

**Summary of the Statement of Merrill Matthews, Ph.D.
Director, Council for Affordable Health Insurance**

**Testimony Before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Tuesday, June 28, 2005**

I. The Growing Cost of Health Insurance and Its Effect on the Uninsured. The rising cost of health care leads inevitably to the rising cost of health insurance premiums. And the cost of health insurance is one of the primary reasons why we have roughly 45 million uninsured Americans. Unless Americans have access to affordable coverage, the number of uninsured will only grow.

II. The States' Role in Regulating Health Insurance. State mandates and guaranteed issue and community rating laws have only made health insurance more expensive. As a result, health insurance costs differ significantly from one state to another. For example, an individual living in New Jersey buying coverage for himself pays, on average, about \$4,080 a year. However, the average annual premium in Iowa is \$1,236 and Wyoming \$1,284, the lowest in the country; and it's only \$1,800 for the nation as a whole.

III. The Expansion of Markets. Some fear the Health Care Choice Act will disrupt the current health insurance model, bypassing most state regulations and perhaps even agents. But they both overstate the threat while ignoring the fact that consumers are already searching for new and innovative ways to purchase health insurance.

IV. Impact of the Health Care Choice Act. The Health Care Choice Act won't benefit everyone, in part because the vast majority of working Americans get their health insurance from their employer, and many already have an affordable policy in the individual health insurance market. But it would be an enormous benefit to those individuals, most of whom are uninsured, who live in the high-cost states and have no access to an affordable policy.

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Good morning Mr. Chairman and members of the subcommittee. I am pleased to be here, and I want to thank the Chairman and the subcommittee for calling this very important hearing today on the Health Care Choice Act. I commend your leadership for considering ways that would allow millions of uninsured Americans to have access to affordable health insurance.

I am Merrill Matthews, Ph.D., director of the Council for Affordable Health Insurance (CAHI), which is located in Alexandria, Virginia. CAHI is a research and advocacy association of insurance carriers active in the individual, small group, Health Savings Account and senior markets. CAHI's membership includes health insurance companies, small businesses, physicians, actuaries and insurance brokers. Since 1992, CAHI has been an advocate for market-oriented solutions to the problems in America's health care system.

We at the Council for Affordable Health Insurance believe that all Americans should have access to affordable health coverage. The Health Care Choice Act would go a long way toward reaching that goal.

The Act allows individuals to purchase health insurance coverage across state lines. It requires that the state law where the policy is filed (primary state) would apply both in that state as well as any other state (secondary state). Other consumer protections include requirements regarding disclosure, fraud and abuse, prohibition against "bait and switch"

tactics, financial stability of the insurance company and ensuring an independent review mechanism for all who purchase coverage under the terms of this legislation.

In my testimony today, I would like to address three issues regarding (1) the cost of health insurance and the uninsured; (2) state actions that have frequently exacerbated the problem, making health insurance even more expensive; and, (3) the way the health insurance industry is evolving to provide consumers with affordable options.

I. The Growing Cost of Health Insurance and Its Effect on the Uninsured.

Everyone knows that health care costs have been rising.

- According to a new study in the journal *Health Affairs*, health care spending rose 8.2 percent in 2004, down slightly from 8.4 percent in 2003 and 10.7 percent in 2002. So while we are trending in the right direction, several years of health care spending increases three-plus times the rate of inflation has made health insurance very expensive for American families.¹

- There is some good news: the rapid rise of consumer driven plans appears to be slowing the trend or reducing the cost of health insurance. The *Wall Street Journal* reported on June 14 that data from 13,500 participants in Aetna consumer driven plans showed that companies that offered a consumer driven plan as an option saw their premium increases slow to 3.7 percent, while those companies that offered only a consumer driven plan saw their costs fall by 11 percent.²

The rising cost of health care leads inevitably to the rising cost of health insurance premiums. And the cost of health insurance is one of the primary reasons why we have roughly 45 million uninsured Americans. Unless Americans have access to affordable

¹ Bradley C. Strunk, Paul B. Ginsburg and John P. Cookson, "Tracking Health Care Costs: Declining Growth Trend Pauses in 2004," *Health Affairs*, Web Exclusive, June 21, 2005. (<http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.286>)

² Venessa Fuhrmans, "Patients Give New Insurance Mixed Reviews," *Wall Street Journal*, June 14, 2005.

coverage, the number of uninsured will only grow — to 56 million by 2013, according to a recent estimate published in *Health Affairs*.³

There are several reasons for that rise, including wider access to technology and new health care options. But the states and the federal government also bear a portion of the responsibility.

