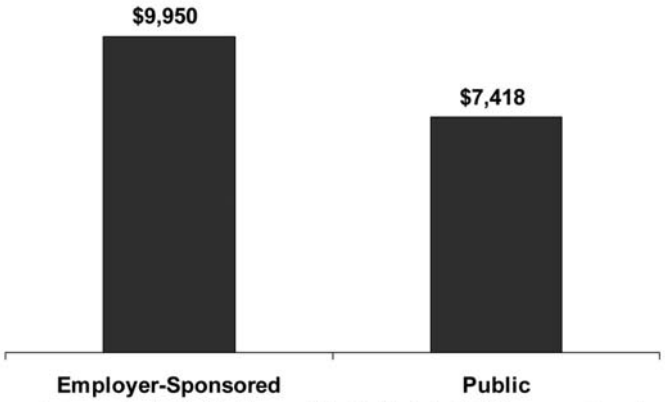


Note: Percentages may not total 100% due to rounding.
Sources: L. Clemans-Cope and B. Garret, *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005*, Kaiser Commission on Medicaid and the Uninsured (December 2006).

When private insurance is available it is often very expensive. Public coverage tends to be less expensive than private insurance for a number of reasons including economies of scale, lower administrative costs and lower reimbursement rates for providers.[1] In 2004, the average cost of covering a family of four through Medicaid nationwide was $7,418 whereas the cost of the average employer-sponsored insurance package for a family of four was $9,950—34% higher (see Figure 3).[2] This annual cost of almost $10,000 for private coverage does not include significant additional costs families will incur—such as copayments, deductibles and other coinsurance. Similarly, a recent study conducted by the Urban Institute for the state of Illinois found that predicted medical spending would be 31% higher if children were covered by private insurance as opposed to covering them through Medicaid/SCHIP.[3]

Figure 3

The Cost of Covering Families Through Employer Coverage vs. Medicaid, 2004



Note: Average cost of coverage for a family of four. These costs do not include family deductibles, co-payments, or coinsurance, which tend to be much higher in employer-sponsored coverage
Sources: Kaiser/HRET, *Survey of Employer Health Benefits, 2004*; and Georgetown Center for Children and Families/Center on Budget and Policy Priorities analysis of 2004 Medicaid Statistical Information System (MSIS) data.

As premium assistance programs continue to hold a lot of attraction, there are two principles that I believe should be given primary consideration when constructing premium assistance approaches. First, participating families should not receive fewer benefits or face higher cost-sharing than they would in the public program for which they are eligible (i.e. Medicaid or SCHIP). In particular, cost-sharing for private policies can be very high and may inhibit access to needed services for low-income families. A recent study found that the average family premium for employer-sponsored insurance in 2006 was $2,973.[4] For a family of four at 150% of the poverty level ($30,000 for a family of four in 2006), this premium constitutes 9.9% of their income. In addition, these families face coinsurance, deductibles and other fees. Premium assistance programs generally offer help with premium costs; but some states do not provide the "wraparound" protection mentioned above, and participants must pay all applicable copays, deductibles and coinsurance. A recent study found that out-of-pocket costs in employer-sponsored plans are, on average, almost as high as a family's premium costs.[5]

The second important principle is that public subsidization of private coverage should occur only when it is a cost-effective use of public funds. This is critically important because private insurance is generally more expensive than public coverage, and costs have been rising at a faster rate in the private sector. It is not prudent for state and federal funds to be invested in an expensive product (considering the benefits provided and the cost-sharing imposed) that costs the public program more, even with an employer contribution.

Premium assistance programs that take advantage of a robust employer contribution and operate in states that offer public coverage to the whole family (including parents) are most likely to save money. Because few employers offer child-only insurance products, a state is far more likely to meet the cost-effectiveness test for public dollars if it is offering coverage to the whole family in its Medicaid or SCHIP program and can count the cost of covering the parent in the equation.[6] Strong participation rates are also essential, as programs with low enrollment are often not able to overcome the high administrative start-up costs to recoup any savings. If all of these factors are not taken into consideration, taxpayer dollars may be wasted by spending the same amount, or in some cases even more money, and buying fewer services for families.

Few data are available to assess whether states are saving money through their premium assistance programs. In an effort to promote the use of private insurance, the Bush Administration's Section 1115 Health Insurance and Flexibility and Accountability Waiver Initiative (known as "HIFA) actually weakened federal cost-effectiveness requirements for the use of Medicaid and SCHIP dollars through waiv-

ers, and there has been little federal oversight in this regard. The states with proven savings are states such as Rhode Island and New Jersey.[7] These states design their program in the most optimal way by providing wraparound coverage to families and doing a case-by-case assessment to ensure that state and federal governments are saving money.

What should Congress do? As Congress considers SCHIP reauthorization, federal policy should encourage and facilitate the ability of states to follow the example of states like New Jersey and Rhode Island. Some states have reported that it can be difficult to obtain information from employers on their benefits packages in order to assess what "wraparound" services are needed and whether it is cost-effective to subsidize that employer's coverage. A change to the ERISA statute such as the one Rep. Andrews is proposing which allows states to require this information from "ERISA" employers will make this easier. Another difficulty that states face in implementing premium assistance programs is that a family that becomes eligible for a premium subsidy under a Medicaid or SCHIP program may have to wait for the employer's plan to have its open enrollment period. A policy change that establishes Medicaid/SCHIP eligibility as a "qualifying event" similar to other events such as births, adoptions, etc. for the purposes of triggering eligibility for subsidized employer coverage will facilitate expedited enrollment.

And finally another related ERISA change which Congress should consider to enhance the coordination of public and private coverage, would be to define the loss of Medicaid/SCHIP eligibility as a qualifying event for purposes of eligibility for employer-sponsored coverage. This could help to prevent periods of uninsurance for children (and in some cases parents) when a parent receives a raise and the child becomes ineligible for public coverage, for example, in April, but the family has to wait for the annual open enrollment period in October and the child is uninsured in the interim.

Even with improvements, premium assistance is not a panacea. Even if these changes are made, state and federal policymakers should have realistic expectations for premium assistance programs, particularly as the cost of private insurance continues to increase. Because employer-sponsored insurance is simply not widely available to low-wage workers, traditional premium assistance programs will not address the causes of uninsurance for these workers. Premium assistance can be a useful tool in some but not all circumstances; it is not a substitute for direct coverage through Medicaid and SCHIP.

In the absence of a broader public program expansion (or in the case of Maine as part of a broader effort), a few states such as Maine, New Mexico and Oklahoma have tried a different approach—offering a public product to small businesses and individuals who are unable to otherwise afford the growing cost of purchasing insurance in the private market. These programs are relatively new so it is hard to assess their ultimate success. It is often difficult to induce employers to participate. In addition, a number of other states offer the opportunity to "buy-in" to SCHIP for children whose family income exceeds eligibility thresholds. These programs have had mixed success with enrollment, but this coverage is a welcome resource for some families who are unable to afford coverage in the private market. Participation rates for both approaches will improve to the degree that government subsidies are available to reduce the costs of participation to employers and families. There is little doubt that public coverage is less expensive than private coverage, so creating these kinds of opportunities for families and employers to purchase public coverage is an intriguing new direction and one that should certainly be explored.

In conclusion, it is important to remember that covering children and their families is an important public policy objective, and one that enjoys widespread public support. We look forward to working with members of the committee on this effort.

ENDNOTES

[1] If provider reimbursement rates are too low, this may create access problems for beneficiaries.

[2] Georgetown Center for Children and Families analysis based on Kaiser/HRET 2004 survey and Medicaid MSIS data for 2004.

[3] Hadley, J. and Cravens, M. The Cost of Using Private Insurance to Cover Uninsured Children in Illinois. Urban Institute, October 20, 2005.

[4] Kaiser/HRET, Survey of Employer Health Benefits 2006 (September 26, 2006).

[5] Survey of employer health benefits by Hewitt Associates, LLC (October 9, 2006).

[6] This is one reason that it has been very difficult for states to meet SCHIP's cost-effectiveness test, because it only includes the cost of covering children.

[7] Rhode Island has been more successful than New Jersey with enrollment.

Chairman ANDREWS. Mr. England, welcome to the committee. We are happy to have you here.

STATEMENT OF BRIAN ENGLAND, OWNER, BRITISH AMERICAN AUTO REPAIR

Mr. ENGLAND. Thank you, Mr. Chairman. Thank you very much for this opportunity.

One of the things that we have really had a problem with, especially with insuring our employees, is just the rising cost of health care, and we have had to look at different ways to try and cut that down.

Chairman ANDREWS. Sir, if I could ask you to pull the microphone a little bit closer so you can be heard clearly.

Mr. ENGLAND. One of the things we have done is to look at deductibles first, and we have changed the deductibles, and this has made it somewhat more affordable to provide it. But one of the things that has really made a big difference for us was from the apprenticeship plan we have in place in our repair shop.

About 5 or 6 years ago, I reactivated the apprenticeship plan, and what this did, it brought in more young blood, and what this did, it brought down the cost of the health care, because in Maryland what they have is an age-weighted plan. So when—every year when you go to renew your insurance, you look at the average age of your employees, and, of course, when you have 18- and 19-year-olds employed, then that brings down the cost. So I have benefited from having an apprenticeship program.

But this is also an area that brings to light young people are not insured as much, and these people are young, and they are healthy, and if they are brought into the plan, this is going to help a lot in keeping the cost of insurance down. So that is what I have for the apprenticeship plan.

The other challenge we had was employing people like a single mother who we had employed. Cheryl. She came to work for us for a number of years. So when somebody works for a real long time, you give them raises. And one of the things that happened was that as we gave her raises, we asked her to do more hours, and what this led to was every time she got a raise, then the amount of time she could work went down. And I think she was allowed up to about $200 a week of income, which is not very much. Then she would lose her health care benefits. And at that time we weren't providing health care benefits for part-time employees. So when it got to the point where we wanted to employ her for 25 hours a week, then that led to the fact where she said, well, I can't do a 25-hour week; I can't risk losing my health care. So in the end, she did leave.

I did call her up on Tuesday and said, well, if we could have provided you coverage for your children and for your family, would you have carried on working for us? And she said, yes, that would have been great to do that.

I am also on the Chamber of Commerce, and the Chamber of Commerce traditionally had two legislative committees, one for State and one for local. And last year I helped develop the white paper which establishes exactly what we feel on different topics. And in the area of health care, I could see when we came to do this

document, there was a really heavy lead-in towards association plans, and that seemed to be the only thing that the Chamber seemed to be really concentrating on. But at the time we got input from everybody, we then realized that if we were going to move forward, we needed to be a bit more imaginative, and we felt the result of this was that if we were going to have association plans, they should not be implemented if it was going to affect our small group market.

Most people that—well, everybody with 50 or less employees in Maryland buys into the small group market, and that allows for standard coverage that we know we have got. Without going out and trying to research lots of different policies, we know what we are going to get for the money.

So that movement towards having a different approach to health care changed this year because we added more, and now we have got a separate part to the health legislation. And what that does for us is to enable us to really look in depth into health care issues and who should be involved with that.

I really think that it is very important that we provide coverage for children. You know, having 9 million children not covered with health insurance, it seems to me it is a disgrace, it is just terrible. So I am really pleased you are doing something to come away from this problem.

And the other week—I expect everybody knew that last week they came out with this plan from UNICEF which put us at the bottom of the list with the United Kingdom in providing coverage for health care and for education. We were right at the bottom of the list, and I think that is disgraceful for one of the richest countries in the world.

Chairman ANDREWS. Mr. England, thank you very much for your perspective.

[The statement of Mr. England follows:]

Prepared Statement of Brian England, Owner, British American Auto Repair

I would like to thank Chairman Andrews, Ranking Member Kline, and members of the Subcommittee for the opportunity to present testimony on covering the uninsured and how the federal government can help small businesses obtain affordable coverage. My name is Brian England and I am a small business owner. I immigrated to the United States in 1972 and became a citizen in 1984. In my remarks I will address the following points:

- How the rising cost of health care has affected my business
- The role of the Howard County Chamber of Commerce
- Opportunities for the federal government

In 1978, My wife and I opened an independent auto repair shop called British American Auto Care in Columbia, Maryland. Our auto shop is fairly small; we employ 20 people. Our staff includes both part- and full-time workers.

At British American Auto Care one of the greatest challenges we face is affordable health care. Like many other small business owners, we want to be able to provide comprehensive, affordable health care plans for all of our employees and their family members, but it is difficult to afford to do so. At the moment health care cost represents 5% of our labor rate.

British American Auto Care currently employs three apprentices and one trainee, who will continue on to be an apprentice. The program is open to high school or trade school students; the students are generally 18-20 years old. Each apprentice receives supervised, structured, on-the-job training combined with technical instruction in a specific occupation. They apprentice for three years and attend college and graduate with an associate's degree. My company provides health insurance to these student apprentices, except in cases where the student is still covered by parental

coverage. In Maryland, insurance rates are calculated by the average age of employees. Having a young pool of workers helps us keep our overall premiums low. We have also tried to keep premiums low by making increasing deductibles and co-payments, which results in employees paying a greater share for their health care.

The rising cost of health care has become an obstacle for both employers and employees. As an employer I believe providing adequate health care support to my employees and their families is an important piece in helping families transition from government support into the workforce. For example, for a number of years I employed a single mother with two children as a part-time office employee. I was pleased with her work wanted her to work more hours. She received her health benefits through Medicaid and when I offered her this opportunity she told me that she was unable to work more hours without losing health care benefits for herself and her children. Unfortunately, she chose to leave our employment last year. In preparing for this hearing I called her Tuesday and asked her if she would have continued working with us if we had been able to provide the necessary health coverage for her family and she said yes.

While I am able to speak as an individual small business owner, I have also had the opportunity to see how the rising cost of health insurance has affected other businesses. I am on the legislative committee of the Howard County Chamber of Commerce and in this role have had a chance to discuss this issue with other business owners. Business owners are increasingly concerned about the rising costs of health care. Every year the Chamber goes to Annapolis and discusses policy issues with the State Legislature. We had two subcommittees that reflect our policy priorities: one on local legislation and the other on state legislation. This year, we added a third subcommittee on health care, which underscores the importance of this issue. I was asked to review the health care section of the Chamber's white paper. The business community as a whole has been moving towards accepting solutions that include everyone, specifically individuals, government and business. It is important that both Maryland's state legislature and the federal government come up with progressive proposals to address cover all uninsured Americans.

The E-SCHIP proposal is coming at just the right time. There are many companies considering dropping family health care coverage and only providing coverage for their employee. This could lead to more uninsured children and there are already too many. Currently more than 9 million children lack health insurance in the United States. Four out of five of these children have parents who work but cannot afford health insurance coverage. Proposals that would offer employers the option of buying into the SCHIP program in order to provide coverage for an employee's family would greatly ease the burden on working parents. The E-SCHIP proposal would also help apprentices that have families.

It is critically important that we invest not only in the health of our employees but also in the health of our children because children are our future. In a recent UNICEF report on child poverty the United States was at the bottom of the list of rich countries with regard to providing health care. It is unacceptable that a country as prosperous as the United States would fail to care for the health of its citizens. I am glad that Congress is working on improving this situation.

Chairman ANDREWS. Mr. Webber, welcome to the subcommittee.

STATEMENT OF ANDREW WEBBER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL BUSINESS COALITION ON HEALTH

Mr. WEBBER. Good morning, Chairman Andrews, Representative Kline and other members of the subcommittee. And let me first acknowledge your excellent opening statement, Chairman Andrews. The bipartisan spirit in which you are approaching this coming health care reform debate is exactly what we need, and building on the employer-based system is a very important part of the reforms that come.

I am Andy Webber, president and CEO of the National Business Coalition on Health. NBCH is a national nonprofit membership association of employer-led health coalitions spread throughout the country, and we are dedicated to advancing value-based purchasing, a strategy to measure, report and reward performance in

health care. I would like to summarize my statement with the following five points.

As we enter a new national debate on health care reform leading up to the 2008 Presidential elections, I urge that our vision of health care reform stretch beyond the issue of access to care and the uninsured, and I appreciate, Chairman Andrews, you acknowledging that in the opening comments.

Two other pressing issues must be recognized and honestly addressed in the coming national debate: health care quality and, as Mr. England has already identified, the issue of affordability. To quote the Institute of Medicine, between the health care we have and the care we could have lies not a gap, it is a quality chasm. In addition, rising health care costs put American industry, as you recognized, Chairman Andrews, at a competitive disadvantage in a global economy, while adding to the economic insecurity of the American public that must increasingly contribute its own hard-earned dollars to an ever-growing health care industry. Simply stated, if we solve the problem of the uninsured tomorrow, the issues of health care quality and affordability would still leave us with a health care crisis.

Mr. Chairman, having said that, I am an eternal optimist and there are signs of hope, and business leaders are probably in the best position to understand from experience in their own industries that product redesign, process reengineering, advanced technology, a commitment to continuous quality improvement, improved worker productivity can vastly improve product quality while reducing operating costs.

Emerging data on quality and cost in health care dramatically demonstrate this point. For example, from the Medicare program, the States with the highest quality of care have the lowest per capita health care expenditures for the elderly population. Put in more striking terms, if the entire Medicare program practiced health care as it is provided in your State, Representative Kline, we could save one-third of total Medicare expenditures while enjoying higher quality. And imagine for a moment how those savings could be redirected to address the uninsured problem.

My third point is now turning to the interest of this committee, and that is the employer-based health care system. While critics from both ends of the political spectrum are quick to attack the employer-based system, NBCH urges, as you are doing, Mr. Andrews, to pause, step back and reflect on its many strengths and accomplishments. As we have talked about, it provides medical coverage to 71 percent of Americans working in the private sector. For over half a century it has spread risk, pooled covered lives through group insurance, creating far greater leverage in the marketplace than individual consumers could ever generate on its own. It has established the employer community as purchasers and change agents for health care, and for real advocates for their workforce. The employer-based system has been innovators and leaders of value-based purchasing, introducing innovations like pay-for-performance, value-based benefit design, health plan and provider report cards.

And just to demonstrate that, the California pay-for-performance program, the Leapfrog Hospital Survey, the Bridges to Excellence

pay-for-performance program are all examples of employer-run programs. Through the work of business and health coalitions, it has established group purchasing arrangements among employers, while giving employers a collective voice in health care reform initiatives at the community level.

Having said all that, NBCH recognizes, and we all recognize, that the employer-based system is not without its weaknesses. In particular, as Mr. England has pointed out, the struggle of small employers to access affordable health insurance, without market leverage or the ability to spread risk across a large population of covered lives, is severe and growing more difficult. And I urge that I think the environment appears ripe for experimentation and identifying and testing a mix of strategies to address the problem, including legislation and market strategies that would allow small business to collectively purchase health insurance to spread risk and leverage economies of scale; small employer tax incentives to provide health care benefits; reasonable exemptions from State coverage mandates; premium assistance, as Joan as talked about; and greater flexibility to allow families to use SCHIP dollars to enroll in employer-sponsored programs; and State initiatives, as we will hear from Dr. Blumberg, like Massachusetts, which mixes strategies like an individual mandate and employer pay or play with aggregated purchasing arrangements.

In closing, Mr. Chairman, let me reiterate that genuine health care reform must address the health care triad of access, quality and affordability issues. We will also need the active engagement, participation and leadership of all stakeholders of the health care system if we are to be successful in advancing this reform agenda.

NBCH urges that a principle of shared responsibility guide our policies moving forward, understanding that businesses, government, health plans, health professionals and consumers must come together in dialogue, action and equal sacrifice for us to realize a new vision of improved health and health care for all Americans.

Thank you, and I appreciate the opportunity to participate.

Chairman ANDREWS. Mr. Webber, thank you very much.

[The statement of Mr. Webber follows:]

Prepared Statement of Andrew Webber, President & Chief Executive Officer, National Business Coalition on Health

Executive Summary

Good morning Chairman Andrews and members of the Subcommittee. I am Andy Webber, President and CEO of the National Business Coalition on Health (NBCH). NBCH is a national, non-profit, membership organization of employer led health coalitions spread throughout the country. Over 10,000 employers, representing 34 million employees and their dependents, have come together through coalitions to advance value based purchasing—a strategy to measure, report and reward performance in health care. I have prepared a written statement that I ask be part of the official record. I would like to summarize my statement with the following 5 points:

1. As we enter a new national debate on health care reform leading up to the 2008 Presidential elections, I urge that our vision of health care reform stretch beyond the issue of access to care and the uninsured. Two other pressing issues must be recognized and honestly addressed in the coming national debate: health care quality and affordability. To quote the Institute of Medicine, "Between the health care we have and the care we could have lies not just a gap, but a chasm." In addition, rising health care costs put American industry at a competitive disadvantage in a global economy while adding to the economic insecurity of the American public that must increasingly contribute its own hard earned dollars to an ever growing health

care industry. Simply stated, if we solved the problem of the uninsured tomorrow, the issues of health care quality and affordability would still leave us with a health care crisis.

2. Mr. Chairman, I'm an eternal optimist and there are signs of hope. Business leaders are probably in the best position to understand from experience in their own industries that product redesign, process reengineering, advanced technology and improved worker productivity can vastly improve product quality while reducing operating costs. Emerging data on quality and costs in health care dramatically demonstrate this point. For example, we know from the Medicare program, that states with the highest quality of care have the lowest per capita health care expenditures for the elderly population. Put in more striking terms, if the entire Medicare program practiced health care as it is provided in Minnesota, we could save one third of total Medicare expenditures while enjoying higher quality. And imagine, for a moment, how those savings could be redirected to address the uninsured problem. Adding to my reason for optimism is the Department of Health and Human Services Secretary Michael Leavitt's effort to integrate value-driven purchasing practices into both the public and private sector through the "Value Driven Health Care Initiative." This strategy of only paying for the true value of a product or service works in all aspects of American business markets, and so it also should be the foundation of health care.

3. Let me now turn to a subject of great interest to this Subcommittee—the employer based health care system. While critics from both ends of the political spectrum are quick to attack the employer based system, NBCH urges the Subcommittee to pause, step back and reflect on its many strengths and accomplishments. It provides medical benefit coverage to 71 percent of Americans working the private sector, according to the latest U.S. Department of Labor data. For over half a century, it has spread risk and pooled covered lives through group insurance, creating far greater leverage in the marketplace than individual consumers could ever generate on their own. It has established the employer community as purchasers and change agents for health care and advocates for their workforce. The employer based system has been the innovator and leader of value-based purchasing, introducing innovations like pay-for-performance, value-based benefit design, and health plan and provider report cards. It has been a leader in health promotion, prevention and disease management. Through the work of business and health coalitions, it has established group purchasing arrangements among employers while giving employers a collective voice in health care reform initiatives at the community level. Finally, competition for talented labor in many industries ensures that health insurance and other worksite health benefits remain comprehensive.

4. The employer based system, NBCH recognizes, is not without its weaknesses. In particular, the struggle of small employers to access affordable health insurance, without market leverage or the ability to spread risks across a large population of covered lives, is severe and growing more difficult by the minute. The environment appears ripe for experimentation and identifying and testing a mix of strategies to address the problem, including: legislation and market strategies that would allow small businesses to collectively purchase health insurance to spread risk and leverage economies of scale; small employer tax incentives to provide health care benefits; reasonable exemptions from state coverage mandates for small employers; greater flexibility to allow families to use SCHIP dollars to enroll in employer sponsored benefit programs; and state reform initiatives, like Massachusetts, that combine a mix of approaches such as an individual mandate with an employer "pay or play" policy to find a comprehensive solution to the uninsured.

5. In closing, Mr. Chairman, let me reiterate that genuine health care reform must address the health care triad of access, quality, and affordability. We will also need the active engagement, participation and leadership of all stakeholders of the health care system if we are to be successful in advancing this reform agenda. NBCH urges that a principle of shared responsibility guide our policies moving forward understanding that businesses, government, health plans, health professionals, provider organizations, and consumers must come together in dialogue, action and equal sacrifice for us to realize a new vision of improved health and health care for all Americans. Let the health care reform debate begin!

Once again, NBCH appreciates the opportunity to participate in this important hearing and I would be pleased to answer any questions regarding my comments and written statement.

Written Statement

Chairman Andrews, Ranking Member Kline, and Members of the Subcommittee, I am pleased and honored to have this opportunity to participate in this hearing today. Thank you for your kind invitation.

The National Business Coalition on Health (NBCH) is a national, non-profit, membership organization of 64 employer led health coalitions, representing over 10,000 employers and approximately 34 million employees and their dependents. These business coalitions are composed of mostly mid- and large-sized employers in both the private and public sectors in a particular city, county, or region.

NBCH and its members are dedicated to value-based purchasing of health care services through the collective action of public and private purchasers in communities and markets of varying sizes and demographics. In developing, identifying and disseminating best practices in value-based purchasing strategies, NBCH is working to accelerate the nation's progress towards safe, efficient, high quality health care and the improved general health status of our nation's entire population.

NBCH's vision is health system reform, through value-based purchasing, community by community, and our mission is to provide superior membership service and to build the capacity of the NBCH membership to advance value-based purchasing of health care services.

There are nearly 50 million uninsured U.S. citizens and millions more that are inadequately insured, many of which are employed by small businesses. The solution to providing some or better coverage to all these people is not simple. It will require that all stakeholders, federal, state and local lawmakers, consumers, providers, and employers, think broadly and creatively to ensure that there are effective options available. As our nation's health care system continues increasing in cost and complexity, people link into the system in a variety of different ways depending on their employment, insurance eligibility, health status and financial situation.

There is not just one "transformational solution" to fix this situation, but we can put policies in place to help the system fix itself. The foundation for a long-term, sustainable health care system that provides accessible, affordable, quality health care to all Americans requires a strong commitment, including a major financial commitment from all stakeholders. Though a long-term investment is needed, the long-term return is even greater. We all benefit from a strong economy and a healthy, vigorous workforce.

Employers are deploying many strategies to improve long-term health and health care. In fact, NBCH member business and health coalitions are working with a national network of 10,000 employers to test and implement successful strategies. Enlightened employers are instituting worksite health and productivity programs to keep employees well and value-based purchasing programs that demand high quality and continuously improving health care for employees and dependents. However, corporate America continuously is faced with intense competition in an increasingly global marketplace, and often forgets that it has a critical role to play in influencing both health and health care. Employers need to be reminded that their success (or failure) in promoting better health and higher quality health care has a direct bearing on bottom line profitability directly and American taxpayers, indirectly. While not immediately connected in the minds of most employers or policy-makers, the link between an employer's viability as a commercial or non-profit enterprise and good health and health care is irrefutable. First, for most employers, the health and productivity of their workforce is a key competitive asset and market differentiator. Second, corporate America provides health insurance to over 70 percent of American workers in the private sector, and thus it is imperative that the rapidly rising costs of health benefits be efficiently managed while still yielding important health status and productivity gains for workers. From this perspective, there is no escaping the fact that employers have a vested interest in improving employee health and the health care that employees and their dependents receive.

