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Hearing on

Protection from Unjustified Premiums

April 20, 2010

Sen. Tom Harkin, Chairman
Sen. Michael Enzi, Ranking

Testimony presented by
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By Grace-Marie Turner, Galen Institute

Thank you, Chairman Harkin, Ranking Member Enzi, Sen. Alexander, and members of the committee for the opportunity to testify today on the issue of health insurance rate authority and premium costs. My name is Grace-Marie Turner, and I am president and founder of the Galen Institute, a non-profit research organization based in Alexandria, VA, devoted to advancing an informed debate over market-based health reform ideas.

In my testimony, I will discuss the proposal under consideration today to give the federal government authority to review health insurance premiums and to impose penalties if they are deemed "unreasonable." I will use the example of Massachusetts' health reform initiative as evidence that this approach is unlikely to succeed.

In addition, I will highlight some of the progress that is being made through innovations in care delivery, in creative benefit offerings, and in lowering the cost of insurance and medical care to show that the competitive market can respond to the demands of consumers for better quality coverage and care at more affordable prices.

Change is indeed needed

American consumers and businesses have been saying for years that the cost of health insurance and health care is a top concern. However, I do not believe that the approach taken in the Patient Protection and Affordable Care Act of 2010 (PPACA) will contain health costs, and evidence shows it likely will exacerbate them. In addition, I believe PPACA will be hugely disruptive to the individual and small and large group health insurance markets as well as to the overall economy and the federal budget.

The fact that this hearing has been called today, I think, supports the concern that the legislation fails to address the central issue of rising health costs.

Just in the few weeks since its enactment, we already are seeing evidence of the flaws in this legislation regarding the lack of clarity involving coverage for younger people with pre-existing conditions and the ambiguity over coverage for members of Congress and staff, for example. These are likely only harbingers of the many, many problems we are likely to see as a result of enactment of this seeping legislation that centralizes control over our huge and extraordinarily complex health sector.

I am not an authority on the entire law and believe that very few people are at this point, but I would like to address today the legislation you are considering to give the federal government authority to establish limits on health insurance premium increases. I believe that this proposed legislation would take the wrong approach by imposing more top-down, government regulatory power. It also would give the federal government power to regulate a sector of the economy in which it has little or no experience or capability.

Dangers of dual regulatory authority

In 47 states and the District of Columbia, insurers are required to file individual market premiums with state regulators. Twenty-eight of them require prior approval before carriers can increase their rates. States have decades of experience in regulating these markets and are able to consider the many forces in their individual states that may impact premium costs. Federal regulators would have much less ability to recognize these differences among states and would therefore be much more likely to inflict damage on health insurance markets.

Health insurers must collect premiums sufficient to pay claims as well as to maintain capital reserves to meet solvency requirements so the company will be able to continue to pay claims. Rate reviews must consider these and other factors when reviewing overall premium prices.

Capping premiums without recognizing the forces that are driving up costs would be like tightening the lid on a pressure cooker while the heat is being turned up. The National Association of Insurance Commissioners[1] (NAIC) writes that "the single most significant contributor to rising health insurance premiums has clearly been the continued growth of health care spending in the United States." The NAIC cites advances in medical technology, multiple treatments available to treat diseases, and the growing reliance on subspecialists, as well as obesity and smoking that lead to health conditions requiring expensive and long-term treatment. In addition, the individual market is subject to much higher risk of adverse selection because people are more likely to seek insurance if they anticipate needing expensive medical care.

The NAIC concludes: "Providing the federal government with authority to override state regulatory determinations on rates while solvency regulation remains at the state level risks uncoordinated financial regulation that would greatly increase the risk of insurer insolvency without providing additional protection for consumers." Further, this federal rate review "can do nothing to reduce claims expenses, which are the biggest component of the premium dollar."

Health costs will continue to rise

The Congressional Budget Office says health insurance premiums will continue their steady upward climb in its analysis of the Senate legislation.[2] Families purchasing insurance in the individual market would see an increase of an additional $2,100 in the year 2016, over and above increases they already will be facing as health insurance premiums continue to rise faster than the rate of general inflation.

That means these families will be paying $15,200 in 2016 for health insurance under the new law, and $13,100 otherwise. Families who get health insurance through small businesses will be paying $19,200 in six years, and those working for large firms, $20,100. PricewaterhouseCoopers released a study, commissioned by America's Health Insurance Plans, which showed the cost of a family plan in 2019 would be $4,000 a year higher under the reform law than otherwise.[3] While the insurance coverage will be more generous, citizens will have many fewer options to select more modest coverage that they may prefer and that likely would be more affordable.

The Patient Protection and Affordable Care Act of 2010 provides subsidies that will help to make this coverage more affordable for some. But the Congressional Budget Office estimates that only 17 million people will be getting subsidized insurance through the state-based exchanges in 2016. However, there are as many as 130 million people in the income categories eligible for this subsidized coverage -- between 133 and 400 percent of the federal poverty line.[4]

As a result, the great majority of Americans will be subject to the mandate to purchase generous and expensive health insurance but only a relative few will qualify for federal subsidies through the exchanges to help them afford the premiums. If tens of millions more do get coverage through the exchange, generally because they have lost their employer coverage or their employers do not provide health insurance, the cost of providing subsidies would soar, driving the federal budget deficits even higher.