II. The States' Role in Regulating Health Insurance.

Frankly, when it comes to the high cost of health insurance, the states have only exacerbated the problem.

A. Health insurance mandates – For 40 years states increasingly have tried to micromanage health insurance, and premiums have ballooned as a result.

A health insurance “mandate” is a requirement that an insurance company or health plan cover (or offer coverage for) health care providers, benefits and patient populations that health coverage might not normally provide. They include:

- Traditional providers such as chiropractors and podiatrists, but also social workers and massage therapists.
- Benefits such as mammograms, well-child care and even drug and alcohol abuse treatment, but also acupuncture, massage therapies and hair prostheses (wigs, usually for those undergoing radiation and chemotherapy for cancer).
- And populations such as adopted and non-custodial children.

While mandates make health insurance more comprehensive, they also make it more expensive because mandates require insurers to pay for care consumers previously funded out of their own pockets. In some markets, mandated benefits increase the cost of health insurance by as much as 45 or 50 percent.

³ Todd Gilmer and Richard Kronick, “It’s the Premiums Stupid: Projections of the Uninsured Through 2013,” *Health Affairs*, Web Exclusive, April 5, 2005. (<http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.143>)

Mandating benefits is like saying to someone in the market for a new car, if you can't afford a Cadillac loaded with options, you have to walk.

So why do so many elected representatives persist in passing mandates? They find it difficult to oppose any legislation that promises enhanced care to potentially motivated voters.

In 1965, only seven benefits were mandated by the states; today, the Council for Affordable Health Insurance has identified 1,824 mandated benefits and providers nationwide.⁴ (Available at www.cahi.org.)

Mandates enjoy wide bipartisan support, and some states are much worse than others.

- Minnesota has 62 mandates, the most of any state, Virginia 54, and Florida 50.
- Maryland has 58 mandates, while Washington DC has only 16.
- Texas has 51 mandates, but Alabama has only 18.

Some mandates will have a much larger impact on health insurance costs than others. In order to remind legislators that mandates usually aren't free, the Council solicited input from a group of respected actuaries who estimated how much each mandate could affect the cost of a health insurance policy. Their conclusion is that, depending on the state where one lives, Americans could be paying between roughly 20 percent to 50 percent more for their policies because of state-imposed mandates.

B. Guaranteed issue and community rating — Even more costly than a multitude of mandates is guaranteed issue and community rating. Guaranteed issue requires insurers to accept applicants regardless of their health status (although some guaranteed issue provisions may include certain restrictions). People may forgo insurance coverage when they are in good health and purchase

⁴ Victoria Craig Bunce and J.P. Wieske, Health Insurance Mandates in the States, 2005" Council for Affordable Health Insurance, January 2005. (http://www.cahi.org/cahi_contents/resources/pdf/MandatePubDec2004.pdf)

it when they are sick. As a result, the pool gets smaller and the insurance more expensive because young and/or healthy people drop out of the pool, knowing they can return when they get sick.

Guaranteed issue is even more destructive when combined with community rating, which requires an insurer to charge the same price to everyone in a “community,” or pool, regardless of the differences in the risk the individuals present. Age, lifestyle, health and gender factors may not be used to determine rates. In other words, everyone can get a policy at roughly the same price. “Modified community rating” will allow some variation in premium, such as for geographic location.

Several states passed guaranteed issue and community rating legislation in the early 1990s, destroying those states’ individual health insurance markets.