The seemingly uncontrollable escalation of health care costs has led many employers to focus on short term fixes, such as employee cost-shifting or even discontinuation of benefits all together. However, according to recent, studies such cost-containment activities by employers, though understandable given current economic conditions, typically compound problems for both the employer and employee over the long-term by costing more in direct and indirect medical costs, as well as in decreased productivity. Every day employers are confronted with difficult decisions about how to most effectively invest their scarce resources to reap better returns for the company. In that same vein, we need to work together to encourage employers to apply this same discipline to a vitally important long-term investment—employee health care benefits.

Value-based health benefit design, which refers to programs that encompass the total cost of providing health benefits to an employee over the course of their entire career with an employer, is a perfect example of employer innovation. This benefit model has demonstrated that employers who have lowered the total cost of man-

aging notoriously expensive employee chronic illnesses, such as diabetes and asthma, are making it more affordable for employees to access the most effective prescription drugs to manage their chronic conditions. While companies pay more up front to subsidize the prescriptions, they can quickly recoup these costs through fewer emergency room visits and inpatient hospital stays, as well as enhanced productivity from their employees.

Through value-based health benefit design, employers can achieve a return on their investment through an improved bottom line, through enhanced worker productivity and through lower long-term employee health care costs and improved health status. Employees benefit too with improved health and typically lower out of pocket costs. With this model there are also positive ramifications globally in that we all benefit when employers, both public and private sector, provide affordable, comprehensive coverage thereby minimizing the strain on the current system, particularly safety net programs such as Medicaid and SCHIP, ultimately lowering the total health care bill to which we all pay, directly and indirectly.

Value-based health benefit design, particularly at the outpatient drug benefit level, has become widespread among private sector employers, but the cause needs the leadership and extensive implementation that only the federal government can provide. Rising health care costs, as well as the lack of transparent quality and cost expenditure data is an increasing challenge for both public and private payers. Our entire health care system needs to be organized to focus on how health benefit design can increase the probability that individual consumers receive evidence-based care leading to improved health outcomes. NBCH believes that a good starting point for value-based benefit design should be a set of core principles, recently developed by an experienced group of NBCH members and applicable to both public and private payers, to help guide responsible health benefit design that can serve as a guidepost for employer decisions moving forward. These NBCH principles are a part of a broader white paper "Promoting Consumerism Through Responsible Health Care Benefit Design" which will be provided to the Subcommittee as an attachment with my written statement.*

The lack of accessible health insurance is having a detrimental impact on generations of Americans as well as significant drain on our economy. Current estimates predict that by 2009, combined national health care spending will absorb nearly $3 trillion dollars of the gross national product annually, while millions of families remain uninsured. We all gain from accessible, efficient, thoughtful, evidence-based health care, but we all lose from perpetuating an opaque system of inefficiency and inaccessibility.

In August of 2006, President Bush released an Executive Order to promote quality, transparency and efficiency in federal government-administered or sponsored health care programs. This Executive Order was heralded in the health care coalition world as a validation of our long-standing efforts to make the system's infrastructure work better for consumers to contain costs and to improve accessibility and quality for everyone. The premise of the Executive Order describes four "cornerstones," all of which are in harmony with NBCH's mission and goals:

1. Identify and implement standards to support information systems that quickly and securely communicate and exchange data.
2. Measure and publicly report health care quality at doctor and hospital levels.
3. Provide consumers with episode of care-based cost information so that they can compare treatment, service, and provider options.
4. Align incentives for both consumers and providers so that high quality, competitively-priced health care will be rewarded at all levels of the system.

Understanding that the key to a sustainable solution is partnership and collaboration, in November 2006, Department of Health and Human Services Secretary Michael Leavitt took the President's Executive Order to a more "aggressive" level by asking private sector purchasers, as well as state and local governments to integrate the four cornerstones within their purchasing practices to move the nation's health care toward a value-based system via the "Value Driven Health Care Initiative." Value-based health care means that physicians, plans, hospitals and other types of providers in the health care delivery system are rewarded based on the real value they bring to consumers and purchasers, namely by using proven procedures and products that reduce costs and improve quality and patient safety. This strategy works in all aspects of American business markets, and so it also should be the foundation of health care.

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*The National Business Coalition on Health white paper, "Promoting Consumerism Through Responsible Health Care Benefit Design," dated November 2006, can be viewed at the following Internet address: *http://www.nbch.org/resources/policypapers/health__benefit__design.pdf.*

NBCH has worked closely with the Secretary and his staff in the development and launch of the Initiative. We have also joined an alliance of leading national employer based associations, called the Partnership for Value Driven Health Care, to advance the Initiative among our collective employer members. The Partnership has recently produced a "Purchaser Guide" to help identify steps employers can take to advance the value driven health care agenda. The Purchaser Guide will be provided to the Subcommittee as an attachment to my testimony.* Not only have we endorsed the initiative, NBCH is committed to the cornerstones and encourages all NBCH coalition members and their employer members to do so as well. In fact, starting in 2007, NBCH included in its *eValue8* program—our national standardized web-based health plan evaluation tool capturing performance indicators—twelve key questions related to implementation of the Value-Driven Health Care Initiative and the four cornerstones. NBCH will be reporting initial *eValue8* performance results in May 2007. *eValue8* is used by NBCH coalitions and their purchaser members to evaluate approximately 200 national and regional Managed Care Organizations (MCOs) and Preferred Provider Organizations (PPOs) annually.

Though we believe health care reform through value-based purchasing to control costs, expand accessibility and improve quality is paramount, NBCH also believes government, business, provider and consumer partnerships that utilize a combination of the following policy incentives could be an effective way to help perpetuate value-based purchasing, as well as meet the diverse health care coverage needs of a diverse population:

- Improve accessibility to tools that help consumers obtain better information about providers' quality of care and prices. Transparency results in better choices, improved care and ultimately lower costs.
- Enhance employer tax incentives to provide employee health care benefits.
- Improve state and federal tax incentives for U.S. residents who purchase individual health insurance.
- Provide reasonable exemptions from state mandates, particularly for small employer coverage.
- Broaden accessibility, application and flexibility of all types of health care spending accounts (HSAs) and high-deductible health plans.
- Support small business-friendly legislation and reforms that will allow small businesses to collectively purchase health insurance to spread risk and leverage economies of scale.
- Extend eligibility and enrollment opportunities, to the extent possible by the states and federal government, for public insurance programs—State Children's Health Insurance Program (SCHIP), Medicaid and Medicare.
- Support "locally grown" public-private partnerships (i.e. three-share model or multi-share program) which distribute the health care benefit premium cost equally between employer, employee and local/state or federal government resources, enabling small and mid-sized businesses to provide a comprehensive mainstream benefit plan.

Simultaneously, with all of these efforts to reform and fix the system, the employer based health care system must be preserved and allowed to thrive. This system has worked well for over half a century, namely through the ability to pool covered lives through group insurance while creating needed leverage in the marketplace. Individual purchasers could never generate this leverage on their own purchasing insurance in the marketplace. The employer system also has been the hotbed for innovation in employee benefit design, wellness, and prevention. As mentioned above, Secretary Leavitt is looking to large private employers to help advance value driven health care. But at the same time we need to recognize that the small employer market is fundamentally broken and needs the government to help with creating both tax breaks and a mechanism (i.e. an insurance pooling mechanism/purchasing alliance that the government would establish) that permits both small employers and individuals (self-employed or working uninsured) to participate.

Leveling the federal tax playing field in terms of a standard deduction for everyone could be an effective strategy to help individuals that purchase coverage on their own. The special tax status for the employer based system has been unfair to individual purchasers, especially self-employed consumers. However, NBCH is skeptical of efforts to contain escalating costs and to bring equality to the system by making the purchase of health insurance over a certain amount of taxable income. Essentially, such a strategy could weaken the foundation of the employer based system, particularly since the current system already is shifting significant costs onto

*The Partnership for Value Driven Health Care document, "Value-Driven Health Care: A Purchaser Guide," dated February 2007, can be viewed at the following Internet address: *http://www.leapfroggroup.org/media/file/Employer__Purchaser__Guide__05__11__07.pdf*

employees through copayments, deductibles and various geographic-based inequities. Nonetheless, the overall issue of a standardized tax deduction for the purchase of health care is worthy of open debate in Congress.

Again, NBCH believes that a combined approach, one with value-driven health care as a central strategy along with an array federal, state and local options is the right direction to help ensure affordable, quality health care for all Americans.

This concludes my written testimony. I look forward to discussing my comments in more detail during the question and answer portion of the testimony. I also again want to thank the Subcommittee for inviting me here today and for its attention to finding viable solutions to improve the accessibility, affordability, and quality of our nation's health care system through the employer based system.

Chairman ANDREWS. And, Dr. Blumberg, welcome. We are delighted you are with us today.

STATEMENT OF LINDA BLUMBERG, Ph.D., ECONOMIST AND PRINCIPAL RESEARCH ASSOCIATE, THE URBAN INSTITUTE

Ms. BLUMBERG. Mr. Chairman, Mr. Kline and distinguished members of the subcommittee, thank you for the opportunity to talk with you today about the problems faced by those without health insurance, and to share my thoughts on strategies for expanding coverage to them. I appreciate the fact that this committee is considering these very important issues.

The problems associated with being uninsured are now widely known. A substantial body of literature shows that the uninsured have reduced access to medical care, and many researchers have concluded that the uninsured often have inferior medical outcomes when an injury or illness occurs. Urban Institute researcher Jack Hadley recently reviewed 25 years of research and found strong evidence that the uninsured receive fewer preventive and diagnosis services, tend to be more severely ill when diagnosed, and received less therapeutic care. Studies found that mortality rates for the uninsured were from 4 to 25 percent higher than would have been the case had the individuals been insured.

But while the negative ramifications of being without health insurance are clear, the number of uninsured continues to grow. According to an analysis by John Holahan and Allison Cook, the number of nonelderly people without health insurance climbed by 1.3 million people between 2004 and 2005, bringing the rate of uninsurance in that population to almost 18 percent. The vast majority of this increase was amongst those with low incomes and among adults. In recent years, the share of the population with employer-sponsored insurance has fallen, while the share of those with public insurance coverage has risen, but by smaller amounts.

Why is the rate of employer-sponsored insurance falling? First and foremost, increasing premiums have outstripped wage and income growth. Second, employment has shifted away from the types of firms that have traditionally had high rates of offering employer-based insurance, such as large firms and firms in the manufacturing, government and finance industries.

The good news is a number of proposals at the State and Federal levels are taking shape. Research is providing significant support, and the components of successful reforms are becoming clearer. I present what I believe are the four key components of an effective approach to achieving universal or near universal health insurance coverage while maintaining a private insurance-based system.

The first component is a comprehensive subsidized set of insurance benefits for the low- and moderate-income population. Subsidies should be directed to individuals as opposed to employers, should increase with increasing need, and should be sufficient to ensure that adequate affordable benefits are made available to meet health care needs. While a high deductible plan may be perfectly adequate coverage for a high-income person, it is not going to be adequate to meet the needs of someone of more modest means, and meaningful reform must take that into account.

The second component is a guaranteed source of insurance coverage for all potential purchasers. The existing private nongroup insurance market is simply not adequate. A guaranteed source of coverage will most likely need to take the form of an organized purchasing entity, such as newly established health insurance purchasing pools. Or coverage can be guaranteed by using existing organized purchasers, such as government employee benefit plans, State high-risk pools or State children's health insurance programs.

The third component is a mechanism for spreading broadly the costs associated with those who have the greatest need for health care services. The premiums charged to individuals and a guaranteed accessible insurance option should not be determined by the specific health care risks of those that actually enroll in that plan. Instead, the premium should be based on what the premiums would be if a broader population enrolled.

The fourth component is either an individual mandate or an individual mandate combined with a light employer mandate. Absent automatic enrollment in a fully government-funded insurance system, an individual mandate is necessary to achieve universal coverage. Many advocate combining an employer mandate of some type with an individual mandate to ensure continued employer responsibility in health care. Such employer mandates raise a number of difficult political, distributional and legal issues. But Massachusetts, for example, is able to enact a nonburdensome employer mandate that is an impressive model of political compromise.

Designing such a reform, complex as it may sound at first, is actually the easy part. The most difficult truth is that financial resources are necessary for ensuring accessible, affordable and adequate insurance for all Americans. If the political will strengthens sufficiently in that regard, many options for identifying the necessary funding are available. If asked my personal favorite, I would suggest we turn to a redistribution of the current tax exemption for employer-sponsored insurance, providing those with the greatest needs the greatest assistance as opposed to the opposite, which is true today. The amount being spent on that exemption is sufficient to accomplish meaningful universal coverage, and the President himself has already opened the door politically to putting that spending to more efficient and effective use.

Thank you very much for the opportunity to share my thoughts on these important issues, and I would be happy to answer any questions that you might have.

[The statement of Ms. Blumberg follows:]

Prepared Statement of Linda J. Blumberg, Ph.D., Principal Research Associate, the Urban Institute

Mr. Chairman, Mr. Kline, and distinguished Members of the Subcommittee, thank you for the opportunity to talk with you today about the problems faced by those without health insurance, and to share my thoughts on strategies for expanding coverage to them. I appreciate the fact that this Committee is considering this important issue. While I am an employee of the Urban Institute, this testimony reflects my views alone, and does not necessarily reflect those of the Urban Institute, its funders, or its Board of Trustees.

The problems associated with being uninsured are now widely known. There is a substantial body of literature showing that the uninsured have reduced access to medical care, with many researchers concluding that the uninsured often have inferior medical outcomes when an injury or illness occurs. Urban Institute researcher Jack Hadley reviewed 25 years of research and found strong evidence that the uninsured receive fewer preventive and diagnostic services, tend to be more severely ill when diagnosed, and receive less therapeutic care.[1] Studies found that mortality rates for the uninsured within given time periods were from 4 to 25 percent higher than would have been the case had the individuals been insured. Other research also indicated that improving health status from "fair" or "poor" to "very good" or "excellent" would increase an individual's work effort and annual earnings by as much as 20 percent.

But while the negative ramifications of being without health insurance are clear, the number of uninsured continues to grow. According to an analysis by my colleagues John Holahan and Allison Cook, the number of nonelderly people without health insurance climbed by 1.3 million between 2004 and 2005, bringing the rate of uninsurance to just under 18 percent of this population.[2] The vast majority of this increase, 85 percent, was among those with incomes below 200 percent of the federal poverty level. About 77 percent of the increase in the uninsured was attributable to adults. In recent years, the share of the population with employer-sponsored insurance has fallen, while the share of those with public insurance coverage has risen, but by smaller amounts. This pattern has persisted since 2000.

Why is the rate of employer-sponsored insurance falling, causing the number of uninsured to climb in recent years? First and foremost is increasing premium costs that have outstripped wage and income growth.[3] But additionally, overall employment has been shifting away from firms with traditionally high rates of employer-based insurance coverage, moving workers into the types of firms that are significantly less likely to offer coverage to their workers.[4] For example, employment in medium size and large firms has fallen, and growth has occurred among the self-employed and small firms. Employment has shifted from manufacturing, finance, and government to services, construction, and agriculture. There also has been a population shift toward the South and the West, regions with lower rates of employer-based coverage and higher uninsurance.

The good news is that policymakers at both the federal and state levels are talking about the need to expand health insurance coverage again, and some states are already taking action. While proposals are being developed in a number of states and at the federal level as well, I will focus my attention here on two of the most notable state designs, that of Massachusetts and California. I chose both states as they delineate potential avenues for bipartisan compromise on this issue. In addition, Massachusetts is the only state that has already passed legislation, enacting far-reaching health care reform, and California is, of course, the largest state, and hence what it can accomplish has significant implications for the country as a whole. I treat these two approaches as case studies in policy design and use them to highlight the types of features required to achieve significant coverage expansions as well as the policy challenges faced by such an undertaking.

Massachusetts

There are four main components to the landmark health care reform legislation enacted in Massachusetts in April 2006:[5]

- A mandate that all adults in the state have health insurance if affordable coverage is available (an individual mandate);
- A small assessment on employers that do not provide coverage to their workers;
- A purchasing arrangement—the Commonwealth Health Insurance Connector (the Connector)—designed to make affordable insurance available to individuals and small businesses and to provide subsidized insurance coverage to qualifying individuals/families; and
- Premium subsidies to make coverage affordable.

Theoretically, these components of reform could move the state to near-universal coverage; however, many practical issues remain to be resolved.

For example, the individual mandate to purchase health insurance will not be enforced unless affordable products are available. The definition of "affordability" and how it will vary with family economic circumstance was not provided in the legislation, and is left up to the board of the Connector. This definitional issue is clearly critical to the success of the Massachusetts reform and any other policy approach to expanding health insurance coverage. Ideally, each family would be subsidized to an extent that would allow them to purchase coverage within the standard set. Setting the affordability standard at a high level (for example, individuals being expected to spend up to 15 percent of income on medical care) would mean that the individual mandate would have a broad reach and thus increase coverage a great deal. This would be true because individuals and families would be expected to pay a considerable amount toward their insurance coverage, more insurance policies would be considered "affordable" by this standard, and thus the individual mandate would apply to more people. But setting the standard at such a level would also place a heavy financial burden on some families and might be considered unreasonable. Setting a low affordability standard (for example, expecting individuals to spend only up to 6 percent of their income on health care) would ease the financial burden of the mandate on families, but would increase the per capita government subsidy required to ensure that individuals could meet such a standard. To the extent the revenues dedicated to the program were not sufficient as a consequence, either further revenue sources would be required or enrollment in the subsidized plans would have to be capped, and some would have to be excluded from the requirement to purchase coverage.

Under the Massachusetts plan compromise, each employer of more than 10 workers that does not make a "fair and reasonable" contribution to their workers' insurance coverage (with "fair and reasonable" yet to be defined) will be required to pay a per worker, per year assessment not to exceed $295 (this amount would be prorated for part-time and seasonal workers). This very modest employer payment requirement was the product of a compromise between those concerned about a potential decline in employer involvement in the financing of health care and strong resistance from the business community (especially small businesses) to potentially burdensome employer payroll tax assessments. The assessment decided upon had widespread support in the business community and was acceptable to consumer advocates as well. This broad-based support was critical for passage of the legislation and continues to prove pivotal in garnering continued support through various implementation challenges.

All employers are also required to set up Section 125 plans for their workers, so that workers can pay their health insurance premiums with pretax dollars, even if their employers do not contribute toward their coverage. Those employers who do not establish Section 125 plans may be required to pay a portion of the care their employees receive through the state's Uncompensated Care Pool, which provides hospital care to low-income uninsured persons.

Ideally, the reform would not cause significant disruption to existing insurance arrangements between employers and their workers. As currently designed, most employers, particularly large employers already offering group coverage, likely will continue to offer coverage. The benefits of risk pooling, control over benefit design, and lower administrative costs associated with purchasing through a large employer will not change under this reform. The situation for small employers is likely to be somewhat different, however.

By allowing workers to purchase coverage on a pre-tax basis through Section 125 plans, the Massachusetts reform reduces the incentive for small employers to offer coverage to their workers independently. The current law tax exemption for employer-sponsored insurance is an important motivator for small employers to offer insurance coverage today, and the Connector combined with Section 125 plans would level the tax playing field between employer provision and individual purchase. This is a more important issue for small firms than for large firms because small firms face significantly higher administrative costs, do not receive the risk pooling benefits of large firms, and are more frequently on the cusp between offering and not offering coverage. Decisions small firms make under the reform will, however, be quite dependent upon the particular plan offerings in the Connector, how attractive they are, and whether negotiating power in the Connector will be sufficient to generate true premium savings.

The attractiveness of the benefits offered in the Connector, and its size as a consequence, will have important implications for its negotiating power—the higher the enrollment, the greater the Connector's ability to be a tough price negotiator and to create savings in the system. This economic reality of purchasing pools may be

somewhat at odds with those who would like to see organized public purchasers playing a small role in relation to private insurance providers. Thus, there is a tension for those that would like to have plans that are offered in such a purchasing pool be low cost/high cost sharing/limited provider network plans, as such plans have not proved popular with most purchasers. Therefore, if a purchasing pool limits its offerings to such plans, it may be unable to reach a critical mass for negotiating purposes.

At this time, the Connector will require each insurer to offer four different benefit packages of defined levels of actuarial value. In another context, offering such variety in benefit generosity could lead to adverse selection, with the healthy attracted to the high cost sharing/limited benefit plans and premiums in the comprehensive plans spiraling upwards. However, in order to protect the viability of more comprehensive plans and thus to better meet the needs of those with serious medical care needs, the Connector board has instituted a policy designed to counteract such a harmful dynamic. Premiums for each benefit plan will be set as if the enrollees in all of the insurer's plan options were enrolled in that plan. In this way, the premium for a particular plan is not a function of the actual health care risks of those people who voluntarily enroll in it. This is clearly an important first step to ensuring broader sharing of high health care risks. It may also be necessary for further risk adjustment across insurers, but that remains to be seen, and modifications within the Connector can be made if appropriate.

In addition to selling unsubsidized health insurance to individual and small employer purchasers, the Connector will also operate the Commonwealth Care Health Insurance Plan (CCHIP), which will provide subsidized coverage for those with household incomes up to 300 percent of the federal poverty level (FPL). CCHIP has no deductibles, has cost-sharing requirements that increase with income, and does not charge premiums for those individuals with incomes below 100 percent of FPL. Premiums on a sliding scale are charged for those between 100 and 300 percent of FPL.

It is widely accepted that those with incomes below 100 percent of FPL have virtually no ability to finance their own health care needs, and that those of modest incomes require significant assistance as well. Deductibles and substantial cost-sharing responsibilities are likely to prevent the low-income population from accessing medical care when necessary; hence, the benefit package offered through CCHIP is considerably more comprehensive than that typically offered in the private insurance market. These policies are available only to those who have not had access to employer-based insurance in the past six months, with the hope of reducing the displacement of private employer spending by public spending.

California

The health care reform proposal Governor Schwarzenegger developed is an ambitious one. Many of its general components are similar to those implemented in Massachusetts, but the details are quite different and illustrate the types of choices that policymakers can make, and the very significant implications that these details can have. The components of the California proposal are the following:

- an individual mandate that all Californians have at least a minimum level of health insurance coverage;
- a "pay or play" employer mandate requiring that all firms with 10 or more workers pay a 4 percent payroll tax, a liability which can be offset by employers' contributions to health insurance for their workers and their dependents;
- a purchasing arrangement that would provide a guaranteed source of insurance coverage for individuals to purchase the minimum level of benefits required to satisfy the mandate and that also would provide subsidized insurance to eligible individuals;
- income-related subsidies to make premiums affordable for those with incomes up to 250 percent of FPL.

The minimum health insurance coverage required to satisfy the individual mandate under the California proposal is a $5,000 deductible plan with a maximum out-of-pocket limit of $7,500 per person and $10,000 per family. This is a package that would require substantially more cost sharing than is typical of private insurance today, and thus can be expected to be made available at premium levels significantly below typical employer-sponsored insurance premiums.

This minimum plan would be made available on a guaranteed issue basis through a new purchasing pool that the Managed Risk Medical Insurance Board (MRMIB) would run. MRMIB is a government agency and currently runs the Healthy Family's Program (California's SCHIP program) and the state's high-risk pool. In the past, the agency also ran a small employer health insurance purchasing pool. It is an agency experienced in health insurance purchasing, contracting, enrollment, and

eligibility determination and has a structure for all the administrative tasks necessary for these roles; thus, it is an excellent choice for basing a new purchasing pool under a broad reform.

However, the policy that would be offered is likely to be unattractive to workers with modest incomes, in particular to those over 250 percent of FPL who would be ineligible for subsidized coverage and often could not afford to pay such a high deductible. Such a family would still be severely limited in their financial access to medical services, even with the guaranteed issue policy. Those that do not buy policies in the new pool, do not have employer insurance offers, and are not eligible for subsidized coverage would be required to purchase a policy in the existing private non-group market, and would face all the shortcomings inherent in that market. This would be a particularly difficult option for older workers and workers with significant health care needs, many of whom may not be able to obtain a policy at all in that market. Even those lucky enough to be offered a policy would likely be unable to obtain an affordable policy with more comprehensive benefits and effective access to needed medical care.

The "pay or play" mechanism is a tool for financing the new low-income subsidies proposed under the plan. This 4 percent payroll tax liability creates a significantly higher employer financial responsibility than does Massachusetts's employer assessment. Employers with fewer than 10 workers are exempt from the tax. Consequently, the reform should not impact the smallest employers at all but will provide new subsidies and a source for buying coverage for their low-income workers.[6] And because the vast majority of large firms already provide health insurance coverage to their workers (98 percent of firms with 100 or more workers offered health insurance nationally, as of 2004[7]), the biggest impact of this reform would be on the employers and workers in firms of 10 to 100 workers.

The proposal provides some competing incentives that make it uncertain whether workers in currently non-offering small firms (of 10 or more workers) would prefer to have their employers begin to offer coverage or would prefer to purchase coverage on their own and have their employers pay the payroll tax. First, small firms do not tend to be efficient purchasers of health insurance. The administrative loads associated with small group insurance can be quite high and might be significantly higher than those in the new purchasing pool. This imbalance, combined with the inability of small groups to spread their health care risks broadly, implies a significant incentive for workers to prefer enrolling in pool-based coverage. This incentive would be particularly strong for lower-wage workers in small firms, who could enroll in a subsidized comprehensive health insurance product through the purchasing pool.

However, the payroll tax assessment works in the reverse direction of these incentives. Economists believe that the burden of employer-paid payroll taxes made on behalf of workers are effectively passed back to workers through lower wages paid over time. In the case of the California proposal, this would mean that workers whose employers opt to pay the tax would experience declines in their incomes relative to what their incomes would have been without the reform, and would then be required to purchase health insurance directly. In essence, they would be paying twice—once for the payroll tax and once for the insurance policy; they would get no credit toward the purchase of health insurance to account for the fact that their employers (and indirectly the employees themselves) were paying the payroll tax.

While workers eligible for generous subsidies on a comprehensive health insurance package might still be better off this way than having their employer offer insurance, the same is unlikely to be true for unsubsidized workers. The only unsubsidized product available in the new purchasing pool would be the very high deductible policies. As noted, these policies may be very unattractive to modest-income workers with incomes over 250 percent of FPL, who would be ineligible for subsidized coverage. Given also the substantial shortcomings of the current nongroup market, these issues taken together might create significant incentives for workers to ask their employers to begin offering health insurance in exchange for wage reductions commensurate with their employers' contributions.

The proposal also would make all children (including undocumented residents) in families with incomes up to 300 percent of FPL eligible for state subsidized health insurance, all legal adult residents with incomes up to 100 percent of FPL eligible for Medicaid at no cost, and those between 100 and 250 percent of FPL eligible for subsidized coverage through the new state purchasing pool. These expansions would cover quite comprehensive health insurance plans and would, on their own, lead to significant expansions of coverage in the state. These policies also would have important implications for employees of small firms in California, since over half of California's uninsured workers are employed by firms with fewer than 25 workers, and approximately two-thirds of the uninsured workers employed in these small

firms have incomes that would make them eligible for subsidized insurance.[8] The lower-income workers in these small firms therefore account for over a third of all uninsured workers in California.