New Jersey is the poster child for how not to reform the health care system. When New Jersey’s guaranteed issue legislation became effective in 1994, a family policy (known as “Plan D”) with a \$500 deductible and a 20 percent copayment (i.e., the insurer pays 80 percent) cost as little as \$463 a month and as much as \$1,076, depending on which of the 14 participating insurers the family chose, according to the New Jersey Department of Insurance. Today, *the lowest monthly premium* for a family Plan D policy is \$3,912, offered by Oxford.

Monthly premiums for family coverage under an Aetna Plan D policy, the least costly after Oxford, rose from \$769 in 1994 to \$6,025 today, a stunning 683 percent increase. Remember, that’s the *monthly* premium.

Supporters of guaranteed issue say it is necessary to make coverage accessible to those who need it most. But state-sponsored high-risk pools are the best way to make coverage accessible to the medically uninsurable. High-risk pools act as a safety net for people who are uninsurable, or whose premiums cost more than the standard. Established more than 25 years ago, high-risk pools operate in 33 states

and covered more than 181,000 people as of June 2004, according to Communicating for Agriculture.⁵

In most states with high-risk pools, applicants have a choice among HMOs or PPOs, and most offer a range of deductibles and copays. In other words, applicants can choose what best fits their needs and budget. State high-risk pools are usually funded by assessing health insurers operating within a state, based on the amount of business the insurer writes. Some states have relied on other funding sources such as lotteries or general tax revenues.

However, in 2002 Congress passed legislation that provided federal money (through 2004) to be used for start-up costs in states where no high-risk pool existed. The legislation further provided funds for states that already had operational high-risk pools, so long as currently existing pools were consistent with regulatory guidelines.

Congress should continue to provide federal funding for these state risk pools, since that is the most efficient way to provide a safety net for the uninsurable while letting the private sector work for most other Americans.

The evidence from guaranteed issue states is in; we have all the data we need. Not one experiment has proved successful. Several more states have tried variations of these requirements, such as modified community rating. But these efforts only “modify” the full damage. States need either to eliminate these destructive regulations, or Congress needs to let families buy their coverage from a state that hasn’t destroyed its market.

C. The eHealthInsurance survey of premiums. eHealthInsurance is an online marketer for health insurance. The company tracks hundreds of thousands of individuals purchasing coverage and how much they pay in premiums. (See the table below, especially bold figures.) For example, an individual living in New Jersey buying coverage for himself (i.e., not a group policy that comes from an employer), pays, on average, about \$4,080 a year. (Note: the New Jersey policies

⁵ “Comprehensive Health Insurance for High-Risk Individuals — A State-by-State Analysis,” Communicating for Agriculture, Inc., Eighteenth Edition, 2004/2005, November 4, 2004.

cited in the previous section were for a specific type of family policy.) That's the highest health insurance premium in the country, according to the survey, with neighboring New York running a close second at \$3,540.

However, the average annual premium in Iowa is \$1,236 and Wyoming \$1,284, the lowest in the country; and it's only \$1,800 for the nation as a whole.

Thus, health insurance is roughly 3.5 times more expensive in New Jersey and New York than in Iowa and Wyoming.

Perhaps the difference is that the cost of living is higher in New Jersey and New York. While that may explain some of the variation, it doesn't explain most of it. New Jersey's neighbor Pennsylvania has an average premium of \$1,488. Even high-cost California is only \$1,680 per year, according to eHealthInsurance — still less than half that of New Jersey and New York.

The point is that health insurance premiums vary significantly by state, leaving thousands of individuals in high-cost states, such as New Jersey, New York and Maine, struggling to find affordable coverage. If they could buy health insurance coverage that is already available to people in another state, millions could leave the ranks of the uninsured.