Conclusions

A number of states are already developing comprehensive health insurance reform plans. However, many more states will not be able to accomplish significant reforms on their own due to financial and political constraints. Indeed, it is not feasible for any state to finance any of the plans and proposals currently on the table without accessing at least some federal matching funds. As a consequence, federal legislators are now engaged in discussions and policy development of their own. Federal involvement will be necessary to spread further the early successes some states are seeing.

Therefore, I would like to take this opportunity to delineate what I consider to be the most critical components for the effective development of universal or near universal health insurance coverage within a private insurance-based system.

The first component is a comprehensive, subsidized set of insurance benefits for the low- and modest-income population. Subsidies should be directed to individuals (as opposed to employers), should increase with increasing need, and should be sufficient to ensure that adequate benefits are made available to meet health care needs at an affordable price. While a high deductible plan may be perfectly adequate coverage for a high-income person, it will not be adequate to meet the needs of someone with more modest means, and meaningful reform must take that into account.

The second component is a guaranteed source of insurance coverage for all potential purchasers. The current nongroup insurance markets are simply inadequate to do the job. The guaranteed source of coverage will most likely need to take the form of an organized purchasing entity, such as newly established health insurance purchasing pools, or it may also be developed using existing organized purchasers, such as government employee benefits plans, state high risk pools, or State Children's Health Insurance Programs.

The third component is a mechanism for broadly spreading the costs associated with those who have the greatest need for health care services. Importantly, the health care risks of those that enroll in a guaranteed accessible insurance plan should not determine the premiums charged to individuals in that plan. Instead, the premiums should be based on what the premiums would be if a broader population enrolled. In this way, choice of varied benefit packages can be maintained, and the needs of the most vulnerable Americans can be met.

The fourth component is either an individual mandate or an individual mandate combined with a "light" employer mandate. Absent automatic enrollment in a fully government-funded insurance system, an individual mandate is necessary to achieve universal coverage. Many advocate combining an employer mandate of some type with an individual mandate to ensure continued employer responsibility in health care. Such employer mandates raise a number of difficult political, distributional, and legal issues. But Massachusetts, for example, was able to enact a non-burdensome employer mandate that should be considered a model of political compromise.

Designing such a reform, complex as it may sound at first, is actually the easy part. The most difficult truth is that financial resources are necessary for ensuring accessible, affordable, and adequate insurance for all Americans. If the political and public will strengthens sufficiently in this regard, there are many options for identifying the necessary funding. If asked for my personal favorite, I would suggest we turn to a redistribution of the existing tax exemption for employer-sponsored insurance, providing those with the greatest needs the greatest assistance, as opposed to the opposite, which is true today. The current level of this tax expenditure is sufficient to finance comprehensive health care reform and is already dedicated to subsidizing health care insurance. The current spending is not particularly effective in expanding coverage, however, since it subsidizes most those who are most likely to purchase coverage even in the absence of any subsidy. And while the notion of restructure the current tax subsidy has been somewhat politically taboo in the past, the president himself has recently opened the political conversation regarding how best to spend that that money.

Thank you very much for the opportunity to share my thoughts on these important issues.

ENDNOTES

[1] J. Hadley. 2003. "Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income," Medical Care Research and Review 60(2): 3S—75S.

[2] J. Holahan and A. Cook. 2006. "Why Did the Number of Uninsured Continue to Increase in 2005?" Kaiser Commission on Medicaid and the Uninsured Issue Paper. *http://www.kff.org.*

[3] M. Chernew, D. Cutler, and P. Kennan. 2005. "Increasing Health Insurance Costs and the Decline in Insurance Coverage," Health Services Research 40(4): 1021—39; T. Gilmer and R. Kronick. 2005. "It's the Premiums, Stupid: Projections of the Uninsured through 2013," Health Affairs Web Exclusive (April 5): w5-143—w5-151; J. Hadley. 2006. "The Effects of Recent Employment Changes and Premium Increases on Adults' Insurance Coverage," Medical Care Research and Review 63(4): 447—76.

[4] J. Holahan and A. Cook. 2006. "Why Did the Number of Uninsured Continue to Increase in 2005?" Kaiser Commission on Medicaid and the Uninsured Issue Paper. *http://www.kff.org.*

[5] J. Holahan and L. Blumberg. 2006. "Massachusetts Health Care Reform: A Look at the Issues," Health Affairs Web Exclusive, September 14: w432—43.

[6] It should be noted that this "carve-out" of employers with fewer than 10 workers may provide incentives for the smallest employers to stay small and may also create incentives for somewhat larger employers to break up into smaller pieces.

[7] Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey—Insurance Component 2004, calculations based on published tables, tables available at *http://www.meps.ahcpr.gov/*.

[8] Author's estimates from the 2004/2005 March Current Population Survey.

Chairman ANDREWS. I would like to thank each of the four witnesses for very provocative and thoughtful testimony. Thank you. And I hope that today is the beginning of the end of a very partisan divide over this issue.

I was fortunate enough to come to Washington in 1990, and people identified the problem in 1990 the way they do now, lots of uninsured, problems of access and quality. And we have been through several iterations of political warfare over that question. We haven't gotten it done. So I am really very appreciative of the spirit of the comments from the four witnesses as well as the substance of the comments.

Ms. Alker, I would like to start with you and thank you for your participation developing our thoughts. You have been an invaluable asset, and we are very grateful to you. You talked about the idea of a possibility of buy-in by employers, voluntary buy-in by employers, to the SCHIP program. In my State of New Jersey, the estimate is that the SCHIP program for family care, because we at one time had a family care program, would be about $8,760 a year. And the market cost of a family coverage in my State is over $13,000 a year.

Describe to me how a voluntary buy-in for SCHIP might work from the point of view of Mr. England, who is an actual employer. What kind of options would he be given, and what would the cost be?

Ms. ALKER. Well, I think the idea is to offer employers another choice, and the choice would be the public product, and the benefits of offering the public product is that you have certain economies, and that is why it is cheaper.

I will say some of those reasons are good reasons. For example, there is usually lower administrative cost in public products. Obviously there is no return profit needed to be returned to shareholders that you are looking at with the public product, and there is the advantages of a large pool that would help a small employer, I think, like Mr. England.

One of the disadvantages as to why public coverage is cheaper is because providers are paid less, so that is sometimes a concern if that rate gets too low.

But overall, I think studies have consistently shown that public coverage is about a third cheaper than private coverage, and in the State of New Jersey, your private insurance rates are quite high.

Chairman ANDREWS. Just wanted to walk through what some of the numbers would like look like. Hypothetically let's say a State did a pilot where the SCHIP payment—let's take a family with two adults and two children, two SCHIP-eligible children. My understanding is the SCHIP allocation for those two children would be around $1,200 a year roughly, maybe a little bit more. So it would be $2,400, $2,500, $2,600. And presently SCHIP permits an employee contribution of up to 5 percent of gross contribution, although it need not be that high. If it was a maximum contribution for a $30,000 family, it would be about $1,500. So you would have about $2,600 in SCHIP contribution, $1,500 in employee contribution, which would be $4,100. There would be a $4,600 difference then between the cost of the SCHIP family coverage of $8,700 and the amount of money that would be available.

Would it be your understanding under these proposals States would be given the option of subsidizing, of kicking in toward that cost?

Ms. ALKER. Yes. I think that is right.

Chairman ANDREWS. Do you think States would be likely to do that if given that option?

Ms. ALKER. I think that if they really wanted to make it work, yes.

Chairman ANDREWS. What is interesting, if States, say, were to pick up half of that difference, it would drop the employer's contribution maybe $2,400, $2,500 a year. What is interesting about that is that many employers are able to insure an employee, and I think Mr. England spoke of this—they can insure an employee, but not the employee's family, and I know not because they are harsh people, but that is all they can afford. In my State, the cost of the insuring the employee only would be about $3,600 a year. So at least in theory, if the employer were given this option at a cost that would be less than what the employer is paying to insure just the employee, the employer could insure the entire family.

Now, one concern, if I may, I am sure Mr. Webber would have about this is I am troubled about the idea of a publicly subsidized program competing against the private sector on an unequal playing field. I anticipate that question. I would think, though, Mr. Webber, that one way we might address this is who is competing in what market? There is something like three-quarters of the uninsured children in the country are eligible for either SCHIP or for Medicaid. So they are families with incomes way below $40,000 a year. Again, in my State where we have a situation where family coverage costs $13,000 a year, it appears to me that most of the people who would take advantage of the example we just gave you aren't really in the private insurance market anyway because they can't afford to be in it.

Do you agree that there is—and you don't have to adopt my way. Do you agree that there is a surgical way that we could do this in a way that would not crowd out the private insurance market?

Mr. WEBBER. I agree with you. And I think in this environment that we have got to experiment, as I said, in my State. And I think

the notion of public-private partnerships so we can recognize that, you know, it is going to take a joint solution and some equal sacrifice, it is not something that we would be opposed to in theory.

The devil is in the details, as always, Chairman Andrews, and I am not an expert, let me tell you, on the SCHIP program, and the premium-sharing notion, but I think in this environment, given the issues that Brian England has described here today, that creative solutions need to be found. And we certainly find business people around the country increasingly willing to recognize that public-private partnerships to address this problem is at the core of the solution.

Chairman ANDREWS. Thank you. My time has expired. We want to exorcise those devils if we can and work out details mutually agreeable.

I will turn to my friend Mr. Kline.

Mr. KLINE. Thank you, Mr. Chairman, and let me thank the witnesses. We had a chance to chat for a minute or two before the hearing, and I had expressed my opinion that this was going to be one of those informative rather than controversial and partisan sorts of hearings, and it is certainly proving to be true.

I want to thank all the witnesses for your real insight and your testimony. And again, thank you, Mr. Chairman. Rob, I think it is a good approach. These are excellent witnesses, and I am writing notes as fast as I can. And then, of course, he confuses me by doing all this math, mental arithmetic. So now I am confused again.

You know, Mr. Webber, we in Minnesota, we are sort of a destination health care, medical care State. People fly in from all over the world, and we tend to brag a little bit that we can't have anything but the finest medical care, health care quality with the Mayo Clinic just south of my district. Nevertheless, there are enormous concerns about the value, and how we know what the value is, and how we are going to rate that value as we make decisions on what sort of medical services to purchase, and the advent of the health savings accounts have increased that pressure to know what you are buying if you are going to spend your own money.

Let me ask you this one question if time allows. I have got several for Dr. Blumberg about the Massachusetts initiative. So if you want to sort of read ahead.

What can you tell us about Secretary Leavitt's Value-Driven Health Care Initiative? I don't want an explanation of it, but do you see areas where they are showing promise or areas where it is not?

Mr. WEBBER. Oh, absolutely. And as I further described in the written statement, having someone at a Cabinet-level position put squarely on the table that in addition to this issue of the uninsured, the issue of value-based purchasing, the need for consumers and employers and government to assure that their investments in health care are yielding the highest quality, is, again, an instrumental part of the solution moving forward. And to make that happen, the four cornerstones, since Secretary Leavitt has talked about, is, number one, transparency, the need for business people and consumers to understand the health care that they are buying both in terms of quality and in terms of price; the issue that the good doctor talked about in terms of HIT adoption, the need—why

not in health care, like we have in every other industry, do we not have information technology to drive some of the solutions to help us track patients over time, for example; and finally, the need to change the incentives in the system. We pay for bad quality. We have a reimbursement system that does not recognize performance.

And so Secretary Leavitt has brought together public and private-sector leaders. He has gotten State Governors to sign onto those four cornerstones, and we are working quite closely with him through our business and health coalitions to create a dialogue around this issue of Value-Driven Health care. It is part of the solution to the health care reform issue.

Mr. KLINE. Let me follow up. I hadn't intended to do this, but the health IT, information technology, we are seeing some tremendous examples in Minnesota as different hospital systems are moving to that. And the potential for reducing, if not eliminating, some pretty egregious errors seems to be pretty high.

I am just interested, are you watching that across the board? And can you give me some sense of how it is coming?

Mr. WEBBER. Right. We are watching that throughout the country, and I think increasingly hospitals in particular are investing in health information technology. The real lack is at the physician level. You know, only 15 percent of physicians have electronic health records that allow them to track their patients over time. I mean, I hate to say it, but my vet caring for my little cat gives me more reminders about, you know, annual checkups than I get from my physician.

So health information technology is coming, but, again, requires some joint sacrifice and contribution to get the health care system wired.

Mr. KLINE. Right. We are seeing, of course, the same thing. It is the hospital and the systems of hospitals that are moving out and the individual physicians.

My time is about to expire, and rather than get into the Massachusetts example with Dr. Blumberg, perhaps we will get a chance later. I yield back.

Chairman ANDREWS. Thank you very much, Mr. Kline.

Mr. Kildee is recognized for 5 minutes.

Mr. KILDEE. Thank you very much, Mr. Chairman. I also want to commend you for summonsing such a panel. The quality of the panel both collectively and individually is very, very good, and I appreciate it.

Last fall I was instrumental in bringing the CEOs of the Big Three automakers to Washington to meet with both Democratic and Republican leaders because I think we have to recognize this has to be done in a bipartisan way to get it right. They indicated that the single most effective thing that we could do for them, because they have enormous health care costs, would be some type of catastrophic reinsurance. And there are various ways you can craft that; both Senator Frist and Senator Kerry have indicated some inclination that way with various ways of forming it.

Is there any role that some type of catastrophic reinsurance could be helpful to small business?

Mr. ENGLAND. Well, you know, I don't think a small business can take on the in-between risk. So you could have a policy that really

covered for, you know, major problems like a heart attack or something like this, but I think it should be around the other way. We should be really encouraging preventive care.

You know, we just talked about—you just said about the reminders from the vet. When we repair cars, we send service reminders out, and I talk to my doctor the other day, and she had not—she didn't have a facility to remind me when to go for checkups, which I think is terrible. Here we are, we care more about cars than we do about ourselves.

Mr. KILDEE. Well, I have in mind a small business in Flint, Michigan, a small chain of pretty well locally established restaurants where we had a very socially responsible owner, a good friend of mine, who offered health care, and he was able to do that until just one of his workers came down with a very long, debilitating disease, and he finally had to drop out of providing health care. Mr. Webber, could you comment?

Mr. WEBBER. Yeah. Representative Kildee, I would certainly share that. I ran a small association. We had one bad medical risk. We could not find an insurance carrier to provide us care except for the local Blue Cross plan that had to do so by State charter.

To your issue of reinsurance, there is no question that that would dramatically bring down the premium cost for employers and get more employers in the game. And so I think—again, in the spirit of a fresh look at these issues, I think all these proposals need to be put on the table. Obviously that issue gets to, okay, who is going to finance that reinsurance system that is established? And obviously there are constraints, particularly in this environment, with the Federal Government or even State government to provide a level of contributions to make that happen. But there is no question in my mind that that would relieve some of the pressure that employers are feeling about contributing to this voluntary employer-based system.

Mr. KILDEE. They could run a big company such as General Motors down to——

Mr. WEBBER. Right. Well, I am glad you are working with the large autos. So are we at the National Business Coalition on Health. The Greater Detroit Health Area Council, which is a multistakeholder organization with the large autos in a leadership role, bringing together all the stakeholders in health care, have put together some exciting initiatives; the one that we have been working on as a whole community initiative on save lives and save dollars, this notion that if we really were to drive higher quality in health care, there is gold at the end of the rainbow. And the autos have been taking a leadership role in that effort, and we are thankful to be working with them.

Mr. KILDEE. And I am not advocating the Canadian system, but I know I live near the Canadian border. And if one of the Big Three, everything else being equal, decides to build a new plant, and they can build it in Michigan or in Ontario, everything else being equal, they are going to build it in Ontario because their health care costs are virtually zero in Ontario. So that does have a profound effect not only upon the people who are ill and the employer, but our whole economy.

Mr. WEBBER. Again, I couldn't agree more. Rising health care costs, as I said in my statement, puts American industry at a competitive disadvantage in a global economy. And increasingly it is hard to compete. So, you know, we are losing jobs overseas; outsourcing is a major dilemma. Of course we want to keep these jobs here in America and create a vital economy, but we have to address the health care issue. And again, as I said in my statement, it is not just the issue of the uninsured, it is the issue of affordability and driving better and higher quality.

Mr. KILDEE. Thank you very much. Thank you, Mr. Chairman.

Chairman ANDREWS. Thank you very much.

Ranking Member McKeon.

Mr. MCKEON. Thank you, Mr. Chairman.

I am sorry that I wasn't here to hear your testimony, but Mr. Kline was, and I would like to yield my time to him, and he may ask the question that I would have thought of if I had been smart enough.

Mr. KLINE. This is all pretty scary. Thank you, Mr. McKeon.

I would like to take advantage of your yielding the time to go back to where I was going to go earlier with Dr. Blumberg and the Massachusetts law as sort of a model out there that a lot of people are looking at. And you mention the President has an initiative out there that he has put forward. We have got Massachusetts, we have got California, Minnesota, New Jersey. We have a lot of things going, and I quite frankly think that is probably a good idea because it is letting us look at a lot of possibilities.

But let's—I don't understand the Massachusetts law as well as I should, and you apparently do. So I would like to explore it just a little bit. Under the Massachusetts law, there is an individual mandate, you have to have the coverage. What is the enforcement mechanism for that? What if you don't have it?

Ms. BLUMBERG. The enforcement mechanism would be through the income tax system. Right now the mandate is not in place. Theoretically it should be in place and effective as of the end of the calendar year. So what happens is when it is time to do State income taxes, they will—every individual will have to have some way of verifying on their income taxes with something from their insurer presumably, or from a public program if they are enrolled in a public program, that they—as of December 31, 2007, they were covered by health insurance.

There will be penalties assessed that right now their focus is really on voluntary compliance and trying to make it as easy as possible to comply with the mandate. There will be some financial penalties that will be imposed for those who do not comply through the income tax systems and that presumably, over time, as the system has been in place and people are more familiar with what their options are and what their requirements are, those penalties may increase over time, but they will start out relatively modest.

I think it is important to note, too, the individual mandate in Massachusetts applies only to adults, not to children. We have expanded their Medicaid program, Mass Health, eligibility for children, so people should be enrolled. The children are not covered by the individual mandate.

And, in addition, the mandate will only be in effect if there is what is considered an affordable health insurance policy available to that individual and that those details are—those details are still being determined right now.

Mr. KLINE. So there are still a lot of unanswered questions.

Ms. BLUMBERG. But they really had what I considered to be a pretty short implementation plan. And so a lot of things are getting done at the same time right now.

Mr. KLINE. I have heard Governor Romney say this was going to save—at the end of the day, this was going to save public resources at one point. Do you have any update on what the projections are now in terms of State dollars?

Ms. BLUMBERG. I am not sure what the estimates are at the moment in terms of comparing what their projected spending is on the program compared to what spending would have been in the absence of the program. My personal sense of health care reform and coverage expansion is that one shouldn't expect, at least in the near term, to be spending less in a system-wide way under a universal coverage system than you would with having individuals uninsured. But I don't know what the State's own projections are.

Mr. KLINE. And this is like Mr. Andrews doing math in his head. I have got a piece of paper here, and I am not sure I am getting it exactly right. What happens, under the Massachusetts law, if the employer contribution levels prove insufficient? What happens?

Ms. BLUMBERG. Well, under the law, employers in Massachusetts that have workers, at least 10 workers or more, are required to make a fair and reasonable contribution to health insurance for their workers. Now fair and reasonable is another one of those details that is being determined at the moment. However, if an employer does not comply with the fair and reasonable requirement once it is determined, then the—if they are an employer of over 10 workers, they can be assessed an assessment for every worker per year that they are not making that contribution for. And that contribution, the assessment, can be up to $295 per worker per year. So it is considerably less than providing health insurance.

So that is why I referred to it as a light employer mandate, unlike California, where the requirement on the employers who do not provide health insurance is that they pay a 4 percent payroll tax on every worker.

So they do have an employer requirement if they don't participate. But it is not a tremendously onerous one.

Chairman ANDREWS. Thank you, Mr. Kline.

I will mention, again, that the subcommittee would like to explore these State plans in the forthcoming weeks and work with the minority to bring in some of the proponents of the plan from around the country so we can learn more about it, and we appreciate you helping us out that way.

Mr. Loebsack is recognized.

Mr. LOEBSACK. Thanks for having this hearing today. And thank you to all of the witnesses. Unfortunately, I have been here sort of sporadically not only because of votes but for other reasons.

I am going to say a couple of things, and I am not going to have any questions at this point.

I am a new Member, and I am learning about how to deal with the media the hard way. The Sunday after the election, my photo was above the fold on the front page of the New York Times, and under my photo was my position on health care during the campaign and the position that I have now, which is that I favor a single-payer system, whether it is Canadian or whatever the case may be. But at the same time, I am pragmatic enough to realize that is unlikely to happen at any time soon, if at all, in America. So I am open to options, and I am happy to be here today.

With that, I am going to pass because I have been here, as I said, only sporadically this morning, and like my colleague from California, who just left, I don't feel as though I have a particularly intelligent question to ask at this point. But I promise I will in the future.

Thank you, Mr. Chair.

Chairman ANDREWS. I thank my friends. I actually think it is a huge improvement in the level of quality work around here when Members say that. We have had a lot of questions over the years asked that—we also do more listening than talking, myself included, and we appreciate that.

Mr. LOEBSACK. I forgot to yield back, but your comments are okay.

Now I yield the rest of my time.

Chairman ANDREWS. Mr. Courtney, who has had extensive experience with Connecticut legislature in health care, is recognized.

Mr. COURTNEY. Thank you, Mr. Chairman.

As someone who has chaired the public health committee at the State level, this is sort of dj vu all over again, listening to the ways you squeeze the balloon on the system, and actually up until about a hundred days ago, I was also a small employer, had been for over 20 years, and the dilemmas you described in trying to balance the need to retain quality workers with their own family needs and in terms of wages and benefits, I could probably get over on the other side of the table here and share some of the stories there because that really is a reality that you described that small businesses experience over and over again out there.

And listening to Mr. Webber talk about the value-based consumer-driven path as sort of a way out of the situation they are in right now, I have to tell you, again, as somebody who was a small employer, I am a skeptic because, at some point, small employers want to basically repair cars or practice law or practice medicine. I mean, they really don't want to be in a position of having to sort through data as far as making choices on health care plans. It is too much. We are already dealing with that with our retirement plans, the 401(k) options that people have to—it is drudgery for staff to go through those meetings with their financial planners. And at the end of the day, we are really looking for—I say "we." I mean, they are looking, my former compatriots, for better choices to buy into plans like the ones that Ms. Alker described. And I want you to one more time, because I, like Mr. Kline, wasn't able to retain those numbers quite as quickly.

If we were to sort of adopt the approach that Mr. Andrews suggested, which is to give employers that opportunity to buy into

SCHIP, again, if—we will use New Jersey as an example. You said the cost of a family in SCHIP would be about $8,000 today, $8,000.

Ms. ALKER. That is what you said. I had a cost of—a national cost which was about $7,400 as the national average. And the private was a little bit under $10,000.

Mr. COURTNEY. And the very attractive scenario that you went on to describe indicated that there was a way to sort of reducing that to bring it down in half. But you described it as it would be an optional choice for States in terms of whether or not to subsidize a portion of that premium.

Ms. ALKER. I think the attractive feature of the proposal that the chairman is considering is that we have—we are talking about low-income families, low-wage workers earning twice below the poverty line, and the children are, by and large, eligible for coverage, Medicaid and CHIP. And as Congressman Andrews indicated, we have a long way to go on getting to the finish line with covering all uninsured kids. But it looks very positive that Congress will make a lot of steps forward in the CHIP program. But where we have a real chasm is the growing number of uninsured low-income adults, the parents and also childless adults because typically, they are not eligible for public coverage. Parent coverage is very low. Nationwide, it is about 65 percent of poverty, about $13,000. Your state of Connecticut is high or low. As you remember, there were some issues about rolling that back as well as New Jersey. But that is where this proposal, which combines the commitment we have already to cover those kids through Medicaid and CHIP with some kind of contribution from the family, and then we can use the employer contribution and any additional subsidies State and Federal Government can kick in to address the needs of the parents.

And I would say childless adults should be included as well, but that is a detail that is still remaining. But that is what is attractive about this. Looking at that group, and I am sure Dr. Blumberg will speak to this more where we really have problems of low-wage workers not having access to coverage. And this would offer an opportunity for those employers who would like to help out those workers, and the kids may be CHIP or Medicaid eligible.

Mr. COURTNEY. So, again, for the auto repair shop who has a worker who qualifies or whose family income is within SCHIP, if this system existed and they wanted to cover or buy into the SCHIP program, the reduction in costs would be somewhat contingent on whether or not the State sort of opted to subsidize a portion of the premium.

Ms. ALKER. I think the idea is that for his family—and he indicated he had an employee who was working part time and she had been eligible, I believe, for Medicaid, but then when she earned more money, she was no longer eligible

for Medicaid even though her kids were. So the idea would be the States would still be paying the cost of the kids and whereas now he would have to buy a whole family policy in the private market, he could purchase coverage through the CHIP pool for his worker who is not eligible for public coverage. But the State would be paying the costs for the kids. So that would be a lot less expensive than if he had to buy for the whole family policy on the private market.

Mr. COURTNEY. That is where you would arrive at that point where the total cost of the employer would be about $3,000 or $4,000.

Ms. ALKER. Yeah. We would have to figure out the numbers in different places.

Chairman ANDREWS. If the gentleman will yield. What we find intriguing about this idea is that, if there were no State match and you could get down to that kind of number, this is using Federal dollars we are spending anyway, you understand. The real reduction here for the employers, as Ms. Alker just said, being able to participate in that SCHIP pool, giving him or her the economies of scale and the purchasing power.

Next, Mr. Hare is recognized for 5 minutes.

Mr. HARE. Thank you, Mr. Chairman. Thanks very much for chairing a hearing on a subject that I think is probably one of the most important issues that we have facing us today.

I toured several hospitals in my district. I am from west central Illinois, and I spoke to hospital administrators and asked them in your emergency room, what percent of uninsured people come through the emergency room, which, you know, is the most expensive? We are averaging now at four hospitals about 30 to 35 percent of people that are going through the ER are people who are uninsured. So, clearly, we have a significant problem here, people using that, using health care—using the emergency rooms for health care and we have to do better. We have to do a lot better than we are doing.

I just want to ask a couple of questions if I could.

First of all, Ms. Alker, you said that New Jersey's premium assistant program, you called it exemplary. What lessons can other States learn that New Jersey has been doing as a model?

Ms. ALKER. The reason I like the New Jersey program, and I should mention that Illinois has one as well, which I think they have—it is an alternative model. Their heart is really in the right place. I have some concerns about it, but what I like about New Jersey's program is, they have made sure that families still retain the same benefits package as they would in Medicaid and CHIP so they provide a wrap-around. And these families face very high private costs. So the State will come in and pay those so the family is not exposed to higher costs because, for low-income families, that is challenging and causes them to lose services.