Health Insurance Premiums for Single Policies by State							
State	Population	% of U.S. Population	Avg. monthly premium per single: all ages	Avg. annual premium per single: all ages	Avg. age	Guaranteed Issue (1)	Community Rating (2)
California	34,705,060	12.4%	\$140	\$1,680	32		
Texas	21,266,000	7.6%	\$133	\$1,596	33		
New York	19,027,190	6.8%	\$295	\$3,540	40	Yes	Yes
Florida	16,349,150	5.8%	\$148	\$1,776	34		
Illinois	12,406,690	4.4%	\$140	\$1,680	33		
Pennsylvania	12,139,190	4.3%	\$138	\$1,656	31		
Ohio	11,220,060	4.0%	\$132	\$1,584	34		
Michigan	9,898,680	3.5%	\$112	\$1,344	33		
New Jersey	8,521,890	3.0%	\$340	\$4,080	38	Yes	Yes
Georgia	8,332,840	3.0%	\$159	\$1,908	31		
North Carolina	8,071,000	2.9%	\$130	\$1,560	32		
Virginia	7,022,090	2.5%	\$154	\$1,848	34		
Indiana	6,060,210	2.2%	\$125	\$1,500	34		
Washington	5,953,980	2.1%	\$169	\$2,028	35		
Tennessee	5,662,530	2.0%	\$127	\$1,524	33		
Missouri	5,552,640	2.0%	\$139	\$1,668	32		
Wisconsin	5,402,080	1.9%	\$126	\$1,512	36		
Maryland	5,377,260	1.9%	\$166	\$1,992	32		
Arizona	5,349,660	1.9%	\$153	\$1,836	34		
Minnesota	4,983,580	1.8%	\$143	\$1,716	33		
Colorado	4,409,790	1.6%	\$120	\$1,440	33		
Alabama	4,408,280	1.6%	\$173	\$2,076	28		
Louisiana	4,391,090	1.6%	\$135	\$1,620	30		
South Carolina	3,997,220	1.4%	\$138	\$1,656	35		
Kentucky	3,996,680	1.4%	\$125	\$1,500	33		
Oregon	3,477,490	1.2%	\$145	\$1,740	31		
Oklahoma	3,404,120	1.2%	\$134	\$1,608	35		
Connecticut	3,378,790	1.2%	\$174	\$2,088	35		
Iowa	2,878,650	1.0%	\$103	\$1,236	35		
Mississippi	2,781,560	1.0%	\$131	\$1,572	34		
Arkansas	2,657,680	0.9%	\$209	\$2,496	37		
Kansas	2,641,180	0.9%	\$128	\$1,536	30		
Utah	2,283,860	0.8%	\$114	\$1,368	31		
Nevada	2,125,890	0.8%	\$155	\$1,860	33		
New Mexico	1,820,030	0.6%	\$121	\$1,452	32		
Nebraska	1,685,440	0.6%	\$129	\$1,548	32		
Idaho	1,304,910	0.5%	\$162	\$1,944	36		
Rhode Island	1,047,970	0.4%	\$116	\$1,392	33		
Montana	893,600	0.3%	\$145	\$1,740	31		
Delaware	790,930	0.3%	\$131	\$1,572	34		

South Dakota	740,970	0.3%	\$124	\$1,488	32			
Alaska	621,520	0.2%	\$157	\$1,884	36			
Dist. Columbia	561,370	0.2%	\$193	\$2,316	32			
Wyoming	485,510	0.2%	\$107	\$1,284	28			
Subtotal	270,086,310	96.3%	\$150	\$1,800	33			
States not included:								
State	Population	% of U.S. Population	Avg. monthly premium per single: all ages	Avg. annual premium per single: all ages	Avg. age	Guaranteed Issue (1)	Community Rating (2)	Other (3)
Massachusetts	3,679,620	1.3%	N/A	N/A	N/A	Yes		
West Virginia	1,760,310	0.6%	N/A	N/A	N/A			Yes
Maine	1,270,120	0.5%	N/A	N/A	N/A	Yes	Yes	
New Hampshire	1,259,120	0.4%	N/A	N/A	N/A	Yes	Yes	
Hawaii	1,198,920	0.4%	N/A	N/A	N/A			Yes
North Dakota(4)	619,280	0.2%	N/A	N/A	N/A			Yes
Vermont	611,540	0.2%	N/A	N/A	N/A	Yes	Yes	
Subtotal	10,398,910	3.7%						
Total US	280,485,220							

(1) Law requires all applicants to be issued a policy regardless of health

(2) Law requires policies to be priced independent of age and/or health

(3) State Department of Insurance and/or state-based carriers limits on non-residential broker sales.