And the other thing they do, and this has been a troubling feature of the Bush administration's waiver policy in the past 6 years, the Bush administration has actually weakened Federal standards regarding cost-effectiveness for premium assistance programs in an effort to really encourage the use of private insurance. And they haven't really required States to be very aggressive about assessing whether they are saving money under these programs, and because, as I indicated, private coverage is much more expensive than public coverage. And when enrollment is low, you have high start-up costs. Some of these programs haven't been cost-effective.

New Jersey's also does a good job—they do an actual assessment looking at the cost of the employer plan and the cost for the wrap-around services, and they make sure that they are saving money

or they don't enroll the family. They enroll them in the direct coverage. That has been the strong feature. Those two aspects of it.

Mr. HARE. Dr. Blumberg, most people that I talk to, including my friend Mr. Loebsack, is a supporter of a national health care system where everyone has a right to go to the hospital. This debate always seems to be of the question of, how are we going to pay for a system like that? In your experience as an economist and researcher, can you speak to the question about national health care?

Ms. BLUMBERG. I think of it as a redistributional issue. If there is—when you go to a government—fully government funded system as opposed to doing something that more closely approximates what we have today with extra subsidies for people who are in greater need, when you are going to that fully government system, there is a lot more redistribution of spending. And when I say redistribution, I am talking about moving dollars that are currently paid by the private system and moving those dollars through new revenue-raising mechanisms into the public sector. And so it really can be set up to not cost tremendously a lot different, but a lot of it is what your taste for redistribution is.

So you can set up a system on what is more closely based on what we have now, as I mentioned, with other assistance for people who are at a higher need, but without redistributing quite as many dollars from private payers into the government system. So some people are going to politically feel that they either can't or don't want to shift those private dollars into the government system and then redistribute them out that way. And some people are going to be very happy to redistribute those dollars to the government system because they feel like they can make those payments then more closely based on people's ability to pay.

So in terms of what we have seen and with States trying to do reform and from previous efforts at the Federal level, I think that the country has a way to go in terms of getting to the mindset of feeling comfortable with the really substantial degree of redistribution that would be required under a single-payer system. So we already see they have difficulty even talking about new revenue-raising mechanisms to pay for a system that wouldn't be quite as huge a shift in terms of where the dollars are coming from.

So that is my assessment. Obviously, you all have a better sense of politics than I do.

Mr. HARE. I doubt that.

Ms. BLUMBERG. There really is a redistributional issue, and what your taste is for redistribution is going to drive you to one corner or the other on this.

Mr. HARE. Thank you.

Chairman ANDREWS. Thank you, Mr. Hare.

The gentlelady from New York, Ms. Clarke, is recognized for 5 minutes.

Mr. CLARKE. Thank you very much.

It is one of those days where I have so many meetings and hearings that I am at simultaneously, but this is an important issue, and I want to thank you for your leadership in this regard. And just to say that, you know, this issue has resonance throughout

this body. This week, I was in a hearing in small business where this issue is being vetted as we speak.

Mr. Chairman, approximately 47 million Americans are currently uninsured, and I believe that health care is a right for every woman, man and child in America. Traditionally, health care coverage has been a component of the social contract between employers and employees. However, that social contract is dissolving more and more each day, particularly for small businesses and, in many instances, for good reason.

As a result, the Federal Government must create innovative solutions to bridge the gap between the uninsured and the insured and make sure quality health care is affordable and available to all. It is not a luxury. Specifically, I believe that every American should have a guaranteed adequate level of health care, and health care should be managing the cost of premiums, co-payments and deductibles. Moreover, every American should have the ability to pick his or her own doctor, and it should be the patient and doctor, not the insurance company bureaucrats, who make the critical medical decisions. And, finally, preventative care and access to preventative medication must be an integral component of any health care plan. So having that as a backdrop of my philosophy, let me say and ask a couple of questions with regard to SCHIP.

Does the SCHIP program give assistance to everyone regardless of residency and immigration status? And I put that out there—I want to ask a couple of questions in a row.

With respect to uninsured children, and this is something I am really concerned about, if a child is no longer financially eligible for Medicaid and SCHIP, could there be a period of time where the child is uninsured because the parent is waiting for the employer's annual open enrollment period? And has there been any study as to this and to determine what, on average, is the waiting period before a parent gets that coverage?

I just want to open up those questions to all of you.

Ms. ALKER. I think I can respond to those.

On your question regarding immigrant children, SCHIP, Federal SCHIP money currently does not pay for most immigrant children. There is an effort this year to restore some Federal funding for children of illegal immigrants. Right now, there is a 5-year bar when they enter the country. And that is something that Congress will be considering this year. There are a few States that do, through their own funds, pay for all children, including undocumented immigrant children, not very many, and then there are some that pay for those 5-year-bar kids, which the Federal Government used to pay for but did not allow States to use SCHIP to fund for that.

And your second question, can you restate it, Ms. Clarke?

Mr. CLARKE. I wanted to get a sense of that period of time where a child is uninsured because they may be waiting for the employer's annual enrollment period. And whether we have done any studies to determine what the average waiting period could be. And if that child is no longer financially eligible for SCHIP, you know, what is the impact of that?

Ms. ALKER. I haven't seen any studies of that. I don't know if you have, Linda. I think the issue you are raising is children who

would be over-income for SCHIP eligibility but waiting for the open enrollment period. I haven't seen any numbers for that. I think that would be a problem, and that would be something that would be relatively easy to address.

Chairman ANDREWS. I think the committee would have some interest in asking HHS or the States the answers to that very profound question. If Ms. Alker and Dr. Blumberg don't know the answer, I don't think anybody does. But we, perhaps, could look at the appropriate government agency and do a joint letter, and we could ask them. It is a very good question.

Mr. CLARKE. Just in closing, you know, we think about oftentimes health care sort of in a very sterile way. I hope that we begin to address the issue of visitors, folks who may be immigrants here out of status. Because oftentimes, the issues that we are talking about are public health issues as well. And so, to the extent that we leave anyone out of a health care infrastructure to address either preventative health care or containment, we are all at risk for the dimunition of our health.

And I yield back, and I thank you all for your testimony here today.

Chairman ANDREWS. Thank you for your contribution.

Mr. Sestak is recognized for 5 minutes.

Mr. SESTAK. Dr. Blumberg, I would like to ask a couple of questions, and they may have already been asked—and I regret that I just showed up—about the Massachusetts plan. I am intrigued by it because it was a Republican governor and a Democratic legislator that came together, and I honestly think if you are ever going to affect something that is eventually going to cover everyone, it is going to take a bipartisan approach.

The outlines of it I found—and it was an education for me—I found this of some interest. It is, if you do think that transparency of standards and competition might ultimately discipline costs and that it is a shared responsibility between society and individual, that here you have a mandate. And if I am not wrong, about a fifth of the uninsured and the top one-fifth of the wage earners of America, those young youth that think they don't need to be insured, and they are in motorcycle accidents or some other problem, it is my limited understanding that a benefit may be that premiums could go down if there are more healthy individuals in the pool. Premiums might go down if you do this pooling because, again, my stats might be wrong, but like small businesses, depending on how you define "small business," may cover upwards of 60 percent of workers in America presently. And that if you are able to pool them together through a quasi-government connector to negotiate among plans that may not be dissimilar to what the Federal Government has, premiums may ultimately go down.

I understand Massachusetts is a unique State in terms of how many are uninsured and all of that. But if it is mandated and most of them go to the emergency room for care, ultimately, potentially, taxes aren't needed as much to subsidize that, but they can then cover those who truly are insured because they are not employed but meanwhile they need coverage until they do. That simplifies the Massachusetts plan a lot, I understand.

But I thought those were the principles that made it somewhat attractive for the broad support that it did have as a step towards a bipartisan approach on affordable and accessible andadequate coverage.

I am intrigued by it. What is it I should be looking at to really say whether this is some model that we should think seriously about?

Ms. BLUMBERG. You covered a lot of ground in your comments. I will try to talk about what I think the most important points are in the plan and how they fit into the issues that you are raising.

It is true that some of the uninsured are young and healthy. Many of them are not. And when you bring in, just for purposes of the discussion, hypothetically, when you bring in the whole population into a system, you are going to bring in both people who are low-cost and high-cost. When you have more low-cost people in there in a particular health insurance risk pool, a particular pool in which premiums are determined, that is going to bring the average health care costs in that pool down. But it is important to remember that that doesn't mean we are bringing total health spending down. It means we are bringing the average for that pool down.

So there are also a number of people who are uninsured today who, as a consequence of being uninsured, are not receiving as much medical care as they would had they been covered. And so when those people are brought in and given a comprehensive health insurance policy, then those individuals are going to end up spending more in the system than they would have spent without insurance. And many for good reason because they need more medical care for particular types of conditions, and they weren't receiving sufficient care.

But I want to be clear that some people are going to increase their use once they have insurance, and some people are going to come in and not cost too much.

Mr. SESTAK. But the whole system, they may decrease their use in terms of cost because now they are not waiting until it is an acute illness and going into the emergency room; correct? There will be that initial—theoretically, the cost will ultimately be less if they are getting the coverage, correct?

Ms. BLUMBERG. There will be some efficiencies that are created by people having the usual sources of care outside of settings such as emergency rooms. Some people will get more preventative care. But there is not a great deal of research evidence to support that the preventative care is going to end up decreasing costs over time. It may increase quality to have preventative care that is more accessible for individuals, but we don't necessarily know that that is going to end up leading to system-wide savings, the more preventative care that people get. It may be that people end up getting conditions identified and have better quality of care and better health outcomes and get better services as a consequence of that. But the research isn't there——

Mr. SESTAK. I thought Medicaid had done two pilot programs that did show the savings that could accrue from preventive care and managed care. That would show you do save—of course, these are more chronically ill individuals—that you do have some ultimate savings, but that is wrong then?

Ms. BLUMBERG. I am saying there is not a great deal of research evidence to show that you are going to get significant system-wide savings as a consequence of the preventive care, but you may increase quality, and that is also obviously a value to society.

In terms of the savings from the connector, there are clearly some efficiencies from bringing individual purchasers and small group purchasers into an entity that will be negotiating for premiums as a larger group. There are also some administration costs that go into administering that pool so it is not costless. But it is certainly better than what individuals in the smallest groups experience today.

We should be very mindful when we are thinking about these purchasing pools, in terms of how much negotiating power we are going to allow them to have. Sometimes politically it is very difficult to get all of the stakeholders together to support legislation where the insurers are concerned because the purchasing entity is going to have too much negotiating power. And so that is a real difficult balance because, on the one hand, for system-wide efficiencies in savings, we would like to have a very strong purchasing entity. And politically, sometimes that is difficult to achieve. So I think that is an important point to keep in mind that these purchasing entities won't necessarily have a great deal of cost-saving potential unless we give them the power to really be a serious negotiator.

Chairman ANDREWS. Mr. Webber, if you would like to respond.

Mr. WEBBER. Thank you for raising those very good issues.

On the issue of investments and prevention and chronic care management yielding savings over time, sort of my response to Dr. Blumberg is, if the research isn't there, let us do the research because I think there is intuitive logic there, and I think if we go outside of the big academic studies and we look at some observational studies, that we can actually begin to prove the point. And one example of that: Pitney Bowes, a large company, put together a very interesting what we call value-based benefit design where they looked at their population and saw that their diabetic patients were not getting the services that they needed. And they had actually set up a pharmacy benefit mechanism where individuals, again, could not get access because of high out-of-pocket expenditures. So they said, we have got to rethink this. We need to make sure that the people that are chronically ill are getting appropriate access to medications that they need, and we are convinced that it is going to pay off over time. So they put all branded and generic drugs into a preferred tier. They reduced barriers to access. They actually drove up the front-end cost for pharmacy benefits, but then they looked at emergency rooms, they looked at hospitalizations over time, and total costs were saved.

Chairman ANDREWS. Last year, the full committee had a hearing which talked about this topic, and there was a witness who talked about an effort on diabetes where, in addition to what you are talking about pharmaceutical products, they actually increased the physician reimbursement for physicians who had gone through the Good Housekeeping Seal of Approval in the endocrinological field. And they did have some results which, at least in the short-term, showed much better outcomes for diabetic patients.

And I concur with you and Dr. Blumberg, we would like a more robust body of knowledge on this topic.

Mr. WEBBER. And, Chairman Andrews, thank you for raising that. That is the Bridges To Excellence Program that I referred to in my oral statement where, again, physicians who are designated as driving better quality in the field of diabetes, driving better outcomes, controlling their patients with greater blood-sugar control, they get paid more. But if you look at, again, total health expenditures over time, the entire picture, we are actually improving quality and reducing costs at the same time.

Chairman ANDREWS. Certainly.

Mr. Kline, did you have any closing comments?

Mr. KLINE. Only this. Again, thank you to the witnesses. This has been a fabulous panel. As I guessed in the very beginning, this was going to be very, very informative. It turned out to be just that. Your testimony has been excellent.

Chairman ANDREWS. Let me join in thanking each of the four of you for provocative, very well-thought-out comments. We are delighted you were able to give us your time today.

Here is where we intend to go from here. In subsequent weeks, the committee is attempting to put together a hearing. We can have witnesses from the more innovative State programs like Massachusetts, like California, so we can learn more about their approaches.

With respect to the SCHIP idea, which Ms. Alker has been instrumental in educating us about, we invite the comments of all of the Members of the committee, Republicans and Democrats, as to their views in helping to put together legislation. And in the longer term, I would acknowledge that many of the more creative State experiment ideas do run into issues about the ERISA Statute, and we are interested in exploring the idea of appropriate modifications to the ERISA Statute that would facilitate intelligent and wise State experiments that could reduce the number of uninsured and increase quality and reduce costs.

All members will have 14 days to supplement the record with any other comments they would like to make. We, again, thank the witnesses for an extraordinary performance.

The committee stands adjourned.

[Additional submissions for the record follow:]

["Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs," dated September 2006, Internet address follows:]

http://www.chipcentral.org/Files/Charting—CHIP—III—9-21-6.pdf

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[Congressional Research Service report for Congress: "State Children's Health Insurance Program (SCHIP): A Brief Overview," updated January 30, 2007, Internet address follows:]

http://www.congress.gov/erp/rl/pdf/RL30473.pdf

[Congressional Research Service memo prepared for Congress: "State Health Insurance Reforms," dated February 2, 2007, follows:]

Memorandum February 2, 2007

SUBJECT: **State Health Insurance Reforms**

FROM: Jean Hearne
April Grady
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This memorandum describes state efforts to expand coverage to uninsured persons and families. It includes descriptions of more and different types of initiatives than have been summarized in previous CRS reports (RS21393, *State Health Insurance Programs for the Uninsured* and RL32385, *Expanding Health Care Coverage for the Uninsured: Lessons Learned From States*). In addition to describing state efforts to provide direct coverage for uninsured individuals, we describe premium assistance programs, state reinsurance programs, and health insurance purchasing pools, among other programs and policies.

The initiatives described below are indicative of the innovation and wide variation of state actions to reduce the number of uninsured. In our research, we found that a few states have pursued universal coverage using tools such as employer and individual mandates. Some of those programs are in the process of being implemented, and others are not yet operational. Other states are reportedly beginning to consider such reforms. Some states have extended Medicaid and State Children's Health Insurance (SCHIP) coverage or established new programs for uninsured people who are not eligible for Medicaid or SCHIP. Others have focused on assisting employers in offering coverage as a workplace benefit or helping low-income workers afford their share of a health insurance premium.

Summarized below are only those state-wide initiatives that are either in place now, or have been enacted into law but are not yet implemented. Press reports indicate that a number of states are now or will soon be considering proposals to extend insurance coverage. To control the scope of this project, those proposals, reportedly under (or soon to be under) consideration in a number of states --- including California, Connecticut, Illinois, Pennsylvania, Rhode Island, Minnesota, Ohio, Wisconsin, Colorado, and New Mexico --- are not described.

In addition, states' laws that prohibit coverage denials or limit the pricing of health insurance products based on personal characteristics (for example, health status) are not described. While some of the objectives of community rating and other insurance regulations may be similar to the objectives of purchasing pool laws --- such as to improve

the possibility that reasonably priced plans are available, even for high-risk individuals --- a comprehensive description of the regulatory environment in each state is beyond the scope of this project.[1] States have also passed other insurance requirements that may improve the likelihood of plans being available to special populations, such as college-age children.[2] Those more narrowly applicable laws are not described below. Finally, the descriptions of Medicaid and SCHIP expansions are limited to populations that are generally ineligible for public coverage under these programs, such as childless adults.

The memorandum is divided into the following three sections: a description of comprehensive state reforms intended to achieve universal or near-universal coverage, a summary of state reforms in **Table 1**, and a set of tables with state-specific information on each type of reform. **Table 2** describes state programs providing Medicaid or SCHIP coverage to non-traditional populations; **Table 3** describes state high risk pools; **Table 4**, other state-sponsored coverage; **Table 5**, premium subsidy programs; **Table 6**, health insurance purchasing pools; **Table 7**, reinsurance programs; **Table 8**, limited benefit plans; and **Table 9**, unique state initiatives that do not fall into any of the other categories. Additional information about these classifications can be found at the bottom of **Table 1**.

The limited time available to prepare this document prevented CRS from conducting a 50 state (and D.C.) survey. Instead, we have relied on literature reviews, web searches, and other secondary sources. Two important sources used heavily included Academy Health's State Coverage Initiatives [http://statecoverage.net/] and individual state websites. This method may have resulted in inadvertent omissions of some programs. In addition, the active legislative environment has made identifying and describing such actions a moving target.

Comprehensive State Reforms

Over the years, a number of states have enacted comprehensive reforms intended to achieve universal or near 100% health insurance coverage. Actually putting the reforms into place has been challenging and no state has achieved full coverage yet. Three states, Maine, Massachusetts and Oregon, have passed recent reforms and each has some of the pieces in place. One state, Vermont, plans to begin implementation of its reforms in 2007. Finally, Hawaii's reforms, dating back to the early 1980's, include an employer mandate.

Hawaii

Hawaii is unique among states because it is the only one with an employer mandate for health insurance coverage. The Prepaid Health Care Act of 1974 (PHC) requires nearly all employers to provide health benefits to at least some of their workers. Eligible employees are those who work a minimum of 20 hours a week and make a certain amount above the

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[1] For more information on state regulation of health insurance premiums, see [http://www.nahu.org/consumer/GroupInsurance.cfm].

[2] Children typically lose health coverage under a parent's policy on their 19th birthday, but many insurers provide an exception for full-time students (with dependent status ending at graduation or a specified age). Some states have passed laws mandating that insurers allow dependent status for all young adults up to a certain age (CO, DE, MA, NJ, NM, UT) or for specified groups of young adults --- for example, full-time students or those who take a leave of absence from school due to illness, injury, or service in the armed forces, etc. (IL, ME, MD, MI, NH, OR, PA, RI, SD, TX, VT). See [http://www.ncsl.org/programs/health/dependentstatus.htm].

state minimum wage. The coverage offered must meet state-prescribed standards. A worker may have to cover part of the premium although there are limits to that contribution, and cost sharing requirements vary based on the type of plan chosen.[3]

Hawaii's unique status as the sole employer mandate state is due in large part to the state's exemption from the federal Employee Retirement Income Security Act of 1974 (ERISA). Among ERISA's provisions is a "preemption clause" that declares the federal law supercedes all state laws that "relate to" employee benefits. The courts have broadly interpreted this clause to mean ERISA prohibits state laws that directly (and in some cases indirectly) regulate employer-sponsored health benefits.[4] Employer health insurance mandates fall into this category of prohibited state laws. The conflict between the PHC mandate and ERISA's preemption clause soon lead to litigation (the preemption provisions took effect on the same day that the PHC was implemented). Years later, Congress authorized the nation's only exemption from ERISA for Hawaii's mandate law.

There is disagreement among policymakers, academics and others about the lasting impact of Hawaii's employer mandate. Some observers point to the state's high uninsured rate before the mandate (around 30 percent according to one estimate) and the rate by the late 1980s (around 5 percent according to state analysis) as evidence of the mandate's success in expanding coverage.[5] Others question the methodology used to measure the state's uninsured population, and attribute broad coverage to characteristics of the population and the state, not the PHC.[6]

In addition to the employer mandate, Hawaii has a comprehensive Medicaid waiver that expands eligibility to multiple target populations, including childless adults. Among the components of the Section 1115 demonstration is the creation of a public purchasing pool that arranges health benefits through managed care plans. Depending on the eligibility group, enrollees are entitled to either full Medicaid benefits or reduced Medicaid/SCHIP benefits. Some groups also must cover part of the premium.[7]

In general, Hawaii's uninsurance rate is relatively low–approximately 9 percent during 2005. While the state's rate for employer-based health coverage in that year was the same as the national average (around 68%), Hawaii's rate for coverage under government-sponsored programs was higher than the national average. Some of this can be attributed to the share of the population enrolled in military health programs. Over 10 percent of Hawaii's population receives military health care, almost triple the national rate of nearly 4 percent.

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[3] For additional information about the PHC, see the state's webpage at [http://hawaii.gov/labor/dcd/aboutphc.shtml], and a historical overview at [http://www.statecoverage.net/statereports/hi6.pdf].

[4] For additional information about ERISA, see ERISA Preemption Primer at [http://statecoverage.net/pdf/primer2000.pdf].

[5] For a discussion of the mandate's impact, see John C. Lewin, and Peter A. Sybinsky, "Hawaii's Employer Mandate and Its Contribution to Universal Access," *Journal of the American Medical Association*, May 19, 1993, vol. 269, no. 19, pp. 2538-2543.

[6] For example, see Andrew W. Dick, "Will Employer Mandates Really Work? Another Look at Hawaii," *Health Affairs*, Spring 1994, pp. 343-348.

[7] To review Medicaid waivers and demonstrations by state, refer to [http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/].

Maine

Maine's Dirigo Health Reform Act was signed into law in June 2003 with the goal of achieving universal coverage within five years, as well as containing health care costs and improving health care quality.[8] Among a variety of other reforms, the legislation expanded Medicaid eligibility for parents to 200% FPL and created DirigoChoice, a state-sponsored health insurance option for small businesses, the self-employed, and certain individuals who do not have access to employer-sponsored insurance. DirigoChoice offers sliding-scale premium subsidies and reduced deductibles and out-of-pocket maximums for employees and individuals with incomes below 300% FPL. Funding comes from voluntary employer and individual contributions, state general and federal Medicaid funds, and an assessment on insurers (who pay up to four percent of their revenues, so long as the state can document savings from Dirigo reforms). The state has also had a Section 1115 waiver in place since 2002 to provide Medicaid coverage for childless adults up to 100% FPL, but enrollment was capped in 2005 and a plan to expand eligibility to 125% FPL was repealed by the legislature because of cost concerns.

When DirigoChoice became operational in January 2005, the state expected to enroll 31,000 uninsured people within a year. As of August 2006, only about 11,000 people were enrolled, with about 40% having been previously uninsured and the remainder switching from other coverage.[9] Although DirigoChoice has appealed to people who qualify for subsidies and those who would otherwise have a difficult time buying insurance due to pre-existing conditions or a lapse in coverage, the program is not attracting as many businesses as expected. Insurance agents report that premiums for DirigoChoice can be higher than those for other health plans that offer similar coverage to small employers, and despite the potential benefit of subsidies for employees, some employers have been unwilling to take on the necessary paperwork or unable to afford the required contribution of 60% of the cost of a single premium for each participating employee.[10]

There has also been controversy over the assessment on insurers, which is intended to recapture savings that accrue to insurance companies as a result of Dirigo reforms and is the main source of funding for DirigoChoice subsidies. A lawsuit filed by insurers and the Maine State Chamber of Commerce is pending in state court, but the assessment for 2005 is being collected while the outcome of the case is determined. Insurers have been granted authority by the state's insurance bureau to pass on the cost to policyholders instead of paying it out of their profits as originally intended, angering businesses and consumers whose premiums have increased as a result. It is unclear whether the assessment for 2006 will be collected, and state lawmakers will consider tax increases or other funding sources

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[8] See Dirigo Health, at [http://www.dirigohealth.maine.gov/] and Jill Rosenthal and Cynthia Pernice, *Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine*, National Academy for State Health Policy, June 2004, at [http://www.nashp.org/Files/GNL_56_Dirigo_brief.pdf].

[9] Karynlee Harrington and Will Kilbreth, *Dirigo Health Agency: A Snapshot of the Program 2005 & 2006*, Sep. 18, 2006, at [http://www.dirigohealth.maine.gov/Agency%20Fact%20Sheet%20Final%20091506.pdf].

[10] Clarke Canfield, "Dirigo Health Not Attracting Businesses," May 27, 2006, at [http://www.boston.com/news/local/maine/articles/2006/05/27/dirigo_health_not_attracting_businesses/].

this year. As a fallback, DirigoChoice may stop enrolling new policyholders as of April 1, 2007.[11]

Massachusetts

In April 2006, Massachusetts passed legislation that aims to achieve near-universal health insurance coverage by expanding Medicaid and SCHIP eligibility, providing premium subsidies for certain individuals, and mandating the purchase of insurance for those who can afford it. To make private health insurance plans more affordable and accessible, it modifies state insurance laws and creates a public entity called the Connector to serve as a clearinghouse for the purchase of insurance by small employers and individuals who are not offered subsidized insurance by a large employer. To pay for the legislation, the state will redirect some existing Medicaid funds that are used to reimburse health care providers (primarily hospitals) for treating uninsured and other patients who generate uncompensated care costs. It will also obtain additional federal Medicaid and SCHIP dollars using new state general fund appropriations and revenues from employers that do not offer health insurance. Another significant source of funding, while not necessarily flowing through state coffers, is the mandate that requires individuals to purchase insurance or face financial penalties. Over time, the state expects to redirect additional funds from uncompensated care reimbursement to other uses (e.g., premium subsidies) as its uninsured rate declines.[12]

Uninsured individuals at or below 300% FPL who meet certain qualifications are eligible for subsidized health insurance plans offered through the Connector. Those with incomes below 100% FPL, who receive full premium subsidies from the state, began enrolling in October 2006.[13] Enrollment for this group is expected to reach 40,000 by the end of January 2007. Those with incomes between 100%-300% FPL, who receive premium subsidies on a sliding scale, began enrolling in January 2007. It is too early to predict enrollment for this group, in part because individuals are required to contribute toward their premium costs, but about 73,000 people are estimated to be eligible. Total premiums charged by the four insurers that are currently authorized to provide subsidized coverage range from $276 to $391 per month for a single person. Individuals between 100%-300% FPL contribute $18 to $106 per month (1.8% to 4.7% of income) for the lowest cost plan. Couples between 100%-300% FPL contribute $36 to $212 per month (2.6% to 7.0% of income) for the lowest cost plan. Program participants must pay more if they wish to enroll in a higher cost plan. Children under 300% FPL are eligible for MassHealth, the state's public coverage program funded with Medicaid and SCHIP dollars.

Beginning in April 2007, the Connector will also facilitate access to unsubsidized plans for small employers and individuals who are not offered insurance by a large employer that pays part of the premium. It is hoped that premiums for unsubsidized plans offered through the Connector will be low enough to enable most uninsured individuals above 300% FPL to purchase insurance, but initial bids have come in much higher than anticipated, at about

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[11] "Dirigo Health Votes to Collect $34.3M Offset," *Bangor Daily News*, Dec. 30, 2006, at [http://bangordailynews.com/news/t/news.aspx?articleid=144664&zoneid=5].

[12] CRS Report RS22447, *The Massachusetts Health Reform Plan: A Brief Overview*, by April Grady.

[13] See [http://www.mass.gov/?pageID=hichomepage&L=1&L0=Home&sid=Qhic].

$380 per month for an individual. The board of the Connector plans to work with insurers over the next two months on ways to bring the price down before actual premiums are set.[14]

Although the state has distributed grants to a variety of associations, health centers, and community agencies to help with outreach and education, many people are still unaware that health insurance coverage is mandated for people who can afford it as of July 1, 2007.[15] The Connector will define affordability this spring for purposes of determining who may be exempt from the mandate. It will also determine what constitutes "minimum creditable coverage" for purposes of the mandate. The Massachusetts Association of Health Plans estimates that more than 200,000 people who currently have insurance would have to buy additional coverage to meet the minimum standard that has been proposed --- but not yet adopted --- by the Connector.[16] Given that significant financial penalties will not be levied until tax year 2008 (when residents will have to pay the state an amount equal to 50% of the lowest premium available to them for each month they are uninsured), prospects for individual compliance with and state enforcement of the mandate are unclear at this time.

Oregon

Beginning in 1987, Oregon passed a number of health reforms that included, as an explicit objective, the achievement of universal coverage. Collectively, the reforms became known as the Oregon Health Plan (OHP).[17] An important part of the OHP was an employer "pay or play" type mandate. In addition to the employer mandate, Medicaid was to be expanded to first cover all state residents with income below 100% of poverty and later, to all of those with income below 185% of poverty. Funding for those Medicaid expansions was to come from multiple sources, but primary among them was a limitation on Medicaid benefits for those already enrolled. The savings from those limitations would fund, in part, the expansions to other non-traditional enrollees. Combining the Medicaid program changes with the employer mandate, was expected to bring the state to universal or near universal coverage.

Early on, the OHP met with barriers. First the state was unable to implement its employer mandate because it did not secure an exemption from the Employee Retirement Income Security Act (ERISA), which pre-empts states from passing laws that "relate to" employer benefits. As a result, in 1996 the state repealed this portion of the OHP. After a highly successful implementation of both Medicaid benefits changes and the expansion in coverage of a limited benefits plan to individuals under poverty, the state faced expanding to the next coverage group during a period of considerable fiscal stress. The planned expansion to individuals between 100 and 185% ended up being implemented without any

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[14] Alice Dembner, "Sticker Shock for State Care Plan," *The Boston Globe*, Jan. 20, 2007, at [http://www.boston.com/news/local/massachusetts/articles/2007/01/20/sticker_shock_for_state_care_plan/].

[15] Christopher Rowland, "Hospitals Push Insurance Enrollment," *The Boston Globe*, Jan. 4, 2007, [http://www.boston.com/business/globe/articles/2007/01/04/hospitals_push_insurance_enrollment/].

[16] Alice Dembner, "200,000 May Need to Get More Insurance," *The Boston Globe*, Jan. 30, 2007, at [http://www.boston.com/news/local/articles/2007/01/30/200000_may_need_to_get_more_insurance/].

[17] See [http://www.oregon.gov/DHS/aboutdhs/budget/0507budget/w-m_omap_ph1_ov.pdf], and [http://www.oregon.gov/DHS/healthplan/data_pubs/ohpoverview0706.pdf].

new funds appropriated. Instead, the state cut benefits for a portion of those who were already enrolled in OHP and simultaneously raised premiums and other cost sharing amounts in order to finance the expansion. The unintended consequence of these changes resulted in enrollment into the OHP plummeting and the number of uninsured in the state rising accordingly. Another piece of the OHP puzzle, however, the Family Health Insurance Assistance Program, a premium subsidy program for private insurance, was successfully implemented during the same period. This program remains in effect, with current enrollment of 5,383 individuals in employer groups, and 10,902 individual enrollments.[18]

Today, the OHP remains in effect but in a much more modest condition than that imagined by its originators, withering not only as a result of fiscal distress, but also waning political support, lack of federal support (no waiver of ERISA), and the policy miscalculation that raising premiums and reducing benefits would not erode participation and interest in the product.

Vermont

In 2006, Vermont enacted the Governor's Health Care Reform Act.[19] The Act seeks to to control the steeply rising costs of health care by better managing chronic care and making health care affordable and accessible for all Vermonters. The major components of the reforms include Catamount Health (CH), a health plan for uninsured Vermonters; chronic care initiatives called the "Blueprint for Health"; and a premium assistance program for individuals with available employer-sponsored health insurance. In addition, the Catamount plan will be re-insured by the state to protect the state against the high costs of newly enrolled CH enrollees.

Once implemented, uninsured Vermont residents will be eligible to purchase the CH plan. Those with income below 300% of poverty will be eligible to receive sliding scale subsidies toward the plan's premium. The state will contract with a single private health plan to administer the benefits, much like under the state employee health benefits plan. CH will be negotiated by the state with a private health insurance carrier or HMO and will be structured to resemble the point of service plan provided to Vermont state employees, including deductibles and copays. The state has the right to establish an enrollment cap if it determines that the appropriation may not be sufficient to cover all eligible applicants. CH is expected to be implemented in October of 2007.

The premium assistance program, called Vermont Health Access Plan (VHAP) predates the recent reform, but changes to the premium subsidy program are part of the overall reforms. Beginning in October of 2007 applicants for VHAP and CH will be required to purchase their employer-sponsored insurance plan if the employer's plan is as good as the typical plan of four largest insurers in the small group and association market. The state will review the plan to see if enrolling the individual in employer-sponsored insurance—rather than VHAP—is cost-effective to the state. If enrolled, those individuals with income below 300% of poverty will receive premium and cost-sharing assistance.

Funding is being provided through Vermont's tobacco tax, premiums from Catamount health plan holders, and proceeds from a tax on employers with more than 8 (in 2007) full

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[18] See [http://egov.oregon.gov/OPHP/docs/snapshot/1_30_06.pdf].

[19] See [http://www.leg.state.vt.us/HealthCare/2006LegAction.htm].

time employees with no health insurance. Employers will pay $1 per day per full time uninsured employee. These figures will change as necessary over the coming years. In addition, permission to include Catamount health and the ESI program in the state's Medicaid waiver will be sought.

Table 1. Summary Table for State Health Insurance Reforms

State	Compre-hensive	State-Sponsored Coverage			State Support for Private Insurance				Other
		Medicaid or SCHIP	High Risk Pools	Other	Premium Subsidies	Purchasing Pools	Reinsurance	Limited Benefits	
Alabama			X						
Alaska			X						
Arizona		X					X		
Arkansas			X	X		X		X	
California		X	X		X	X			
Colorado			X					X	
Connecticut			X				X		
Delaware		X							
District of Columbia		X		X					
Florida			X					X	
Georgia								X	
Hawaii	X	X							X
Idaho			X				X		
Illinois			X		X				
Indiana			X						
Iowa		X	X		X				
Kansas			X			X			
Kentucky			X					X	
Louisiana			X						
Maine	X	X		X	X				
Maryland			X	X	X			X	
Massachusetts	X	X		X	X		X		X
Michigan				X	X				
Minnesota			X	X				X	
Mississippi			X						
Missouri			X						
Montana			X			X		X	
Nebraska			X						
Nevada									
New Hampshire			X				X		
New Jersey								X	
New Mexico			X	X		X	X		
New York				X			X	X	
North Carolina									
North Dakota			X					X	
Ohio						X			
Oklahoma			X	X	X				
Oregon	X	X	X		X				
Pennsylvania				X					
Rhode Island									
South Carolina			X						
South Dakota			X						
Tennessee			X						
Texas			X			X		X	
Utah			X	X				X	
Vermont	X	X			X				
Virginia									
Washington			X	X	X			X	
West Virginia			X			X			

State	Compre-hensive	State-Sponsored Coverage			State Support for Private Insurance				Other
		Medicaid or SCHIP	High Risk Pools	Other	Premium Subsidies	Purchasing Pools	Reinsurance	Limited Benefits	
Wisconsin			X			X			
Wyoming			X						

Source: Congressional Research Service.

Note: *Comprehensive* includes states that have passed health insurance initiatives that collectively are intended to achieve universal or near universal coverage.

State-Sponsored Coverage: Medicaid or SCHIP includes expansions of Medicaid or SCHIP to populations that are generally ineligible for public coverage under these programs (e.g., childless adults) through traditional statutory eligibility pathways.

State-Sponsored Coverage: High Risk Pools includes state programs providing access to health insurance for individuals who face difficulty in obtaining private coverage, generally because they have pre-existing health conditions.

State-Sponsored Coverage: Other includes state-funded programs that provide health coverage to uninsured individuals. Programs falling under this category are distinct from Medicaid/SCHIP or the benefits offered are substantively different from traditional Medicaid/SCHIP.

State Support for Private Insurance: Premium Subsidies includes state-funded programs providing financial assistance in the form of premium subsidies to individuals purchasing insurance in the private market. Includes both employer-sponsored group insurance and individual insurance premium subsidy programs.

State Support for Private Insurance: Purchasing Pools includes state initiatives intended to facilitate the purchase of insurance in the private market by pooling eligible individuals and/or groups. Some states may also provide funding to subsidize the cost of coverage offered to pool participants.

State Support for Private Insurance: Reinsurance denotes state-administered programs that provide secondary insurance to health carriers, by bearing the risk of covering catastrophic (high-cost) claims.

State Support for Private Insurance: Limited Benefits includes state initiatives that allow health insurance carriers to offer insurance products in the private market that do not meet some or all state-mandated benefits.

Other includes unique state initiatives that do not fit in any of the other categories.

Table 2. State-Sponsored Coverage: Medicaid or SCHIP

State	Major Features of Reform	Target Population	Implementation Date	Funding Source	Individuals Covered
Arizona	Arizona Health Care Cost Containment System. The entire Arizona Medicaid Program operates as a Section 1115 demonstration and includes a Health Insurance Flexibility and Accountability Initiative (HIFA) waiver component. Provides full Medicaid benefits for all demonstration enrollees, except those in the targeted family planning program. Cost sharing requirements vary based on eligibility population.	HIFA amendment: single adults and childless couples up to 100% FPL; and adults with children enrolled in Medicaid or SCHIP, but not themselves eligible for either program, up to 200% FPL.	HIFA waiver implemented 11/1/01. Expiration date: N/A.	HIFA waiver uses unspent SCHIP funds. Medicaid funds will be spent for childless adults if necessary.	50,929 (SCHIP-funded waiver expansion eligibles).
California	California Parental Coverage Expansion uses Health Insurance Flexibility and Accountability Initiative (HIFA) Section 1115 waiver. Benefits based on SCHIP with slightly reduced dental benefits; $1,000 benefit limit on hearing aids, no tobacco cessation classes or orthodontia services. Imposes premiums and copays for specified services.	Multiple demonstration populations, including parents, relative caretakers, and legal guardians of Medicaid/SCHIP kids w/ incomes up to 200% FPL.	Implemented 7/1/02. Expiration date: N/A.	SCHIP funds.	Not available.
Delaware	Diamond State Health Plan. Implements mandatory managed care and covers additional persons. Provides full Medicaid benefits for all demonstration enrollees, except those in the targeted family planning program. No cost-sharing imposed.	Childless adults with incomes up to 100% FPL.	Implemented 1/1/96. Expires 12/31/06.	Medicaid funds.	14,336 (Medicaid-funded waiver expansion eligibles). Total demo: 104,000 (6/30/05).
District of Columbia	District of Columbia 1115 demonstration for Childless Adults. Primary and preventive health services. No cost-sharing imposed.	Childless non-disabled adults, between the ages of 50 and 64 with incomes up to 50% FPL who are not custodial parents or resident care takers of children under age 19.	Implemented 2/1/03. Expires 1/31/08.	DSH funds.	1,372 (Enrollment cap: 2,400).

State	Major Features of Reform	Target Population	Implementation Date	Funding Source	Individuals Covered
Hawaii	QUEST Expanded. This is a comprehensive 1115 demonstration that creates a public purchasing pool to arrange health benefits through managed care plans, and expands Medicaid coverage to specified populations including childless adults. Includes several components:QUEST, QUEST-Net, and QUEST-ACE. QUEST enrollees and QUEST-Net kids receive full Medicaid benefits. QUEST-Net adults and QUEST-ACE enrollees receive reduced Medicaid/SCHIP benefits. Imposes premiums that vary based on eligibility population.	Multiple target populations, including childless adults who meet Medicaid asset limits up to 100% FPL; childless adults who are General Assistance cash recipients but are otherwise ineligible for Medicaid up to 100% FPL; and others.	Original demo implemented on 9/1/93. Expires 6/30/08.	Medicaid and SCHIP funds.	1,933 (Medicaid-funded waiver expansion eligibles). (Enrollment cap of 125,000 for childless adults who meet Medicaid asset limits up to 100% FPL).
Iowa	IowaCare. This is an 1115 demonstration that expands coverage to specified populations and includes other reforms. Provides limited Medicaid benefits to adults using a specified provider network. Imposes premiums on specified adult enrollees. For certain adults whose income is below 100% FPL, annual premium amount cannot exceed 2% of individual's annual family income. For certain adults whose income is between 100% and 200% FPL, annual premium amount cannot exceed 5% of individual's annual family income.	Multiple target populations, including persons between the ages of 19 and 64 up to 200% FPLwho are otherwise ineligible for Medicaid or other waivers.	Implemented 7/1/05. Expires 6/30/10.	Medicaid funds. Uncompensated care funds, beneficiary premiums.	30,300.
Maine	The state has a Section 1115 waiver to provide Medicaid coverage for childless adults. Enrollment was capped in 2005 and a plan to expand eligibility to 125% FPL was repealed by the state legislature because of cost concerns.	Childless adults to 100% FPL.	2002.	State redirected a portion of its Medicaid disproportionate share hospital (DSH) allocation.	As of June 2005, 20,556.
Massachusetts	The state's Section 1115 Medicaid waiver provides Medicaid coverage or premium subsidies for employer-sponsored health insurance to a number of previously uninsured individuals. (Most recent extension is part of the state's comprehensive reform. Also listed under "Premium Subsidies" category.)	In addition to groups that can be covered under regular Medicaid rules, waiver also includes coverage for long-term unemployed (including childless) individuals <= 100% FPL and individuals with HIV <= 200% FPL.	Waiver first received approval in 1995, has been extended twice.	Part of comprehensive reform that includes a Medicaid Section 1115 waiver; financed with federal Medicaid/SCHIP dollars, assessments on hospitals, insurers, and employers, state general funds, and an individual mandate.	On June 30, 2006, long-term unemployed childless adult enrollment was 42,315 (150 premium assistance); HIV enrollment was 953 (23 premium assistance).

State	Major Features of Reform	Target Population	Implementation Date	Funding Source	Individuals Covered
Oregon	Oregon Health Plan is comprised of two health plans; the OHP Plus and the OHP Standard covering a prioritized list of services. The OHP plus is for traditional Medicaid beneficiaries and includes more comprehensive services. The OHP standard is a limited benefit package for adults who are not traditionally eligible for Medicaid. Enrollees are required to pay monthly premiums of between $6 and $20, but there is no cost sharing required.	OHP Standard is for Adults with income below 100% of FPL	OHP Standard was created in 2003, although the OHP has been in development since the 1980's.	Medicaid waiver, tobacco tax, provider taxes and general revenue among other sources.	8,693 OHP Parents, 14,883 Childless Adults (Ever enrolled July - Sept 2006).
Vermont	Vermont Health Access Plan - (predated Catamount Health Plan). Medicaid waiver program provides limited benefit coverage for parents under 185% of FPL and uninsured childless adults under 150% FPL. Program fees and copayments are required.	Uninsured childless adults with income below 150% FPL and assets of less than $2,000.	1996	Increase in state tobacco tax, tobacco settlement, general funds.	Not available.

Source: Congressional Research Service.

Table 3. State-Sponsored Coverage: High Risk Pools

State	Program Name	Individuals Covered
Alabama	Alabama Health Plan.	3,558 (6/05)
Alaska	Alaska Comprehensive Health Insurance Association.	498 (5/05)
Arkansas	Arkansas Comprehensive Health Insurance Plan.	2,930 (2004)
California	California Major Risk Medical Insurance Program.	8,572 (5/05)
Colorado	Cover Colorado.	4,896 (6/05)
Connecticut	Connecticut Health Reinsurance Associaion. (Also listed under "State Support for Private Insurance: Reinsurance" category.)	2,376 (2004)
Florida	Florida Comprehensive Health Association.	443
Idaho	Idaho Individual High-Risk Reinsurance Pool. (Also listed under "State Support for Private Insurance: Reinsurance" category.)	1,462 (6/05)
Illinois	Illinois Comprehensive Health Insurance Plan.	16,660 (6/1/05)
Indiana	Indiana Comprehensive Health Insurance Association.	8,030
Iowa	Health Insurance Plan of Iowa (also known as Iowa Comprehensive Health Association).	118 (5/31/05)
Kanasas	Kansas Health Insurance Association.	1,750 (5/31/04)
Kentucky	Kentucky Access.	3,363 (5/31/05)
Louisiana	Louisiana Health Plan.	1,236 (2004)
Maryland	Maryland Health Insurance Plan.	5,078 (2004)
Minnesota	Minnesota Comprehensive Health Association.	30,000 (2005)
Mississippi	Comprehensive Health Insurance Risk Pool Association.	4,304 (2004)
Missouri	Missouri Health Insurance Pool.	2,800 (2004)
Montana	Montana Comprehensive Health Association.	3,540 (6/30/05)
Nebraska	Nebraska Comprehensive Health Insurance Pool.	5,600 (5/2005)
New Hampshire	New Hampshire Health Plan.	479 (5/31/05)
New Mexico	New Mexico Medical Insurance Pool.	1,553 (6/1/05)
North Dakota	Comprehensive Health Association of North Dakota.	1,784 (2004)
Oklahoma	Oklahoma Health Insurance High Risk Pool.	2,729 (10/2005)
Oregon	Oregon Medical Insurance Pool.	12,400 (6/2005)
South Carolina	South Carolina Health Insurance Pool.	2,263 (2004)
South Dakota	South Dakota Risk Pool.	600 (7/2005)
Tennessee	AccessTN.	Not available.
Texas	Texas Health Insurance Risk Pool.	27,000 (9/2005)
Utah	Utah Comprehensive Health Insurance Pool.	3,085 (5/30/05)
Washington	Washington State Health Insurance Pool.	2,970 (6/1/05)
West Virginia	AccessWV.	Not available.
Wisconsin	Wisconsin Health Insurance Risk Sharing Plan.	18,341 (2004)
Wyoming	Wyoming Health Insurance Pool.	689 (5/31/05)

Source: Congressional Research Service.

Note: See CRS Report RL31745, *Health Insurance: State High Risk Pools*, by Bernadette Fernandez, for more detailed information.

Table 4. State-Sponsored Coverage: Other

State	Major Features of Reform	Target Population	Implementation Date	Funding Source	Individuals Covered
Arkansas	Arkansas Safety Net Benefit Program uses a Health Insurance Flexibility and Accountability Initiative (HIFA) Section 1115 waiver to provide a limited "safety net" benefit package to program participants through private insurers. Imposes premiums and cost-sharing: premiums up to $15/mo, $100 deductible, 15% coinsurance for all services except pharmacy, and a $1,000 out of pocket maximum per year for the deductible and coinsurance.	Small business employees. Eligibles include uninsured childless adults and uninsured parents & spouses of Medicaid/SCHIP kids, who are not eligible for Medicaid or Medicare up to 200% FPL.	Projected Implementation: Oct. 2006 (Expires 9/30/11).	Medicaid and SCHIP funds.	Years I and II: enrollment cap at 15,000. Year III: enrollment cap at 35,000.
District of Columbia	DC Healthcare Alliance–provide HMO-like coverage through a primary care network.	Uninsured individuals w/ incomes below 200% FPL	Implemented 2001.	State funds.	As of Fall 2006, around 35,000.
Maine	Maine's Dirigo Health Reform Act was signed into law in June 2003 with the goal of achieving universal coverage within five years, as well as containing health care costs and improving health care quality. The legislation created the Dirigo Health Plan (DirigoChoice), a state-sponsored, state-subsidized health insurance option for certain individuals and small businesseses. DirigoChoice has two plan options, one with higher premiums and lower out-of-pocket costs and one with lower premiums and higher out-of-pocket costs. Employers may choose either option and are required to contribute at least 60% of the cost of a single premium for each participating employee. Individuals must enroll in the second option. (Also listed under "Premium Subsidies" category.)	Small businesses, the self-employed, and certain individuals who do not have access to employer-sponsored insurance may purchase DirigoChoice. Sliding-scale premium subsidies and reduced deductibles and out-of-pocket maximums are available for employees and individuals with incomes below 300% FPL.	January 2005.	Funding comes from voluntary employer and individual contributions, state general and federal Medicaid funds, and an assessment on insurers (which is intended to recapture savings that accrue to companies as a result of Dirigo reforms and is the main source of funding for DirigoChoice subsidies).	As of August 2006, about 11,000.
Maryland	Maryland Primary Adult Care program provides primary care, outpatient mental health, and pharmacy services.	Adults up to 116% FPL who are ineligible for Medicaid and Medicare.	July 2006.	Medicaid (Section 1115 waiver).	As of Fall 2006, 23,000.

State	Major Features of Reform	Target Population	Implementation Date	Funding Source	Individuals Covered
Massachusetts	The Children's Medical Security Plan provides basic medical and dental care to children and adolescents who are uninsured and are not eligible for MassHealth (the state's public coverage program funded with Medicaid/SCHIP dollars). Inpatient hospital and emergency services, among others, are not covered. Premiums are based on a sliding scale according to income.	All children under age 19 living in Massachusetts, regardless of immigration status or income.	Authorizing legislation passed in 1993, expanded in 1996.	State-only funds.	As of February 2006, 28,976.
Massachusetts	The Commonwealth Care Insurance Program provides subsized health insurance by making premium assistance payments on behalf of program enrollees. Until June 2009, the state's four Medicaid managed care organizations are the only plans that may receive payments unless specific enrollment targets are not met. Enrollees face no deductibles. Those at or below 100% FPL receive full premium subsidies, and those between 100% and 300% FPL receive subsidies on a sliding scale.	Uninsured individuals with family incomes <= 300% FPL who are neither eligible for public coverage nor eligible in the past six months for insurance offered by an employer that pays at least 20% of the premium for family coverage or 33% for individual coverage.	October 2006.	Part of comprehensive reform that includes a Medicaid Section 1115 waiver; financed with federal Medicaid/SCHIP dollars, assessments on hospitals, insurers, and employers, state general funds, and an individual mandate.	As of January 2007, 40,000 people at or below 100% FPL, with enrollment for people up to 300% FPL just beginning.
Michigan	Adults Benefits Waiver program was designed to provide new beneficiaries with (1) a benefits package that is less broad than Michigan's standard Medicaid or SCHIP coverage OR (2) for those with access to employer-sponsored insurance, a voucher that is equal in value to the state's cost of providing services. (Also listed under "Premium Subsidies" category.)	Childless adults with incomes at or below 35% FPL.	Received approval in 2004.	SCHIP (Section 1115 waiver).	As of February 2006, 62,715.
Minnesota	MinnesotaCare was established to provide health coverage to the growing number of uninsured. In addition to children and parents, childless adults are eligible. Childless adults have a $10,000 limit on inpatient hospital services, and those between 75% and 175% FPL receive more limited benefits. Premiums are charged on a sliding scale.	Childless adults up to 175% FPL who do not have access to employer-subsidized or other health coverage and who meet a residency requirement and asset limit.	1992.	Tax on health care providers and enrollee premiums (childless adults are not covered under the state's Medicaid/SCHIP Section 1115 waivers).	As of September 2005, about 31,000 childless adults.

State	Major Features of Reform	Target Population	Implementation Date	Funding Source	Individuals Covered
New Mexico	New Mexico's State Coverage Insurance (SCI) program offers state-subsidized coverage for uninsured adults. The state contracts with managed care organizations through a competitive bidding process to provide the product. Individuals may enroll on their own or through a small employer. (A Small Employer Insurance Program is planned for employers and employees that do not meet SCI eligibility criteria). The premium is paid through contributions from individuals and employers in combination with state and federal SCHIP funds. Employee premiums and co-payments are paid on a sliding scale basis. Benefits are similar to a comprehensive commercial plan with a $100,000 annual limit.	Uninsured adults with family income below 200% of FPL.	July 2005 (waiver approved in 2002).	Premiums paid by individuals and employers, SCHIP funds (Section 1115 waiver).	As of Fall 2006, 4,400.
New Mexico	Legislation passed in the 2005 New Mexico legislative session (HB523) creates a structure for small employers to voluntarily buy into a state-administered health insurance pool. The Small Employer Insurance Program (SEIP) will be available to working employees and their dependents. This product will have a benefit design similar to SCI but cost sharing will be more reflective of the commercial market. (Also listed under "Purchasing Pools" category.)	Employees who work for a small employer and do not meet State Coverage Insurance eligibility criteria.	To be determined.	Premiums paid by employers and employees, backed by a stop-loss insurance policy.	Not applicable.
New York	Family Health Plus (FHPlus) expanded health insurance to certain parents and childless adults previously covered in the state's Safety Net program. FHPlus is delivered via managed care organizations and has a smaller benefit package versus traditional Medicaid.	Childless adults to 100% FPL.	Received approval in 2001.	Medicaid (Section 1115 waiver).	As of February 2006, 525, 951 (figure includes parents as well as childless adults).

State	Major Features of Reform	Target Population	Implementation Date	Funding Source	Individuals Covered
Oklahoma	Oklahoma Employer/Employee Partnership for Insurance Coverage, Individual Plan (O-EPIC-IP) is for those individuals who do not have access to employer sponsored insurance. Instead, subsidies are to be provided for the purchase of individual insurance coverage. A parallel program, O-EPIC-Premium Assistance (O-EPIC-PA) provides subsidies for individuals to purchase employer based coverage offered by small employers (see "Premium Subsidies" category).	Fallback for those not eligible for O-EPIC-PA (those under 185% FPL); self-employed individuals, workers not eligible to participate or whose employers do not offer a Qualified Health Plan, sole proprietors, those currently seeking work, and individuals working with a disability.	Not yet implemented.	Tobacco tax, Health Insurance Flexibility and Accountability Initiative (HIFA) Section 1115 waiver.	Not applicable.
Pennsylvania	AdultBasic provides limited benefits coverage for low-income adults. Enrollees must pay a monthly premium and copayments for most services.	Inidividuals 19-64 under 200% FPL who were uninsured for prior 6 months	2002.	Tobacco settlement and Blue Plans pay a percentage of premium collections into Annual Community Health Re-investment Fund	55,296. Approximately 110,000 wait listed.
Utah	Primary Care Network provides enrollees with preventive care and limited primary care coverage. The state made an informal agreement for hospitals to provide charity care for those needing inpatient services.	Adults with income below 150% FPL	2002.	Medicaid waiver restricted benefits for some beneficiaries and raised cost sharing.	18,008 (2005). Currently enrollment is closed.
Washington	Basic Health Program provides coverage to eligible individuals through private health plans. Enrollees pay a monthly premium plus copayments, deductible and coinsurance on non-preventative services. Monthly premiums are based on family size, income, age, and the chosen plan.	Individuals with family income below 200% FPLwho are not eligible for Medicare and are not full-time students	1988.	Tobacco taxes and premium contributions.	100,000. 25,000 with financial sponsors, and 300 with employer sponsors.