(4) Recently added to www.ehealthinsurance.com, average premium and age data not available to date.

Source: eHealthInsurance.

III. The Expansion of Markets.

The Internet has opened access to a world, literally, of new — and old — products and services.

Of course, the U.S. company Ebay is perhaps the best known source for being able to buy virtually anything at a price the consumer is willing to pay. And while Ebay doesn't sell health insurance over the Internet, eHealthInsurance and a few other websites do.

Some fear the Health Care Choice Act will disrupt the current health insurance model, bypassing most state regulations and perhaps even agents. However, this ignores the fact that consumers are already searching for new and innovative ways to purchase health insurance.

The U.S. workforce is much more mobile and decentralized than it was 30 or 40 years ago. The Internet and other communications tools allow millions of workers to live in a

different location than where their employer is based. For example, I live in Dallas, Texas, while the Council is headquartered in Alexandria, Virginia.

I don't get my health insurance through the Council, but if I did, it would be from a health insurance company licensed in Virginia, and adhering to Virginia's regulations and mandates: hence a Texan with a Virginia-based and regulated health insurance policy. Sounds a little like the Health Care Choice Act — and that is in practice today.

In addition, one of the fastest growing sectors of the health insurance market is what is known as “association group insurance,” in which individuals who are members of an association (e.g., the Chamber of Commerce) are offered health insurance from a state-regulated and fully licensed insurance company. States impose some oversight on these policies, but most impose far fewer restrictions and regulations on association group insurance than they do on a traditional insurance policy sold to individuals. The reduced regulations and the ability to be more flexible and innovative in their policies allow those insurers to keep their premiums low.

So you have an insurance company that is domiciled in one state selling less-regulated, affordable health insurance through an association in almost every state in the country.

The point is that despite concerns that the Health Care Choice Act could disrupt the current system, deprive states of their ability to oversee insurance and protect consumers, and generally undermine the health insurance market, the market is already moving in that general direction.

IV. Impact of the Health Care Choice Act.

What will happen to the insurance market if the Health Care Choice Act passes?

It will likely have little or no impact on small or large group coverage, and that represents nearly 90 percent of the under-age-65 people who have private (i.e., not Medicare, Medicaid or some other public program) health insurance coverage.

And it will likely have relatively little impact on those individuals who buy their own coverage in the individual market and are relatively satisfied with that coverage (which would include my wife and youngest daughter).

It may not even have much impact on the (mostly young and healthy) uninsured who live in relatively low-cost states because they already have access to affordable policies and choose not to buy them. But the Health Care Choice Act could be an enormous benefit to those individuals, most of whom are uninsured, who live in the high-cost states and have no access to an affordable policy.

V. Conclusion.

We as a society would think it very self-centered if that Cadillac dealer discussed earlier took the position that if people couldn't afford one of his Cadillacs loaded with options, they would be better off without any car. Yet that is happening to many American citizens who live in states where good intentions have led to a lack of choice of insurers, health plans and affordability.

We are not advocating the dissolution of state regulatory authority over health insurance. We are advocating an option and health care choices for the millions of individual Americans who are currently uninsured because they can not afford all the services and "protections" prescribed by their state.

Merrill Matthews Jr., Ph.D.

Merrill Matthews Jr., Ph.D., is director of the Council for Affordable Health Insurance in Alexandria, Virginia, and a resident scholar with the Institute for Policy Innovation. He is a public policy analyst specializing in health care issues, and is the author of numerous studies in health policy. He is past president of the Health Economics Roundtable for the National Association for Business Economics, the largest trade association of business economists, and health policy advisor for the American Legislative Exchange Council, a bipartisan association of state legislators.