Source: Congressional Research Service.

Table 5. State Support for Private Insurance: Premium Subsidies

State	Major Features of Reform	Target Population	Implementation Date	Funding Source	Individuals Covered
California	Health Insurance Premium Payment (HIPP) Program. Covers the health insurance premiums for eligible individuals with group, nongroup or continuation coverage.	Persons who are enrolled in Medi-Cal and their share of costs does not exceed $200 per month, have a high-cost medical condition, and have a private health insurance policy.	Not available.	State funds.	1,057 (July, 2003).
Illinois	KidCare Parent Coverage. This Health Insurance Flexibility and Accountability Initiative (HIFA) Section 1115 waiver expands coverage to multiple target populations, including persons previously enrolled in the state's uninsurable program, and provides a choice to receive direct coverage or premium assistance for enrollment in ESI plans. Provides comprehensive benefits for individuals who elect direct state coverage. For those enrolled in the rebate program, the benefits are defined by the ESI plans but must meet minimal standards. The state issues a check to cover the employee share of the total premium for the ESI plan (or provides premium assistance for an individual insurance policy). Cost sharing requirements vary based on eligibility population, and direct coverage or rebate program enrollment.	Multiple target populations, including high-risk individuals participating in the state's high risk pool and parents who are not pregnant.	Implemented 10/1/02. Expires 9/30/07.	Medicaid and SCHIP funds.	8,225 (Medicaid-funded waiver expansion eligibles) and 50,587 (SCHIP-funded waiver expansion eligibles).
Iowa	Health Insurance Premium Payment (HIPP) Program. Pays premiums and cost-sharing, when cost effective, for eligible indivdiuals.	Medicaid beneficiaries who have access to employer-based or private health coverage.	Implemented in 1991.	Not available.	8,441 (Nov. 1999).

State	Major Features of Reform	Target Population	Implementation Date	Funding Source	Individuals Covered
Maine	Maine's Dirigo Health Reform Act was signed into law in June 2003 with the goal of achieving universal coverage within five years, as well as containing health care costs and improving health care quality. The legislation created the Dirigo Health Plan (DirigoChoice), a state-sponsored, state-subsidized health insurance option for certain individuals and small businesseses. DirigoChoice has two plan options, one with higher premiums and lower out-of-pocket costs and one with lower premiums and higher out-of-pocket costs. Employers may choose either option and are required to contribute at least 60% of the cost of a single premium for each participating employee. Individuals must enroll in the second option. (Also listed under "State-Sponsored: Other" category.)	Small businesses, the self-employed, and certain individuals who do not have access to employer-sponsored insurance may purchase DirigoChoice. Sliding-scale premium subsidies and reduced deductibles and out-of-pocket maximums are available for employees and individuals with incomes below 300% FPL.	January 2005.	Funding comes from voluntary employer and individual contributions, state general and federal Medicaid funds, and an assessment on insurers (which is intended to recapture savings that accrue to companies as a result of Dirigo reforms and is the main source of funding for DirigoChoice subsidies).	As of August 2006, about 11,000.
Maryland	Maryland AIDS Insurance Assistance Program helps pay for the cost of health insurance premiums under COBRA or other insurance continuation policies, Medigap plans, or other group or individual health insurance.	People with HIV up to 300% FPL.	Predates SFY2002, when program was transferred from one state agency to another.	State-funded.	As of February 2006, about 300.
Massachusetts	The state's Section 1115 Medicaid waiver provides Medicaid coverage or premium subsidies for employer-sponsored health insurance to a number of previously uninsured individuals. (Most recent extension is part of the state's comprehensive reform. Also listed under "Medicaid or SCHIP" category.)	In addition to groups that can be covered under regular Medicaid rules, waiver also includes coverage for long-term unemployed (including childless) individuals <= 100% FPL and individuals with HIV <= 200% FPL.	Waiver first received approval in 1995, has been extended twice.	Part of comprehensive reform that includes a Medicaid Section 1115 waiver; financed with federal Medicaid/SCHIP dollars, assessments on hospitals, insurers, and employers, state general funds, and an individual mandate.	On June 30, 2006, long-term unemployed childless adult enrollment was 42,315 (150 premium assistance); HIV enrollment was 953 (23 premium assistance).

State	Major Features of Reform	Target Population	Implementation Date	Funding Source	Individuals Covered
Massachusetts	The Medical Security Plan provides temporary coverage for unemployed adults through two pathways. The Premium Assistance plan subsidizes COBRA premiums to continue health insurance an individual had while employed, paying 80% of the premium up to a cap established for both family and individual plans. Direct Coverage is available to income-eligible individuals who have no access to health insurance benefits or cannot afford to maintain their COBRA insurance. Individuals, who are responsible for co-pays, are enrolled in an HMO plan and eligible to receive health insurance benefits through Blue Cross and Blue Shield of Massachusetts.	Individuals who are unemployed with income up to 400% of FPL, and who are receiving or are eligible to receive unemployment compensation benefits.	Legislation passed in 1988.	Part of comprehensive reform that includes a Medicaid Section 1115 waiver; financed with federal Medicaid/SCHIP dollars, assessments on hospitals, insurers, and employers, state general funds, and an individual mandate.	For SFY06, the average monthly number of enrollees and dependents was 3,693 (55% Direct Coverage, 45% Premium Assistance).
Michigan	Adults Benefits Waiver program was designed to provide new beneficiaries with (1) a benefits package that is less broad than Michigan's standard Medicaid or SCHIP coverage OR (2) for those with access to employer-sponsored insurance, a voucher that is equal in value to the state's cost of providing services. (Also listed under "State-Sponsored: Other" category.)	Childless adults with incomes at or below 35% FPL.	Received approval in 2004.	SCHIP (Section 1115 waiver).	As of February 2006, 62,715.
Oklahoma	Oklahoma Employer/Employee Partnership for Insurance Coverage, Premium Assistance (O-EPIC-PA) is a subsidy program for employees of small businesses. Employers must offer qualified plans and contribute at least 25% of the premium. Employees must contribute up to 15 percent of the premium. If employers do not offer a qualified plan, they may apply to determine if their existing offering meets the minimun standard acceptable to qualify. An employer is eligible for up to 12 months. Child dependent coverage is not included under O-EPIC. Children, however are eligible for other public program coverage.	Employers with fewer than 50 employees may obtain subsidies for those employees with income below 185% of FPL.	2005.	Tobacco tax, Health Insurance Flexibility and Accountability Initiative (HIFA) Section 1115 waiver.	As of January 2007, 1,557 (1,283 employees and 274 spouses).

State	Major Features of Reform	Target Population	Implementation Date	Funding Source	Individuals Covered
Oregon	Family Health Insurance Assistance Program (FHIAP) provides premium subsidies to individuals who buy employer sponsored insurance and to those who buy a plan in the individual market if no employer sponsored plan is available. The amount of money FHIAP pays for the health insurance premium depends on family size and income and varies from 50 percent to 95 percent of the premium. Individuals seeking insurance independent of an employer group must choose from a list of policies negotiated by the state. Children may be included as dependents.	Individuals under 185% of poverty, and assets below $10,000 who were uninsured for prior six months.	1997.	Tobacco tax, Medicaid waiver, Medicaid provider taxes, general fund, among other sources.	5383 individuals in employer groups, 10,902 individual enrollments. (January 2006) Individual enrollment is closed at this time. There is a waiting list.
Vermont	Vermont Health Access Plan (VHAP). Individuals enrolled in or applying for VHAP will be required to purchase their employer-sponsored insurance plan if the employer's plan is as good as the typical plan of four largest insurers in the small group and association market. The state will review the plan to see if enrolling the individual in employer-sponsored insurance --- rather than VHAP --- is cost-effective to the state.	Uninsured Vermont residents with income below 150% of FPL.	October 1, 2007.	Not applicable.	Not applicable.
Washington	Small Employer Health Insurance Partnership (SEHIP) program, created by the 2006 Legislature, is designed to assist employees of small businesses in purchasing health insurance. The program will provide a subsidy for eligible employees to offset the cost of health insurance their employer purchases from commercial carriers (the Partnership program will not purchase the coverage). The subsidy will be income based on a sliding scale with the maximum amount equal to the cost of enrolling the individuals into BasicHealth.	Individuals working for employers of size 2 to 50 who are income eligible enrolled in ESI for which the employer pays at least 40% of the premium	Planned implementation date of July 1, 2007.	Not applicable.	Not applicable.

Source: Congressional Research Service.

Table 6. State Support for Private Insurance: Purchasing Pools

State	Major Features of Reform	Target Population	Implementation Date	Funding Source	Individuals Covered
Arkansas	Small Employer Health Insurance Purchasing Group Act of 2001 allows the formation of purchasing groups for the purpose of buying health insurance. Purchasing groups may be comprised of small and medium-sized firms, and operate as non-profit entities. Insurers are allowed, under the Act, to offer to consumers participating in the purchasing group coverage that includes all, some, or none of the state coverage mandates. (Also listed under "State Support for Private Insurance: Limited Benefits" Category.)	Firms with less than 200 full time employees.	Effective Nov. 2003. First purchasing group initiated Jan. 2005.	Not available.	Not available.
California	Pacific Health Advantage (PacAdvantage) offered coverage options to small businesses and self-employed persons. Originally established by the state in 1993 as the Health Insurance Plan of California (HIPC), it was the country's largest group purchasing arrangement. Acting as an intermediary between small firms and health plans, it offered a variety of plan options throughout the state. In 1999 the HIPC was privatized, renamed Pacific Health Advantage, and was run by the Pacific Business Group on Health--a non-profit coalition of large businesses.	Small groups and self-employed persons.	Established 1993. Discontinued 12/31/06.	State provided some start-up funds but the program received no public monies to subsidize the purchase of insurance for the businesses that participate.	Peak enrollment: nearly 137,000 individuals. Represented over 6,000 small businesses.
Kansas	Kansas Business Health Partnership–a non-profit purchasing pool that stipulates employee choice, minimal administrative costs, and benefits that meet standards of federal and state law. The original legislation would have made subsidies available for low-income workers, but budget troubles delayed the subsidy. In 2005, the Kansas Legislature authorized $500,000 for subsidies.	Low and moderate-income workers in small businesses.	Implemented in 2001. The original partnership has been dissolved and is planning to be reorganized.	State funds.	Not available.

State	Major Features of Reform	Target Population	Implementation Date	Funding Source	Individuals Covered
Montana	Small Business Health Care Affordability Act allows small businesses (2 to 9 employees) in Montana to join a purchasing pool to obtain health insurance or obtain a state income tax credit. The Insure Montana program provides a monthly assistance payment for both the employer and the employee's portion of the health insurance premium for one of two Blue Cross Blue Shield of Montana plans offered through the new State Health Insurance Purchasing Pool, or through a qualified Association Plan. Insure Montana also provides a refundable state income tax credit to employers who currently pay some or all of the cost of group health insurance for their employees.	Small businesses and their employees.	Approved in 2005.	Tobacco tax (approximately 60% for premium assistance, 40% for tax credits).	As of Fall 2006, 6,995.
New Mexico	Legislation passed in the 2005 New Mexico legislative session (HB523) creates a structure for small employers to voluntarily buy into a state-administered health insurance pool. The Small Employer Insurance Program (SEIP) will be available to working employees and their dependents. This product will have a benefit design similar to SCI but cost sharing will be more reflective of the commercial market. (Also listed under "State-Sponsored: Other" category.)	Employees who work for a small employer and do not meet State Coverage Insurance eligibility criteria.	To be determined.	Premiums paid by employers and employees, backed by a stop-loss insurance policy.	Not applicable.
Ohio	State law allowing group purchasing arrangements facilitated the Group Purchasing Cooperative. The cooperative is a private entity run by the Council of Smaller Enterprises.	Small group market.	1973.	No state funding.	Enrollment is 225,000.
Texas	State law allows for the formation of group purchasing arrangements. As of August 2005, 14 cooperatives and coalitions were registered with the state.	Differs depending on the cooperative.	Mid 1990's.	No state funding.	Not available.

State	Major Features of Reform	Target Population	Implementation Date	Funding Source	Individuals Covered
West Virginia	The West Virginia Small Business Plan allows small businesses access to the buying power of the Public Employees Insurance Agency (PEIA). Through a private-public partnership between the PEIA and insurance companies that choose to offer the plan, the West Virginia Small Business Plan allows participating carriers to access PEIA's reimbursement rates, enabling the new small business coverage cost to be reduced significantly. PEIA is the largest self-insured plan in the state, providing insurance to public employees in state agencies, state universities, and colleges, as well as county boards of education.	Businesses that have been uninsured for the past 12 months with 2-50 employees.	2005.	No state funding.	500 people/100 small businesses (2005).
Wisconsin	"Co-op Care" is 2003 legislation that created 5 regional purchasing alliances, called Wisconsin Federation of Cooperatives, to bring farms and small businesses together. WFC plans to implement Co-op Care statewide over the next three years.	Currently the co-ops serve farms. At some point, the cooperative purchasing arrangements will open up to other co-ops, small businesses, municipalities, among other possible groups.	Signed into law on December 11, 2003.	FY 2005 federal budget appropriation of $2.23 million will help establish and administer a "stop loss fund" that will pay for some of the higher-cost claims incurred by cooperative members.	Not available.

Source: Congressional Research Service.

Table 7. State Support for Private Insurance: Reinsurance

State	Major Features of Reform	Target Population	Implementation Date	Funding Source	Individuals Covered
Arizona	Healthcare Group of Arizona (HCG) is a state operated reinsurance program. HCG acts as a purchasing pool that negotiates with insurers to offer coverage; HCG reinsures that coverage. Insurance carriers participating in HCG must offer guaranteed issue coverage; that is, carriers must accept any applicant regardless of health status or claims history. A choice of benefit options is delivered by managed care companies. HCG uses modified community rating, provides no premium subsidy, and does not require an employer contribution to participate.	Small businesses (50 or fewer employees), the self-employed and political subdivisions.	Established in 1985.	General state funds.	Major medical enrollees: 25,263 (1/07). All products: 44,226 (1/07).
Connecticut	Connecticut Health Reinsurance Association. Premium cap: either at 125 or 150% of FPL. Pre-existing health condition exclusion period: up to 12 months. Reinsurance pool. (Also listed under "State-Sponsored Coverage: High Risk Pools" category.)	HIPAA eligibles, HCTC eligibles, small groups, state residents under age 65.	Operational 1976.	Member premiums, insurer assessments.	2,376 (2004).
Idaho	Small Employer Health Reinsurance Program--state operated reinsurance program for small businesses. Above specified amounts, the pool pays claims up to maximums of $25,000 for the basic plan, $100,000 for the standard plan and $200,000 for the catastrophic plan.	Small businesses.	Established in 1994.	Member premiums, insurer assessments.	Not available.
Idaho	Idaho Individual High-Risk Reinsurance Pool. Premium cap: either at 125% or 150% of FPL. Reinsurance pool. (Also listed under "State-Sponsored Coverage: High Risk Pools" category.)	HIPAA eligibles, HCTC eligibles, inability to obtain adequate or affordable coverage in private market	Operational Jan. 2001.	Member premiums, carrier reinsurance premiums, tax revenue.	1,462 (6/05).

State	Major Features of Reform	Target Population	Implementation Date	Funding Source	Individuals Covered
Massachusetts	Massachusetts has a reinsurance pool for its small group and individual markets. The small group pool reinsures commercial plans (excluding HMOs) for whole groups and specific workers or dependents within groups. In exchange for a premium paid into the pool, plans pay the first $5,000 in claims for a covered individual and 10 percent of the next $50,000. The pool pays all claims above $55,000. The non-group pool reinsures all commercial and HMO plans. Plans pay the first $10,000 in claims and 10 percent of the next $40,000. The pool pays all claims above $50,000. Although all carriers may be assessed for pool losses (regardless of whether they purchase reinsurance), premiums for participating insurers are set high to reduce the probability of such losses.	Small and non-group health insurance plans.	1992.	Premiums paid by plans.	As of October 2004, 8 small group plans were reinsuring 13 individuals; non-group plans were reinsuring 3 individuals.
New Hampshire	The New Hampshire Small Employer Reinsurance Pool reinsures carriers for individuals or groups in the small employer health insurance market. Insurers must sell a standard benefit package and may purchase reinsurance from the pool for claims that exceed $5,000 per covered life.	Small employer plans.	January 1, 2006.	Carriers pay a fee for each individual or group ceded to the pool. If pool expenses exceed premiums, carriers are assessed in proportion to their volume of business in the state.	As of December 2005, 900 individuals.
New Mexico	The New Mexico Health Insurance Alliance (HIA) was created by the state legislature and is composed of independent health insurers who have agreed to offer similar health plans to small businesses and other qualified individuals. Features of the HIA include the elimination of medical or industry underwriting, easier participation requirements for employers, and rates that are set for one year. HIA carriers are reimbursed for paid claims that exceed a certain threshold.	Businesses with 50 or fewer eligible employees, self-employed individuals, and certain people who have lost group health coverage.	1994.	Financing is available through a reinsurance premium withheld from the gross premiums of HIA carriers (on average, 10%). All carriers in the state are assessed annually for HIA costs that exceed the reinsurance premiums collected.	As of January 2005, about 4,400.

State	Major Features of Reform	Target Population	Implementation Date	Funding Source	Individuals Covered
New York	The Healthy New York Program makes lower-cost health insurance available to certain individuals and small employers by combining a limited-benefit health insurance product with a state-subsidized reinsurance mechanism. All health maintenance organizations (HMOs) in the state are required to offer the standard Healthy New York policy, which provides optional prescription drug coverage and excludes home health, chiropractic, mental health, and alcohol and substance abuse treatment services. Under the reinsurance mechanism, the state reimburses HMOs for 90% of claims paid between $5,000 and $75,000 on behalf of Healthy New York members in a calendar year. (Also listed under "Limited Benefits" category.)	Qualifying small employers, sole proprietors, and individuals are eligible for the program provided they have not been insured in the past 12 months (some exceptions do apply). Small employers must have less than 50 employees (30% of whom earn less than $34,000, adjusted annually for inflation), contribute at least half of the premium, and enroll at least 50% of employees.	January 2001.	State funds, including tobacco taxes.	As of December 2005, approximately 107,000 active enrollees - 56% working individuals, 18% sole proprietors, and 26% from small business groups.

Source: Congressional Research Service.

Table 8. State Support for Private Insurance: Limited Benefits

State	Major Features of Reform	Target Population	Implementation Date	Individuals Covered
Arkansas	Arkansas Health Insurance Consumer Choice Act of 2001 allows insurers to offer as an option insurance products including all, some, or none of the state benefit mandates.	Health care consumers in the group and nongroup health insurance markets.	Effective Aug. 2001.	Not available.
Arkansas	Small Employer Health Insurance Purchasing Group Act of 2001 allows the formation of purchasing groups for the purpose of buying health insurance. Purchasing groups are comprised of small and medium-sized firms, and are operated as non-profit entities under the direction of a board. Insurers are allowed, under the Act, to offer to consumers participating in the purchasing group coverage that includes all, some, or none of the state benefit mandates. (Also listed under "State Support for Private Insurance: Purchasing Pools" Category.)	Firms with less than 200 full time employees.	Effective Nov. 2003. First purchasing group initiated Jan. 2005.	Not available.
Colorado	State law (House Bill 02-1164) requires insurance carriers in the small group market to offer limited-benefit plans ("basic plans") as long as those carriers also offer standard plans. The basic plan may be one of the following types: Basic Health Benefit Plan without specified mandates, Basic High Deductible Health Benefit Plan, or Basic High Deductible Plan without specified mandates.	Small firms (2-50 employees).	Effective Jan. 2003.	65,000+ lives (10/05).
Florida	Health Flex Plan--insurance policies can limit/exclude benefits required by law, cap the total amount of claims paid per year, limit enrollment, or take any combination of these actions.	Individuals with incomes below 200% FPL, uninsured for past 6 months, and ineligible for public programs.	Implemented as a pilot in July 2002. Applied statewide in 2004.	Not available.
Georgia	Georgia Consumer Choice Benefits Health Insurance Plan Act allows insurers who offer group and nongroup health insurance products with mandates to also offer plans with fewer mandates.	Small groups (50 employees or less) and individuals.	Implemented July 2005.	Not available.
Kentucky	State legislature passed HB278, the Small Business Insurance Relief Act, which creates a basic health benefit plan to make insurance more affordable by tailoring benefits to specific needs, creating a uniform system for physicians to receive credentials with insurers or hospitals, and establishing an advisory committee to help Kentucky provide patients with quality and cost information about their health care.	Individuals and employers with fewer than 50 employees.	Passed in 2005.	Not available.

State	Major Features of Reform	Target Population	Implementation Date	Individuals Covered
Maryland	Minimum Benefit Legislation (SB 570), enacted in 2004, requires carriers who insure > 10 percent of the covered lives in the small group market to offer a limited-benefit plan. Other carriers may offer if they choose. The actuarial value of the limited plan cannot exceed 70 percent of the actuarial value of the state's comprehensive standard health benefit plan.	Small employers with an average employee wage of less than 75% of the state average annual wage and who have not offered health benefits within the last 12 months.	July 1, 2005.	Not available.
Minnesota	State legislature enacted a law that allows health plans to sell "small employer flexible benefit plans" that do not include any of the benefit mandates (except maternity).	Small employers.	Enacted in 2005.	As of Feb. 2006, no insurers had filed to sell small employer flexible benefit plans.
Montana	Montana legislature passed HB 384, which allowed for limited-benefit plans to be available as long as purchasers are notified which services are not covered and have remained uninsured for 90 days or more. Inpatient services are not covered in these plans. Insurers may also limit coverage for newborns, severe mental illness, emergency services, certain basic health services, and services provided by a certain category of licensed health care practitioners. Demonstrations may be renewed for additional 12-month periods for up to five years, effective until 2009.	Those purchasing insurance in the individual market.	Passed in 2003.	Not available.
New Jersey	State passed legislation which required individual market carriers to offer a limited-benefit plan, called Basic and Essential Health Care Services Plan (B&E). The B&E plan provides for 90 days of hospitalizations, limited wellness and practitioner visit benefits, and some other limited benefits. The plan does not include some benefits typically covered by commercial plans such as chemotherapy, outpatient drugs, prenatal care, speech and occupational therapy, home health, or hospice services. A 2004 state report found that the program was modestly effective at providing affordable coverage to young, male residents, but that effectiveness was based on the modified community rating rather than the plan design. Carriers are able to use modified community rating for B&E plans; however, all other products in New Jersey are pure community rated.		Passed in 2002.	According to a 2004 state report, 503.

CRS-32

Table 9. Other

State	Major Features of Reform	Target Population	Implementation Date	Individuals Covered
Hawaii	Prepaid Health Care Act of 1974 (PHC). This state law requires nearly all employers to provide private health benefits to eligible workers. The health insurance plans must be approved by the Director of the Department of Labor and Industrial Relations as meeting minimum standards prescribed by the state. The Director makes such determinations under the advisement of the PHC Advisory Council—a council consisting of health care professionals, consumers, and industry representatives. Employers must cover at least half of the total premium cost of the coverage they provide. The employee's contribution cannot exceed the lesser of half the total premium or 1.5% of the employee's monthly gross earnings. Plan type determines additional cost sharing requirements. The PHC is the only employer mandate for health benefits in the country.	Employees who work at least twenty hours per week for four consecutive weeks, and earn 86.67 times the state minimum wage per month. (Government workers and other specified populations are not covered by the PHC.)	Enacted on 9/2/1974. Implemented on 1/1/75.	Not available.
Massachusetts	State created an independent public entity called the Commonwealth Health Insurance Connector to serve as a clearinghouse for the purchase of private health insurance (the Connector also administers the state-subsidized Commonwealth Care Insurance Program). Plans sold through the Connector will have to meet the same requirements as others in the state, except that they may contract with selected providers (instead of "any willing provider") and offer specially designed, lower-cost plans for young adults (ages 19 through 26).	Small employers and individuals who are not offered insurance by a large employer that pays part of the premium.	Plans will be offered beginning in April 2007.	Not applicable.
Massachusetts	All adult residents of the state (and their children) will be required to have health insurance if it is deemed "affordable" at their income level under a schedule set by the Connector. Beginning with tax year 2007, those who do not have insurance and are not exempt from the mandate will lose their state income tax personal exemption. Beginning with tax year 2008, an additional penalty will be levied for each month an individual is without insurance, equal to 50% of the lowest premium for which he or she would have qualified.	All state residents.	July 2007.	Not applicable.

Source: Congressional Research Service.

[Prepared statement of Dr. Herrick follows:]

Prepared Statement of Devon M. Herrick, Ph.D., Senior Fellow, National Center for Policy Analysis

Mr. Chairman and members of the Subcommittee, please accept my comments for the record regarding the March 15, 2007, hearing about providing health insurance for the uninsured. My comments focus specifically on the issue of health care prices. As was pointed out by many of the witnesses during the hearing, the price of health care is a significant issue to consider as the Subcommittee discusses health care reform.

Prices for medical services have been rising faster than prices of other goods and services for as long as anyone can remember. But the Subcommittee should consider that not all health care prices are rising. Although health care inflation is robust for those services paid by third-party insurance, prices are rising only moderately

for services patients buy directly. For example, the real (inflation-adjusted) price of cosmetic surgery fell over the past decade—despite a huge increase in demand and considerable innovation.

Health Care Costs Rise When Others Pay. A primary reason why health care costs are soaring is that most of the time when people enter the medical marketplace, they are spending someone else's money. When patients pay their own medical bills, they are conservative consumers. Economic studies and common sense confirm that people are less likely to be prudent, careful shoppers if someone else is picking up the tab. Thus, the increase in spending has occurred because third parties—employers, insurance companies or government—pay almost all the bills.