Dr. Matthews served for 10 years as the medical ethicist for the University of Texas Southwestern Medical Center's Institutional Review Board for Human Experimentation, and has contributed chapters to two recently published books: *Physician Assisted Suicide: Expanding the Debate* (Routledge, 1998) and *The 21st Century Health Care Leader* (Josey-Bass, 1998).

He is a "Brain Trust" columnist for Investor's Business Daily and has been published in numerous journals and newspapers, including the Wall Street Journal, Barron's, USA Today and the Washington Times, and cited many times in Forbes. He is the political analyst for USA Radio Network and an occasional commentator for National Public Radio.

Dr. Matthews received his Ph.D. in Philosophy and Humanities from the University of Texas at Dallas.

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House Committee on Energy and Commerce

Witness Disclosure Requirement - "Truth in Testimony"

Required by House Rule XI, Clause 2(g)

Your Name: Merrill Matthews, Ph.D.		
1. Are you testifying on behalf of a Federal, State, or Local Government entity?	Yes	No X
2. Are you testifying on behalf of an entity other than a Government entity?	Yes X	No
3. Please list any federal grants or contracts (including subgrants or subcontracts) which <u>you</u> have received since October 1, 2003: None		
4. Other than yourself, please list what entity or entities you are representing: Council for Affordable Health Insurance		
5. If your answer to question number 2 is yes, please list any offices or elected positions held or briefly describe your representational capacity with the entities disclosed in question number 4: I am the director of the Council for Affordable Health Insurance		
6. If your answer to question number 2 is yes, do any of the entities disclosed in question number 4 have parent organizations, subsidiaries, or partnerships to the entities for whom you are not representing?	Yes	No X
7. If the answer to question number 2 is yes, please list any federal grants or contracts (including subgrants or subcontracts) which were received by the entities listed under question 4 since October 1, 2003, which exceed 10% of the entities revenue in the year received, including the source and amount of each grant or contract to be listed: None		

Signature:



Date: June 27, 2005

**GUIDELINES FOR COMPLYING WITH THE TRUTH-IN-TESTIMONY REQUIREMENT UNDER THE
HOUSE RULES**

Instructions for Completing the Truth-in-Testimony Disclosure Form

1. ***In General.*** The form on the reverse side of the page is intended to assist witnesses appearing before the Committee on Energy and Commerce in complying with rule XI, clause 2(g)(4) of the Rules of the House of Representatives. The rule requires that:

In the case of a witness appearing in a nongovernmental capacity, a written statement of proposed testimony shall include a curriculum vitae and a disclosure of the amount and source (by agency and program) of any Federal grant (or subgrant thereof) or contract (or subcontract thereof) received during the current fiscal year or either of the two previous fiscal years by the witness or by an entity represented by the witness.

Please complete the form in accordance with these directions.

2. ***Name.*** Please provide the name of the witness in the appropriate box.
3. ***Governmental Organization (Item 1).*** Please check the box indicating whether the witness is testifying on behalf of a Federal department or agency, or a state or local department, agency, or jurisdiction. Trade or professional associations of public officials are not deemed to be governmental organizations.
4. ***Other Entity (Item 2).*** Please check the box indicating whether the witness is testifying on behalf of an entity other than a governmental entity.
5. ***Grants and Contracts (Item 3).*** Please list any federal grants or contracts (including subgrants or subcontracts) which the witness personally has received from the federal government since October 1, 1999.
6. ***Entity(ies) Representing (Item 4).*** Please list all entities on whose behalf the witness is testifying.
7. ***Representational Capacity (Item 5).*** If the answer to question number 2 is yes, please characterize the capacity in which the witness is testifying on behalf of the entities listed in question number 4.
8. ***Affiliated Entities (Item 6).*** Please indicate whether the entity on whose behalf the witness is testifying has parent organizations, subsidiaries, or partnerships who are not being represented by the testimony.
8. ***Grants and Contracts (Item 7).*** Please disclose grants and contracts as directed in Item 7.
10. ***Submission.*** Please sign and date the form in the appropriate place. Please submit this form with your written testimony. Please note that under the Committee's rules, written testimony must be submitted 48 hours before the commencement of the hearing.