The Extent of Third-Party Payment of Medical Bills. Although polls show that many people fear they will not be able to pay their medical bills from their own resources, the reality is that most people pay for only a small portion of their medical care:

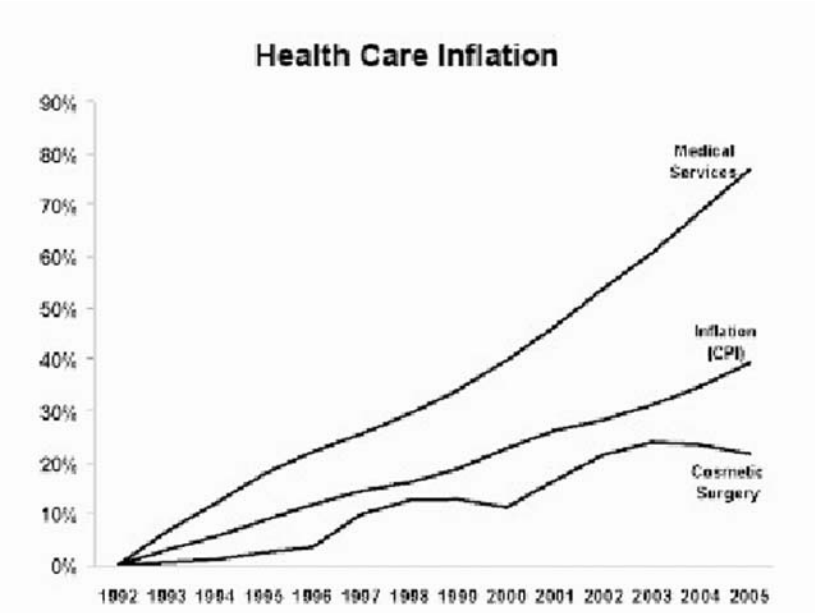
- For every $1 worth of hospital care consumed, the patient pays only about three cents out of pocket, on the average; 97 cents is paid by a third party.
- For every $1 worth of physician services consumed, the patient pays less than 10 cents out of pocket, on the average.
- For the health care system as a whole, every time patients consume $1 in services, they pay only 14 cents out of pocket.

Thus, from an economic point of view, the incentive for patients is to consume hospital services until they are worth only three cents on the dollar, on the average. The incentive is to consume physicians' services until they are worth only 10 cents on the dollar. And for the health care system as a whole, patients have an incentive to utilize everything modern medicine offers until the value to them is only 14 cents out of the last dollar spent.

Medical Inflation. Health care costs over the past 40 years have risen as the proportion of health care paid for by third parties has increased. Prior to the advent of Medicare and Medicaid in 1965, health care spending never exceeded 6 percent of gross domestic product. Today it is 16 percent. These two government programs unleashed a torrent of new spending and led to rising health care prices. For instance, a recent study by Amy Finkelstein of the Massachusetts Institute of Technology found that half the growth in health care expenditures was due to Medicare. There has also been an increase in tax-subsidized employer spending on health care. These two factors, rather than the cost of new technology and drugs, explain why health care costs outpace inflation.

Cosmetic Surgery Prices. Cosmetic surgery is one of the few types of medical care for which consumers pay almost exclusively out of pocket. Even so, the demand for cosmetic surgery exploded in recent years. Of the 10.2 million cosmetic procedures performed in 2005 that were tracked by the American Society of Plastic Surgeons, 1.8 million were surgical procedures. By comparison, in 1992 the American Society of Plastic Surgeons only tracked 413,208 cosmetic procedures—a fraction of those performed in 2005.

Despite this huge increase, cosmetic surgeons' fees remained relatively stable. The average increase in prices for medical services from 1992 through 2005 was 77 percent. [See the figure.] The increase in the price of all goods, as measured by the consumer price index (CPI), was 39 percent. Cosmetic surgery prices only went up about 22 percent. Thus, while the price of medical services generally rose almost twice as fast as the CPI, the price of cosmetic surgery went up slightly more than half as much. Put another way, while the real price of health care paid for by third parties rose, the real price of self-pay medicine fell.



Source: Author's calculations of data from the American Society of Plastic Surgeons; and Consumer Price Index, U.S. Bureau of Labor Statistics, U.S. Department of Commerce.

Another example of price competition is the market for corrective eye surgery. In 1999, only a few years after LASIK was approved, the price was about $2,100 per eye, according to the ophthalmic market research firm MarketScope. Within a short time, competition drove the price down to a slightly more than $1,600. The cost per eye of the standard LASIK is now about 20 percent lower than six years earlier. Competition held prices in check until a new innovation arrived for which patients were willing to pay more. By 2003 surgeons began to perform a newer, more-advanced custom wavefront-guided LASIK procedure.

Keeping Costs Down. What explains this price stability? One reason is patient behavior. When patients pay with their own money, they have an incentive to be savvy consumers. A second reason is supply. For instance, as more people demanded cosmetic surgery procedures, more surgeons began to provide them. A third reason is efficiency. Many providers are increasing their efficiency by locating operating rooms in their clinics, a less-expensive alternative to outpatient hospital surgery. And providers often adjust their fees to stay competitive and usually quote patients a package price. Absent are the gatekeepers, prior authorization and large medical office billing staffs needed when third-party insurance pays the fees. A fourth reason is innovation and the emergence of substitute products.

Fostering Competition. When providers compete for business, the market fosters competition. In competitive markets, producers seek to reduce costs and to offer products that meet customer demands. However, instead of a competitive national market for health insurance, we operate under a patchwork of 50 different sets of state regulations. Since each state insurance market is protected from interstate competition, legislators often require insurers to cover services that drive up premiums. For example, about one-fourth of states mandate benefit packages that cover acupuncture and marriage counseling. More than half require coverage for social workers and 60 percent for contraceptives. Seven states require coverage for hairpieces and nine, hearing aids. Needless to say, these mandates drive up the cost of providing health insurance, often making it prohibitively expensive for an insurer licensed in one state to do business in another state. As a result, consumers have little choice among plans. In many localities, only one insurance product is avail-

able, so the consumer is forced to buy an overpriced product, or forgo insurance altogether.

Fostering Innovation. When patients directly control their health care dollars, not only do prices go down, medical providers begin to offer innovative services to meet the demand of empowered patients. Telephone consultations, walk-in retail clinics, electronic medical records, and personalized care are among the innovative services provided by doctors. These new physician services tend to have two characteristics: (a) they offer patients greater convenience and (b) they step outside normal reimbursement channels. Furthermore, many of these innovations (such as electronic medical records) dramatically improve the delivery of quality health care.

Conclusion. As the Subcommittee deliberates health care issues, I hope you will consider the relationship between the competitive healthcare marketplace and stable prices. Thank you for the opportunity to comment.

[Kaiser Commission issue brief: "Premium Assistant Programs: How Are They Financed and Do States Save Money?," dated October 2005, Internet addresses to executive summary and issue brief follow:

http://www.kff.org/medicaid/upload/Premium-Assistance-Programs-How-are-they-Financed-and-do-States-Save-Money-Executive-Summary.pdf

http://www.kff.org/medicaid/upload/Premium-Assistance-Programs-How-are-they-Financed-and-do-States-Save-Money-Issue-Brief.pdf

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[New York Times article: "The President's Risky Health Plan," follows:]

[The New York Times, January 26, 2007]

The President's Risky Health Plan

The new health care proposals announced by President Bush this week purport to tackle the two toughest problems confronting the American health care system: the rising number of uninsured Americans and the escalating costs of medical care.

But on both counts, they fall miles short of what is needed to fix a system where—scandalously—47 million Americans go without health insurance.

The financial sinkhole in Iraq and huge tax cuts for wealthy Americans have left the administration with no money to really address the problem. To keep the program "revenue neutral," Mr. Bush would instead use tax subsidies to encourage more people to buy their own health insurance, while imposing additional taxes on people who have what Mr. Bush deems "gold plated" insurance.

It is a formula that would do little to reduce the number of uninsured Americans and would have a high risk of producing pernicious results. Even White House officials acknowledged earlier this week that they expected the number of uninsured to drop by only three million to five million people as a result of Mr. Bush's proposals. They expect the states to take on most of the burden.

One enlightened element is that the plan would provide equal tax treatment to those who bought their insurance policies on the individual market and those who got coverage through group policies at work, thus ending a longstanding inequity that favors employer-based policies. To level the playing field, the administration proposes to grant everyone who gets qualifying health insurance a standard deduction—$15,000 for family coverage or $7,500 for single coverage—off their income subject to taxation. Those with family policies exceeding $15,000 in value would have to pay taxes on the excess amount.

After the proposed starting date in 2009, the administration estimates, about 80 percent of workers with employer-provided policies would pay lower taxes and 20 percent would pay higher taxes, unless they reduced the value of their health coverage to fit within the standard deduction.

The new standard deduction would almost certainly entice some people to buy health insurance who had previously elected not to. But a tax deduction is of little value to people so poor that they pay little or no income tax. And unfortunately, it is those people who account for the vast majority of the nation's uninsured.

Instead of trying to fix that fundamental flaw, the administration has decided instead to buck it to the states. The White House has offered few details. But its idea

is to allow states to redirect federal money that now helps to finance hospitals that provide charity care and use it instead to subsidize health insurance for the poor.

In an ideal world, it would make good sense to insure people in advance rather than wait for them to show up in a high-cost emergency room. But this plan could quickly cripple the safety-net hospitals. Fortunately, no governor would have to accept the offer to redirect funds. The scheme is mostly a reflection of how the administration is unwilling to accept true responsibility for the uninsured.

If the administration really wanted to help low-income people, it would have proposed a refundable tax credit that would have the same dollar value for everyone—instead of a tax deduction, which primarily helps people in high tax brackets. Even those who do not pay taxes would get a check for the dollar value of the credit, providing them at least some money to help pay for health insurance. Congress ought to recognize that credits are the better approach for even such a limited plan.

As for the tax increases on those "gold plated" health policies, the White House is hoping to discourage people from using high-priced comprehensive health policies that cover everything from routine office visits to costly diagnostic procedures that are not always necessary.

The administration's goal is to instead encourage people to take out policies that might reduce the use of medical services, like policies with high deductibles or copayments, or managed care plans. But even "copper plated" policies can exceed $15,000 in cost if they are issued in areas where medical prices are high or to groups with high numbers of older or chronically ill workers.

The whole approach rests on the premise that comprehensive prepaid health policies are a major factor in driving up costs; the theory is that people will tend to use services if they are covered. There is probably some truth in that.

But the main drivers in rising health costs are the costly services, high-priced drugs and hospitalizations for people who are seriously ill with catastrophic diseases or multiple chronic illnesses. Making their health coverage less generous would simply make it harder for them to get the care they need.

The greatest risk in the president's proposal is that it would seem likely to lead many small- and medium-size employers to stop offering health benefits altogether on the theory that their workers could buy affordable insurance on their own. That would leave many more Americans at the mercy of the dysfunctional individual policy market, where administrative costs are high and insurers strive to avoid covering people who are apt to become sick and need costly care.

For all its fanfare, Mr. Bush's plan would be unlikely to reduce the ranks of the uninsured very much. And if things went badly, it could actually increase their numbers. That's not the answer Americans are waiting for and not what they deserve.

[Additional materials submitted by Mr. Webber follow:]

[National Business Coalition on Health policy paper, "Promoting Consumerism Through Responsible Health Care Benefit Design," dated November 2006, follows:]

Promoting Consumerism Through Responsible Health Care Benefit Design

National Business Coalition on Health
November 2006

About the National Business Coalition on Health

The National Business Coalition on Health (NBCH) is a national, non-profit, membership organization of more than 70 employer-based health care coalitions, representing over 10,000 employers across the United States. NBCH and its members are dedicated to value-based purchasing of health care services through the collective action of public and private purchasers. In developing, identifying, and disseminating best practices in value-based purchasing strategies, NBCH seeks to accelerate the nation's progress towards safe, efficient, high quality health care. For more information, call 202-775-9300 or visit www.nbch.org.

Table of Contents

Acknowledgments

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Introduction

Corporate America, faced with intense competition in an increasingly global marketplace, often forgets that it has a critical role to play in influencing both health and health care. Employers need to be reminded that their success (or failure) in promoting better health and higher quality health care has a direct bearing on bottom line profitability and, in the context of non-profit and public employers, the ability to fulfill their organizational missions. While not immediately connected in the minds of most employers, the link between an employer's viability as a commercial or non-profit enterprise and good health and health care is incontrovertible. First, for most employers, the health and productivity of their workforce is a key competitive asset and market differentiator. Second, corporate America provides health insurance for approximately 160 million people, and thus it is imperative that the rapidly rising costs of health benefits be efficiently managed while still yielding important health status and productivity gains for workers. Viewed from this lens, there is no escaping the fact that employers have a vested interest in improving employee health and the health care that employees and their dependents receive.

Employers are deploying many strategies to achieve the twin goals of improved health and health care. NBCH member business and health coalitions are working with a national network of 10,000 employers to test and implement successful strategies. Enlightened employers are instituting worksite health and productivity programs to keep employees well and value-based purchasing programs that demand high quality and continuously improving health care for employees and dependents.

One strategic current that runs through all health- and productivity-enhancing programs, including value-based purchasing, is consumer activation, often called "consumerism." Simply stated, the goal of consumerism is to help employees make better choices regarding decisions fundamental to their own health status, including choosing a healthy lifestyle, accessing cost-effective preventive services, selecting evidence-based medical and pharmaceutical interventions, managing one's own conditions, complying with treatment regimens, and selecting high-performing health plans, hospitals and physicians.

At NBCH we believe that a critical component of any employer's consumerism strategy is health insurance benefit design, which is the theme and focus of this white paper. An employee's health benefit is their entry ticket to the health care delivery system, and it influences, in ways we are only now beginning to understand, how an individual selects and uses health care services and navigates the health care system. As such, the design of health benefits is an important determinant of consumer behavior. For example, as many economists have pointed out, the very presence of third-party payment insulates individuals from the cost consequences of their demand for services (this problem is known as "moral hazard"), leading to the provision of excessive and unnecessary services. While some economists have called moral hazard a major flaw in the health care system, it is important to remember that the presence of heath benefits allows consumers to access needed services, which has a positive impact on health care status. The balance between these two extremes lies at the heart of the challenge: how do employers and their health plan partners build a benefit architecture with responsible individual cost-sharing features and attendant information and counseling support that steers individuals towards needed, cost-effective services and providers, while at the same time discouraging demand for unnecessary, marginal services and the selection of poor-performing providers? Or, more

simply stated, how can health benefit design increase the probability that individual consumers receive evidence-based care leading to improved health outcomes?

The answer is a concept and strategy NBCH calls value-based benefit design or VBBD. So how do we get there? NBCH believes that a good starting point should be a set of principles for responsible health benefit design that can serve as a guidepost for employer decisions moving forward. We are hoping that the 10 health benefit design "principles" laid out in this white paper can help fulfill this function. NBCH recognizes and encourages the current proliferation of different benefit design models as employers search impatiently for solutions during a time of rising costs. Our hope, nevertheless, is that public and private employers will take the time to apply a set of core principles to the benefit design models being considered before rushing to judgment.

NBCH also recognizes that benefit design should be influenced by many factors, including an employer's financial resources and the demographics, health profile, and health care utilization patterns of the employed population and their dependents. High-deductible, catastrophic plans, to give just one example, can be a reasonable response for employers with limited resources; certainly such plans are better than offering no insurance at all. At the same time, we should guard against employer decisions that are motivated simply by a short-term interest in shifting costs to employees, or by the presumption, which is yet to be proven, that employees with greater financial "skin in the game" will make better decisions. Employers need to realize that creating economic barriers to front-end preventive and chronic care maintenance services may very well lead to higher employer costs and worse health outcomes for their workforce over the long term. During this time of experimentation, upfront investments in objective evaluations of these benefit models will be needed to measure the impact on worker health status and total costs over time.

These are difficult and challenging times for the employer community. But the opportunities for improving workforce health and productivity and the quality of America's health care system have never been greater. NBCH is convinced that consumerism and responsible health care benefit design will be essential ingredients to the creative solutions that can and must be found. We hope that this white paper and the following principles will play a small part in clearing a path forward to value-based benefit design.

Sincerely,

Andrew Webber
President & CEO
National Business Coalition on Health

10 NBCH Principles for Responsible Health Care Benefit Design

NBCH believes that employers should consider adopting 10 basic principles related to their health benefit design. The primary goal of these principles is to provide "tried-and-true" recommendations for responsible, thoughtful, and thorough approaches to health care benefit design, regardless of whether the employer is working with a health plan, consultant, or independently. These principles encompass the entire benefit development process, from the initial "cost-benefit" analysis, including the company's health care profile, to benefit design architecture, to change management and communication techniques, to strategies to evaluate the impact of benefit changes. Consumers need to be engaged, empowered, and activated to make informed health care decisions regarding choice of providers and treatments. Employers and business coalitions alike continue to play a vital role in bringing the right resources directly to consumers so that they are able to make the best choices for themselves. Each of the 10 NBCH Principles for Responsible Health Care Benefit Design are laid out below, along with guidance and/or considerations related to implementing them.

1) Understand the company philosophy, employee culture, overall business strategy and goals, as well as the health risk and disease burden profile of employees and their dependents (e.g., demographics, disease prevalence, lifestyle factors, geography) to determine the appropriate direction of a new benefit design.

It is critical to think long-term, focusing on the impact of health benefit and design changes on total long-term health care costs and health status. Consider the following when implementing this principle:

- The short- and long-range implications on corporate profits, direct medical costs, productivity, health

The 10 NBCH Principles in Brief

1. Understand the company philosophy, employee culture, overall business strategy and goals, as well as the health risk and disease burden profile of employees and their dependents to determine the appropriate direction of a new benefit design.
2. Consider the company budget for annual health care spending. Provide, when possible, an actuarially equivalent benefit to the historical or traditional benefits offered to employees.
3. Consider using benefit copayment differentials, tiered benefits, and other benefit plan incentives to encourage the use of evidence-based preventive, medical, and pharmaceutical services, to encourage employee use of higher value treatments, and to discourage use of marginal services.
4. Consider tiering providers by performance and use copayment differentials to encourage employees to choose the better-performing providers.
5. Consider an approach to reward providers differentially based on their performance.
6. Promote health care quality data transparency within your company and local community, independently or through contracted health plans.
7. Promote health care price transparency within your company and local community, independently or through contracted health plans.
8. Build employee capacity to understand health care information and use that information to change their behavior and influence provider behavior.
9. Develop an effective change management strategy that focuses on helping employees to understand and accept benefit choices and changes.
10. Evaluate consistently the impact of benefit design changes in health status, workforce health and productivity, and total costs to employers and employees.

outcomes, prevention and treatment compliance, and employee retention

- Whether the company wants to provide more choice and oversight to employees, or if it wants to make care decisions on employees' behalf
- The health status of the employee and dependent population (including age, education, lifestyle factors, marital status, current health care costs, health status, and disease burden), which should form the basis of the design of any benefit and health promotion package

2) Consider the company budget for annual health care spending. Provide, when possible, an actuarially equivalent benefit to the historical or traditional benefits offered to employees, as the development of a more consumer-focused design package should not be perceived as a way to shift costs to consumers.

Key considerations in implementing this principle include the following:

- Can the employer afford the time and resources to make a benefit change? In order to develop a customized benefit plan with a carrier, a company typically needs to be big enough to self-insure (generally 1,000 employees, but perhaps as low as 500). Smaller employers will need to rely on other employers' claims experience to get a perspective on the quality of providers within the network.
- Maintaining a similar benefit will preserve all-important trust between employer and employees, which is critical to a company's success. Maintaining benefit levels creates a perception that change is taking place for the right reasons—i.e., to provide new, more, or perhaps better coverage options, not to simply shift costs

Tips on How to Create a Health Care Profile of Your Population

- Study cost data relative to each disease and injury burden affecting your organization.[4] Try to obtain the following information relative to your organization: specific inpatient and outpatient claims data, workers' compensation claims, and short and long-term disability claims provided by the organization's insurance provider.
- Review absences to determine their causes, length, and whether or not they were elective (this is usually provided by the payroll department).
- Monitor presenteeism (i.e., diminished productivity while on the job), which can be assessed through a survey to find out how employees felt while on the job. Allergies are often a major culprit of presenteeism.
- Consider the total employee population, as demographics and geography have an impact on productivity and health care outcomes. For example, are employees predominantly young or old, single or married? In what area of the country do they live? These factors and others should be part of an assessment tool that allows for predictive modeling of the impact of benefit design on health care status, costs, and how care is provided. Design a program that not only helps the high-risk, high-cost employees to determine their health care needs and to self-manage their conditions, but that also allows focuses on allowing healthy employees to stay healthy.

and administrative responsibilities to employees. This approach should more quickly result in desired behavior changes (i.e., adopting healthy lifestyle changes, enrolling in disease management programs, engaging in self-management of chronic conditions), which is where the proven cost savings ultimately are realized (not through cost-shifting, which has yet to be proven to save money).

3) Consider using benefit copayment differentials, tiered benefits, and other benefit plan incentives to encourage the use of evidence-based preventive, medical, and pharmaceutical services, to encourage employee use of higher value treatments, and to discourage use of marginal services.

Key action steps when implementing this benefit include the following:

- Identify beneficiaries who would benefit from health care education and decision-support, such as a health risk assessment, personal health record, and disease or care management programs.
- Consider providing appropriate clinical support programs for the beneficiary population. Current options that plans make available to employers—some at an additional cost—include the following: online enrollment in disease management programs, low-cost or free preventive services, links to health coaching/nursing advice services, evidence-based information about care guidelines and diagnosis/treatment options, information about community resources, e-mail based inquiry support, and online discussion groups.
- Recognize when benefit design may be creating obstacles to appropriate care related to culture/ethnicity, age, income, education, language, chronic disease, and/or differences in levels of individual expenditures for care.
- Continuously monitor benefit and/or formulary design for efficacy, compliance, value, and efficiency, with a focus on the impact of cost-sharing requirements on low-income employees.

4) Consider tiering providers by performance and use copayment differentials to encourage employees to choose the better-performing providers.

Key action steps in implementing this principle include the following:

- At a minimum, provide robust information on provider performance, including but not limited to information on mortality, complication, readmission, and infection rates, along with data on costs.

Internet-Based Resources on Provider Performance

Leapfrog Group Hospital Quality Ratings (www.leapfroggroup.org)

Center for Medicare and Medicaid Services (CMS) Hospital Compare (www.hospitalcompare.hhs.gov)

CMS Physician Voluntary Reporting Program (http://www.cms.hhs.gov/pvrp/)

National Committee for Quality Assurance (NCQA) Health Plan Report Card (http://hprc.ncqa.org/legal.asp)

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Hospital Accreditation Check (www.qualitycheck.org)

Consumer-Purchaser Disclosure Project (http://healthcaredisclosure.org/resources/)

- When possible, encourage consumers (through education and/or benefit design incentives) to select high-performing doctors, hospitals, and other providers.
- Require contracted plans to make available data on the quality of health plans, hospitals, and, if possible, individual physicians or group practices. Lead employees to this data.
- Educate providers—or encourage contracted plans to educate them—about quality measures, reporting, and performance outcomes. Providers need to understand the quality improvement process and goals.

5) Consider an approach to reward providers differentially based on their performance.

Currently employers are limited in terms of their ability to provide incentives to high-performing providers (i.e., pay-for-performance). Typically payment incentives and rewards are contractual issues between plans and providers, and thus generally outside the domain of employer benefit design architecture. However, there are steps that employers can take to reward provider performance by working with a health plan's network management department to incorporate rewards for high-quality performance into the health plan reimbursement schedules for physicians/providers. Key action steps in implementing this principle include the following:

- Build provider performance expectations into plan contracts and benefit design. This includes locally developed measures which meet the needs of the employer and/or community as well as the adoption and public reporting of measures endorsed by the National Quality Forum (NQF), National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS), and Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).
- Encourage contracted health plans to reward, through direct financial incentives and/or increased patient volume (e.g., consumer incentives to choose the best performers), high-performing providers who participate in national initiatives to measure the quality and effectiveness of the care they provide.

6) Promote health care quality data transparency within your company and local community, independently or through contracted health plans.

Employees must have the right resources to understand differences in the quality and value of treatments. Key action steps in implementing this principle include the following:

- Support and promote standardization of national and local quality, efficiency, and patient experience health care measures for comparing outcomes at all levels of the health care system, including but not limited to health plans, hospitals, medical groups, and individual physicians.
- Collaborate with federal purchasers (e.g., Medicare, Federal Employee Health Benefit Plan) by requiring contracted health plans to share administrative data that can be aggregated with publicly available data to produce robust provider-level quality reports.
- Require contracted health plans to demonstrate their use of standardized performance measures.

- Support national, state, and local anonymous and voluntary medical error reporting and disclosure programs.
- Develop contracts that promote the development of health benefit tools for consumers that provide information on quality, cost, and value. Health plans, carriers, and consultants can and should assist employers with the development and evaluation of health education tools and other support for beneficiaries. Patients need to understand their health care benefits (and ensure that their providers understand them as well) and how the health care system works before they can understand the intricacies of health care quality, cost, and value.
- Evaluate the accuracy of health care information and data that are being used for general consumer education and in incentive programs for consumers and/or providers. Ensure that commercially available quality measurement tools use nationally-recognized, proven measures and methodologies that comply with current scientific standards.[2] [3]

7) Promote health care price transparency within your company and local community, independently or through contracted health plans. Employees must have valid information that provides a fair reflection of the total cost of care for common treatments and procedures, including the employee's share of the cost.

Key action steps in implementing this principle include the following:

- Require plans to provide the cost of services for identified priority areas and conditions, including full charges or rack rate, discounted rate to providers in- and out-of-network, and cost to employees. This data should also provide a price benchmark for the uninsured or for people obtaining out-of-network care.

Improving Access to Employee Decision-Making Tools

Consider the following ways to work with health plans and providers to improve access to employee decision-making tools:

- Require a web-based, searchable practitioner directory that includes the following information on each provider: participation in specific networks and plan product options, disciplinary actions and malpractice history with verification and explanations to maximize effectiveness, publicly available evidence-based quality measures, mortality rates if applicable, and patient experience survey data.
- Require all plan-provided information to be sourced, updated at least annually, and verified.
- Request practitioner-specific performance information (e.g., HEDIS, CAHPS). While often difficult to obtain, this information should be a priority. If only medical group data are available, make sure that at least two practice sites are available for comparison purposes.
- Require hospital-specific performance results, such as performance on The Leapfrog Group's practice standards, H-CAHPS survey or other standardized patient experience results, NQF measures, AHRQ indicators, cost profiles, and/or complication or readmission rates.
- Require personalized prescription information, preferably web-based, such as a personalized member formulary that is searchable by brand name or generic equivalent. This tool should include information on a drug's primary use and its benefits and risks, alternative drugs, drug comparisons, cost management mechanisms (such as off-patent and over-the-counter options), a drug savings calculator for generic versus brand choices, and pill splitting options.[4]

- Provide on-line or a telephone-based tracking system for medical claims, including total charges, line item for each charge, amount paid by plan, amount paid by plan for each line item, and member liability.
- Provide a web- and/or telephone-based system to track an individual's progress toward reaching his or her deductibles, out-of-pocket maximums, and coverage limits.
- Provide web-based tools showing average cost per service, fee schedules, and clinical performance indicators for both physicians and hospitals.
- Support and promote adoption of national standards for health information technology infrastructure. Work with federal, state, and local efforts to develop a single health information exchange infrastructure that will eventually house all health records electronically.[5] [6]

A Call for Better Information for Consumers

Richard Wagoner, Chairman and CEO of the General Motors Corporation, in testimony before the U.S. Senate Special Committee on Aging on July 13, 2006, noted that employees and retirees need better information on effective treatments, better tools to identify effective and efficient health care providers (which will create greater provider accountability), and more effective community and employment-based education and outreach to prevent disease and better manage chronic illness.

8) Build employee capacity to understand health care information and use that information to change their behavior and influence provider behavior.

Key action steps in implementing this principle include the following:

- Focus on personal employee accountability for health and lifestyle choices. Help shift the attitude that health benefits are an entitlement by helping employees to understand that health care requires personal accountability if it is to be used properly and effectively.
- In order to reach all employees in a format that they want, provide a variety of multimedia communications and messages, including use of print/newsletter, personalized messaging, 24-hour phone line, company intranet, and Internet. Train employees on how to access information through these different communication vehicles.
- Ensure consumers understand how to successfully navigate through the health care system. Make sure all health benefit-related resources are written in a clear and easy-to-understand manner.
- Request that contracted plans and vendors verify that they are using and presenting valid, accurate material by regularly and consistently checking the evidence base for the information presented and its usability and applicability to beneficiaries. Protocols should be in place for timely responses to member inquiries.

Tips for Communicating Health Care Information

Employees and dependents must be "health care literate"—that is, they need to understand the information made available to them. Improvements in health care literacy can lead to increased employee satisfaction with health benefits and better communication with health care providers, which in turn leads to safer, higher-quality care. However, according to a 2004 report[7] from the Institute of Medicine, over half of all American adults—or approximately 90 million people—have difficulty understanding and using health information. This problem exists even in those who are highly educated, and among those who speak and read English well. Performance report cards, for example, are often quite complex and difficult for consumers to understand and use.

To help improve health care literacy, employers should consider developing information that is tailored specifically to their employee population, and then create financial and non-financial incentives for beneficiaries to use that information. Coalitions and employers can also use social marketing techniques in an effort to change the "entitlement" mindset and to examine and change risky behaviors and habits. Marketing and public relations consultants can often help with these tasks. In addition, a great deal of research has been conducted on how to present information to consumers. Employers should make use of this research. For more information, employers and coalition members should make use of the following resources on how to communicate information on health care effectively to consumers:

- NBCH's Health Plan Evaluation Toolkit-eValue8 (www.evalue8.org)
- Remaking American Medicine (www.RAMCampaign.org)
- Institute of Medicine, Roundtable on Health Literacy & "Health Literacy: A Prescription to End Confusion" (www.iom.edu)
- The Center for Information Therapy (www.informationtherapy.org)
- Agency for Healthcare Research and Quality, Talking Quality (www.talkingquality.gov)
- Health Literacy Institute (www.healthliteracyinstitute.net)
- National Institutes of Health (http://www.nih.gov/icd/od/ocpl/resources/improvinghealthliteracy.htm)
- Partnership for Clear Health Communication (http://www.askme3.org/PFCHC/)

9) Develop an effective change management strategy that focuses on helping employees to understand and accept benefit choices and changes.

Suggestions to help ease the transition include the following:

- Educate employees about health care costs and their impact on wages and the company's bottom line. For example, provide information on the cost of employee health care benefits compared to other benefits and operational expenses (including payroll costs) and on short- and long-term trends in overall and per-beneficiary health care costs, particularly with respect to the employer and employee share of the premium.

- Educate employees about the important role of health care consumerism in maintaining the employer's ability to provide good benefits at a price that is affordable for both employees and employers.
- Provide sufficient lead time, tools, and support to help employees make the transition.
- Recognize that offering a rich, traditional benefit plan to employees at the same cost as a consumer-centric plan is likely to yield minimal enrollment in the latter.

10) Evaluate consistently the impact of benefit design changes in health status, workforce health and productivity, and total costs to employers and employees.

There is a wealth of information at a company's disposal to objectively evaluate the impact of health care benefit design, including the following:

- Health plan inpatient and outpatient claims data
- Health risk assessments (HRAs) and clinical screening
- Workers' compensation claims
- Short-term and long-term disability claims
- Data on absenteeism, including cause and length of time
- Data on presenteeism (While these data often are not available, some employers track presenteeism through employee surveys.)

Appendix

Consumer-Directed and Value-Based Benefit Design Models

The consumer-directed health benefit model and the value-based benefit design model represent divergent health care consumerism approaches. The latter approach relies on active management of the health of employees by both employer and employee, while the former approach puts the management of health squarely in the hands of the employee, with little intervention by the employer. But both models rely on the use of more and better information to engage employees in decisions about their own health care, which is the "heart" of consumerism. This appendix lays out the advantages and caveats of each model, and provides a list of resources that can assist employers and coalitions that are interested in learning more.

Consumer-Directed Health Benefit Design Model

This paper uses the term consumer-directed health benefit model to describe a health benefit design that relies on financial incentives to influence or directly change consumer and provider behaviors through increased patient cost-sharing. Many other terms have been used to describe this type of model as well, including cost-based health benefit model, consumer-driven health care, and consumer-centric health care.

History and Philosophy

"Consumer-driven health care" or CDHC refers to any of a variety of initiatives that are designed to get consumers to be more responsible for their own health care decisions. The popularity of CDHC has been driven by escalating health care costs, combined with the desire to empower consumers to be more knowledgeable about, and therefore more involved in, issues and decisions that relate to the quality, outcomes, and costs of their own health care. The hope is that knowledgeable, empowered consumers will choose benefits packages and plans that best suit their health care needs and financial situation. Sometimes called consumer-directed, consumer-driven, or consumer-centric health plans, this category of health insurance benefit design remains an ongoing, evolving process.[8]

The operational concept is broadly the same for all aspects of the CDHC model in that employers and/or consumers make deposits into a designated account that is then used to purchase incremental health care services. Qualified personal health accounts must be accompanied by a high-deductible health plan (HDHP). If consumers spend all the funds in the personal health account within a plan year, then the consumer has to compensate for the gap between the annual personal account contribution and the deductible. To promote conservation of spending account contributions, health savings accounts (HSAs) allow funds to be accumulated from one year to the next. The original personal health accounts, flexible spending accounts (FSAs), did not allow consumers to roll over unused funds from year to year. Health Reimbursement Accounts (HRAs), which are still being utilized but typically do not allow fund rollover, require unused funds to revert to employers when an employee resigns or retires. For that reason, they continue to be more popular with some employers, especially as an employee retention tool.

HSAs were created as part of the Medicare Modernization Act that was signed into law in December 2003 and first became available to consumers and employers in January 2004.

These consumer-friendly accounts have become the most popular type of personal spending account. Individuals and employers can contribute funds to HSAs for future medical expenses. Preventive care services are generally covered by HDHPs and typically do not count against an individual's deductible. Earnings on HSA funds accumulate tax-free, balances can be rolled over year-to-year, and withdrawals made for qualified medical expenses are tax-free. While the accounts are permitted in both the group and individual health insurance markets, one of the primary objectives of HSAs is to help level the playing field between individual and group coverage, which previously enjoyed preferential tax treatment.[9]

Regardless of the specific vehicles used, the CDHC model gives greater financial responsibility to the consumer while promoting consumer engagement and investment through personal spending accounts that the consumer oversees. Consumers are free to navigate and make choices in the health care delivery system or network. Advances in information technology, such as the Internet and electronic medical records, have helped promote health care consumerism by giving consumers the information and tools they need to make better decisions. The hope is that a more informed, financially involved consumer will begin to ask more questions, seek more information, and ultimately make better provider selection and treatment decisions based on his or her unique situation.

For More Information on HSAs, FSAs, and HRAs

The American Benefits Council, a preeminent advocate of employer-sponsored benefit programs located in Washington, DC, maintains a substantial set of resources related to legislative and regulatory issues surrounding HSAs, FSAs, and HRAs. For more details, visit http://www.americanbenefitscouncil.com/issues/health/consumer.cfm.

Proliferation of the Consumer-Directed Health Benefit Model

The consumer-directed health benefit model is rapidly increasing in popularity. In 2005, an estimated 75 percent of insurers offered at least one HSA-compatible HDHP.[10] Most major insurers provide at least one HDHP-compatible spending account option to large employers, small employers, and individuals. According to a Kaiser Family Foundation survey, roughly 20% of employers offered such plans to workers in 2005, up from 5% in 2003. By the end of 2005, an estimated 5,000,000 consumers were enrolled in HSAs. HSAs are most popular in the non-group market; large groups (5,000 or more employees) account for only about 3 percent of total HSA enrollment.[11] Employers typically offer these products as a choice alongside more traditional options, as few employers have completely replaced their traditional offerings with CDHPs. The federal government now provides an HSA option, through Aetna, in 32 states and in Washington, DC. Thirty-three percent of small group HSA policies were sold to businesses that previously did not offer insurance, which suggests that HSAs have the potential to expand coverage to small business employees.[12]

Potential Advantages, Disadvantages of Consumer-Directed Health Benefits

Proponents of the consumer-directed health benefits model point to a number of potential advantages to these plans, as outlined below[13]:

- **More cost-conscious consumers:** CDHP enrollees who receive care appear to be more cost-conscious than their peers in more comprehensive health plans. Early evidence shows that people in CDHPs and HDHPs are significantly more likely to say that the terms of their health plan made them consider costs when deciding to see a doctor or fill a prescription. They also are more likely to report that they had checked the price of a service prior to receiving care, and whether the health plan would cover their costs. They are more likely to discuss treatment options and the cost of care with their doctors as well. That said, they are also more likely to go without care.[14]
- **Cost savings**: CDHPs may be less expensive for businesses to offer than standard plans with a lower deductible. While data are limited (due to the newness of this model), there is some evidence that spending accounts combined with HDHPs do reduce consumer spending. Studies comparing costs for CDHP enrollees with costs for PPO enrollees have found lower costs for CDHPs, particularly for prescription drugs.[15] Much more work is needed, however, to determine if CDHPs save money over the long run. If these cost savings pan out, they could ultimately lead to lower premiums for employees and employers.
- **Less inappropriate care:** Greater consumer cost-sharing may encourage consumers to ask more questions about the appropriateness of care, thus leading to reductions in the provision of unnecessary services.
- **Tax free savings for employees:** HSA contributions and earnings are tax free as long as the funds are used for qualified medical expenses. (Taxes and penalties must be paid if the funds are used for non-medical expenses.)
- **Portability**: Employees own the account and can take it with them when they change jobs.
- **Retiree medical care option:** Investment provisions encourage consumers to save funds and treat them as tax-advantaged retirement accounts that can be used to pay for medical or non-medical expenses after the age of 65.
- **Reducing the number of uninsured:** The lower costs of CDHPs may encourage employers to offer insurance, as evidenced by the substantial percentage of new HSA policies written for small companies that previously did not offer insurance.
- **Network flexibility**: CDHPs place fewer restrictions on provider selection than do HMOs, PPOs, and point-of-service offerings.

Despite these potential advantages, many concerns remain about the consumer-directed health benefits model, as outlined below:

- **Long-term cost containment:** While HDHPs may reduce or contain short-term costs for healthy enrollees, there is concern that they will have little or no impact on the long-term costs of high-cost, chronically ill enrollees who account for the vast majority of all health care expenses. These individuals often quickly meet or

exceed their deductible, thus removing any incentive to control costs. The limited evidence to date related to the long-term impact on health care costs for HDHPs is mixed, and more work is needed in this area. In addition, the ability to realize long-term savings depends upon the widespread availability of standardized, comparative price and quality information, something that is not yet a reality. In addition, technological innovation is an important driver of increases in U.S. health care spending, and CDHPs have little impact on this factor. In fact, technological innovation is one important reason that the U.S. spends much more per person on health care than do other developed countries, and also spends a larger share of its gross domestic product.[16]

- **Curbing necessary care**: Some evidence suggests that individuals with CDHPs and HDHPs are significantly more likely to avoid, skip, or delay health care (including non-compliance with prescription medications) because of costs than are those with more comprehensive health insurance. This problem may be particularly pronounced among those with health problems or incomes under $50,000.[17]

"There's a growing body of evidence that demonstrates that cost sharing leads to decreases in essential and non-essential care."

—Mark Fendrick, Center for Value-Base Benefit Design, December 15, 2005

- **Unbalanced insurance risk pools**: There is concern that high-income, healthy people will be more likely to enroll in CDHPs, leaving traditional plans with sicker enrollees. This, in turn, could lead to higher premiums for those who can least afford it.[18] That said, there is some research suggesting that very sick individuals with high out-of-pocket expenses would benefit significantly from the CDHP model.[19]
- **Potential coverage gap:** The maximum HSA contribution is often less than the deductible, creating the potential for the depletion of the personal account prior to satisfying the deductible.[20] In addition, some consumers may choose not to contribute the maximum amount to their HSA each year, which creates the potential for an even larger gap. Some plans, moreover, have increased or eliminated out-of-pocket maximums, thus creating the potential for consumers to be forced to pay even more out of their own resources.
- **Tedious administrative oversight**: State and federal regulations are limited and sometimes conflicting.
- **Promotion of unnecessary care**: Ironically, while CDHPs are designed to reduce unnecessary care, it is possible that some enrollees with "use-it-or-lose-it" accounts will spend money on unnecessary care in order to avoid losing funds at year's end.
- **Insufficient information:** CDHPs will not work unless consumers have the information they need to make more informed decisions. But few plans today provide the kind of standardized, comparative cost and quality information about providers that people need. Available information gives consumers a rough view of some health care costs, but it lacks the detail, accuracy, and customization necessary for comparison shopping. Most of the tools focus more on general

education than on helping consumers with decision-making.[21] In addition, many consumers also do not trust the information provided by health plans, and thus may not be willing to use a health plan-provided tool.[22]

Not Providing Good Information

According to an April 2006 study[23] by PricewaterhouseCoopers, only about one-quarter of executives believe they are doing a good job providing employees with health care quality data that is easy to access, understand, and use. Only 24 percent of top executives at 135 large U.S.-based multinational companies thought their information was good. The study also revealed that most companies are not asking employees whether they are satisfied with the information.

Value-Based Benefit Design Model

A complementary approach to the traditional consumer-directed health care benefit model, the value-based benefit design model (also known as evidence-based benefit design or value-based steerage) creates tiered copayments that offer lower levels of cost-sharing for individuals who select better performing, more efficient providers, and for those who choose evidence-based, cost-effective medical and pharmaceutical interventions, including better preventive screening and disease management. This model is becoming more attractive to employers as it holds the potential to be a long-term solution to cost containment while also improving the health outcomes and productivity of employees.

History and Philosophy

Initial efforts by purchasers and plans to incorporate quality into the provider selection process focused on passive information-sharing with consumers who received data on performance and outcomes. Purchasers and others producing this information assumed that consumers would embrace it and make choices and changes accordingly. However, for a variety of reasons, consumers never really used the information to the degree intended by purchasers. So employers and other purchasers are now pursuing more proactive strategies, such as value-based benefit design. While still a relatively new concept that is being experimented with by employers, there are some established "best-practices" related to applying quality measures and developing appropriate incentives and effective consumer communication.[24]

Value-based benefit design recognizes that while consumers must share in the financial responsibility for their own care, they could benefit from both information and financial incentives to help them identify and select high-performance providers and evidence-based medical and pharmaceutical interventions. Copayments are used to steer consumers towards the highest performing providers and proven treatments. Like traditional HDHP/cost-sharing models, consumers still have the luxury of choosing providers and treatments, but the out-of-pocket expenses vary based on the selections made. This model also may include pay-for-performance programs providing financial incentives to providers if their patients follow care guidelines.

Tiered pharmacy benefits, which are considered the "low-hanging fruit" of value-based benefit design, were the first to be tiered by insurers and pharmacy benefit managers (PBM) in the 1990s. The level cost sharing in these programs depends on whether the consumer chooses generic drugs, preferred brand-name drugs, or nonpreferred drugs. However, the concept has begun to expand to other areas of health care delivery (e.g.,

"Evidence-based benefit design is the pillar of value-based purchasing."

— Andy Webber, President and CEO, NBCH

The Four Pillars of Value-Based Purchasing

- Standardized performance measurement
- Transparency and public reporting
- Payment reform
- Informed consumer choice

hospitals, medical groups). Some experts argue that the best strategy for encouraging the more efficient use of resources lies in varying the benefits depending on the provider, site of service, and type of service selected.[25] To date, however, pharmacy benefit tiering remains far more prevalent than hospital and medical group tiering, primarily because objective quality information relative to prescription drugs is more widely available.

Case Studies in Value-Based Benefit Design

What follows are brief case studies of organizations that have successfully implemented value-based benefit design models.

Oregon's Medicaid Program

Since the mid-1990s, Oregon has been using an evidence-based benefit design in its Medicaid program, which provides coverage to about 15 percent of the state's population. The process involves an independent, systematic review of the evidence that is used to make coverage recommendations related to prescription drugs.

The state has developed a process to determine the effectiveness of a drug or class of drugs. Once the most effective drugs are determined, the relative cost of these drugs is reviewed, including open proceedings with public testimony and third-party review of evidence.

The state uses the Evidence-based Practice Center (EPC) at Oregon Health Sciences University (OHSU) to review the evidence. By purchasing the most effective drugs at the lowest possible price, the state is promoting the highest possible value. The key to developing an evidence-based drug policy is working with the best available evidence and information, being sure to consider the impact of drugs on an individual's overall health and well-being (rather than looking more narrowly at drug costs alone). [26] [27]

Pitney Bowes Tiered RX Model

In 2001, Pitney Bowes' leadership recognized the potential negative impact of increased employee cost-sharing for prescription drugs. The company conducted a predictive modeling analysis and found that 50 percent of its enrolled population had chronic diseases. The analysis also showed that plan costs and illness burden among employees had increased due to a lack of compliance with prescribed pharmaceuticals. In response, Pitney Bowes revised its drug benefit to increase coverage of drugs for certain costly chronic illnesses. This strategy seems to be working; utilization of targeted drugs increased, while overall medical costs fell.[28]

Hospital Tiering at The Boeing Company

Boeing is giving its employees financial incentives to select Leapfrog Group-compliant hospitals, along with extensive education about the importance of hospital quality. The goal is to improve employee health care outcomes and worksite productivity, as well as ensure that Leapfrog-compliant hospitals are rewarded for their efforts to improve quality through increased market share. Under this program, Boeing employees and dependents

who participate in the company's traditional plan and who choose to go to a "Leapfrog Group-approved" hospital receive coverage for 100 percent of hospital expenses and are not required to pay any out-of-pocket expense beyond the plan deductible. Beneficiaries who select a non-Leapfrog Group-compliant hospital must pay five percent of their hospital bill.[29]

Deployment of VBBD

- Identify best practices.
- Measure ROI for the employer.
- Create a generic benefit design model – based on low hanging fruit.
- Link evidence-based benefit design to health and productivity programs.
- Create a distribution network of best practices in the coalition/employer community (NBCH can help with this task).

Potential Advantages and Disadvantages of Value-Based Benefit Design

If value-based benefit design works as theorized, it offers a wide array of potential benefits:

- Improved health outcomes and long-term cost savings, as consumers choose better-performing providers and make evidence-based treatment decisions
- Increased consumer engagement
- Better utilization of health care resources
- Improved provider performance with respect to quality and costs, as providers fear losing market share if they underperform
- Better information, as providers have an incentive to make information available

But the jury is still out on whether value-based benefit design works as intended. There are reasons to believe that it might not, as outlined below:

- **Impact on consumer behavior is not yet known**: Research and evidence is limited on the impact of value-based benefit design. While higher cost sharing should encourage patients to select efficient, high-quality providers (which should pressure other hospitals and physicians to improve quality and control costs), it is not clear what degree of cost-sharing is required to change consumer behavior. Since the majority of health care costs result from a small minority of patients, the net impact of value-based benefit design will depend on how these higher cost patients respond to incentives. Tiered networks could even increase costs if consumers equate high cost with high quality and therefore select nonpreferred, high-cost tiers.
- **Limited access to needed information**: As noted, quality and efficiency measurement metrics are limited and inconsistent, and public reporting of existing measures is mostly voluntary.
- **Implementation challenges**: Deciding what services to cover and when to cover them can be difficult.[30] In addition, it is important that high-quality providers with higher costs not be wrongly placed in nonpreferred tiers, thus making them unaffordable for the poor. Tiered benefit designs should also be structured so as not to penalize poorer-performing hospitals and medical groups that are actively involved in quality improvement programs, or hospitals that are high cost solely because of their provision of charity care or teaching functions.

- **Potential backlash from providers**: Providers with market power may refuse to accept placement in a nonpreferred tier, thus limiting flexibility in developing tiers.
- **Ensuring enough high-quality providers**: This model requires a sufficient supply of high-performing, participating providers for consumers to be able to make real choices. In markets lacking provider competition (e.g., rural areas), purchasers may be forced to accept lower quality and/or less efficient providers in their top tiers to ensure continued access to services.

"More purchasers are going to look closely at value-based steerage, but it's not going to work everywhere."
—Meredith Rosenthal, Assistant Professor of Health Economics, Harvard School of Public Policy

Benefit Design Resources

The following tools and resources are available to assist employers and coalitions with the design and implementation of consumer-directed and/or value-based benefits programs.

Consumer-Directed Health Benefit Resources

- Department of Treasury (http://www.treas.gov/offices/public-affairs/hsa/faq1.shtml)
- The HSA Insider (http://www.hsainsider.com/)
- Health Decisions: For up-to-date information on companies that currently offer HSA-eligible health insurance plans, including a state-by-state locator, please visit www.healthdecisions.org/HSA.
- National Association of Health Underwriters (http://www.nahu.org/consumer/HSAGuide.htm}
- Association of Health Insurance Advisors (http://www.ahia.net/consumers/guide_hsa.html)
- National Association of Alternative Benefit Consultants (http://www.naabc.com/cbcd1.htm)
- National Association of Insurance Commissioners (http://www.naic.org/state_contacts/sid_websites.htm)

Value-Based Benefit Design Resources

Agency for Healthcare Research and Quality Evidence-Based Medicine Resources

- AHRQ-EBM Resources: The National Guideline Clearinghouse (www.guideline.gov)
- Evidence-Based Practice Centers (www.ahcpr.gov/clinic/epcix.htm)
- U.S. Preventive Services Task Force (www.ahrq.gov/clinics/uspstfix.htm)

Oregon's Evidence-Based Reports

Oregon's Health Resources Commission oversees the development of the state's evidence-based drug benefit process and produces recommendations/reports to the state Medicaid program. The state uses the material to choose the highest value drug(s) from each class for the state's Medicaid formulary. Reports and summaries covering approximately 16 drug classes are available at www.OregonRX.org.

NBCH Coalition Member Value-Based Benefit Design Resources

- "Benefit Strategies to Promote Quality, Value and Access in High Deductible Health Plans, Pacific Business Group on Health, 2005.
- "Pacific Business Group on Health Member Benefit Strategies: Promoting Quality, Value and Access," February 2005.
- "Getting What You Pay For: Early Reports from Value-Based Steerage Pioneers," A White Paper from The Alliance (Employers Health Care Cooperative), April 2006.

Other Value-Based Benefit Design Resources

- National Business Coalition on Health eValue8 (www.evalue8.org/eValue8/about/overview.cfm)
- College for Advanced Management of Health Benefits (http://www.nbch.org/events/collegenotice.cfm)
- The Health Management Research Center, University of Michigan (http://www.umich.edu/~hmrc/)
- Integrated Benefits Institute (www.IBIWEB.org)
- Institute for Health & Productivity Management (www.ihpm.org)
- Pitney Bowes Power of 2 Initiative (http://healthproject.stanford.edu/koop/pitneybowes1/description.html)
- Center for Value Based Insurance Design (www.sph.umich.edu/vbidcenter)
- The Leapfrog Group (www.leapfroggroup.org)
- Center for the Evaluative Clinical Sciences at Dartmouth (www.dartmouth.edu/~cecs/)
- Oxford Centre for Evidence Based Medicine (www.cebm.net/)
- State of Oregon (www.oregon.gov/DAS/OHPPR/ORRX/HRC/about_us.shtml)
- National Committee on Evidence-Based Benefit Design (www.businessgrouphealth.org/healthcarecosts/evidenced_benefits.cfm)
- The Asheville Project (www.ncpharmacists.org/displaycommon.cfm?an=1&subarticlenbr=41)
- Prometheus Payment Reform (www.prometheuspayment.org)
- Bridges to Excellence (www.bridgestoexcellence.org/bte/)
- Institute of Medicine (www.iom.edu/CMS/3718.aspx)
- Consumer-Purchaser Disclosure Project (http://healthcaredisclosure.org/)

Employee Health and Productivity Improvement Resources

- The Health Management Research Center, University of Michigan (http://www.umich.edu/~hmrc/)
- Integrated Benefits Institute (www.IBIWEB.org)
- Institute for Health & Productivity Management (www.ihpm.org)
- NCQA Quality Dividend Calculator (www.ncqa.org)

Endnotes

[1] Mahoney J, Hom D. "Total Value, Total Return: Seven Rules for Optimizing Employee Health Benefit for Healthier and More Productive Workforce", Pitney Bowes

[2] National Business Coalition on Health (NBCH) 2006 eValue8 RFI

[3] Centers for Medicare and Medicaid Services, Public/Private Purchaser Value Charter, May 2006

[4] NBCH 2006 eValue8 RFI

[5] NBCH 2006 eValue8 RFI

[6] Centers for Medicare and Medicaid Services, Public/Private Purchaser Value Charter, May 2006

[7] "Health Literacy: A Prescription to End Confusion," Institute of Medicine Committee on Health Literacy, April 2004.

[8] National Business Coalition on Health 2005 Federal & State Legislative Outlook

[9] America's Health Insurance Plans (AHIP), 2006 Member Survey

[10] "Consumer-Directed Health Plans: Implications for Health Care Quality and Cost," California HealthCare Foundation, Rand, June 2005.

[11] Kaiser Family Foundation and Health Research and Educational Trust, 2005 Health Benefits Survey

[12] AHIP, 2006

[13] Improved consumer tools and greater transparency of provider-level performance are not listed among the advantages since these are required components of the model, which presumably lead to some of the advantages listed.

[14] The Commonwealth Fund, December 2005

[15] California HealthCare Foundation/Rand, June 2005 (See also Keeler, EB. "Effects of Cost Sharing on Use of Medical Services and Health," Journal of Medical Practice Management Summer 1992(8):317-21.)

[16] California HealthCare Foundation/Rand, June 2005

[17] The Commonwealth Fund, December 2005.

[18] California HealthCare Foundation/Rand, June 2005

[19] McNeill, D. "Do Consumer-Directed Health Benefits Favor the Young and Healthy?" *Health Affairs* January/February 2004;23(1):186-93.

[20] California HealthCare Foundation/Rand, June 2005.

[21] The California HealthCare Foundation, "Online Health Care Cost Tools: Do They Meet Consumer Needs?" May 2006

[22] The Commonwealth Fund, December 2005.

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[Whereupon, at 12:30 p.m., the subcommittee was adjourned.]

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