Impact of PPACA on the cost of health insurance

Whether the premiums are paid directly by individuals or by taxpayers in the form of subsidies, rising health costs affect us all.

Numerous provisions in PPACA will put upward pressure on health insurance premiums, such as the new taxes on drug companies, device makers, and insurers. When they take effect, these and many other new fees and taxes will be passed along to consumers in the form of higher premiums or reduced services or access to care.

Four health reform provisions that take effect this year are sure to increase health insurance premiums in the short term.[5]

1. *Removal of lifetime and annual limits on health insurance*: Beginning with plan years after Sept. 23, health plans no longer will be allowed to place lifetime limits on new or existing group health plans or individual products. They also will be prohibited from setting annual dollar limits on coverage for "essential benefits" as defined by the Secretary of Health and Human Services. The added cost of these added claims will have to be built into premiums for all policyholders, but it will have secondary effects of causing some employees to lose coverage if their employers cannot afford the higher premiums associated with the no-limit coverage. Self-funded plans will need to purchase additional reinsurance coverage.

2. *Dependent coverage*: Health insurers will be required to allow members to extend coverage to their adult children up to age 26. While this could bring more young and healthy people into the insurance pool, it also has a potential for adverse selection. Privately-purchased health insurance for young people is generally inexpensive; those who have trouble buying coverage in the individual or small group market and who are more likely to take advantage of this new mandate are likely to have higher health risks and therefore higher health costs. Insurers and employers also will be barred from rejecting children under 19 with pre-existing conditions. Insurers are working to determine the actuarial cost and will be adjusting premiums accordingly.

3. *Preventive care*: Newly-written policies will be required to cover not-yet-determined preventive services at no cost to the policyholder. This simply means that co-payments and other cost-sharing will now be built into premium costs, causing them to go up.

4. *Medical loss ratios*: Beginning on January 1, 2011, health insurers will be required to report on the proportion of their premium dollars spent on direct medical care versus administrative costs. If federal regulators decide that wellness, care coordination, and consumer education programs are considered administrative costs rather than actual care delivery, for example, insurers could be forced to drop programs that actually help reduce costs, as I explain on page 8 of my testimony.

   It should be noted that the government is on shaky ground in excessively tight regulation of private health insurance by tightening these loss ratios. The CBO has concluded[6] that excessive regulation of insurance would mean that premiums paid for private health insurance would have to be reflected in the federal budget.

Other cost drivers are yet to come. For example, under PPACA, the Secretary of the Department of Health and Human Services will have authority to determine what benefits must be covered in the generous health insurance policies mandated by the federal government. Massachusetts' experience shows that mandating generous benefits will increase the costs of health insurance and that political attempts to force premiums down will likely fail.

Lessons from Massachusetts

One of the promises of Massachusetts’ 2006 health reform law was that getting everyone covered would force costs down, but that is far from being realized. One third of state residents polled by Harvard researchers in a study published in "Health Affairs" in 2008 said that their health costs had gone up as a result of the 2006 reforms. A typical family of four today faces total annual health costs of nearly $13,788, the highest in the country. Per capita spending is 27% higher than the national average.[7]

The state's stubbornly high health costs are partly the result of government regulations that stifle competition in the insurance market and mandate what services health insurance must cover. A 2008 study by the Massachusetts Division of Health Care Finance and Policy found that the state's most expensive insurance mandates cost patients more than $1 billion between July 2004 and July 2005. The Massachusetts health reform law left all of them in place.

Further, insurance companies in Massachusetts are required to sell policies to people, even if they wait until they are sick to buy coverage. The current structure and fines associated with the individual mandate in PPACA are likely to lead to this same consequence.

In addition, there is growing evidence that many people in the Bay State are taking advantage of the guaranteed issue provisions in the law. They are purchasing health insurance when they need surgery or other expensive medical care, then drop it a few months later.

The Boston Globe reported this month,[8] “Thousands of consumers are gaming Massachusetts’ 2006 health insurance law by buying insurance when they need to cover pricey medical care, such as fertility treatments and knee surgery, and then swiftly dropping coverage, a practice that insurance executives say is driving up costs for other people and small businesses.

“The typical monthly premium for these short-term members was $400, but their average claims exceeded $2,200 per month. The previous year, the company’s data show it had even more high-spending, short-term members. Over those two years, the figures suggest the price tag ran into the millions.

“Other insurers could not produce such detailed information for short-term customers but said they have witnessed a similar pattern. And, they said, the phenomenon is likely to be repeated on a grander scale when the new national health care law begins requiring most people to have insurance in 2014, unless federal regulators craft regulations to avoid the pitfall.

"'These consumers come in and get their service, and then they leave because current regulations allow them to do it,' said Todd Bailey, vice president of underwriting at Fallon Community Health Plan, the state's fourth-largest insurer.

"The problem is, it is less expensive for consumers — especially young and healthy people — to pay the monthly penalty of as much as $93 imposed under the state law for not having insurance, than to buy the coverage year-round. This is also the case under the federal health care overhaul legislation signed by the president, insurers say," *The Globe* reported.

The individual mandate in PPACA likely will lead to the same gaming of the health insurance market that we see in Massachusetts, with people signing up for health insurance when they need it and paying the much-less-expensive fine otherwise. This creates adverse selection and will lead to higher and higher premiums for those who remain in the pool.

In Massachusetts, faced with soaring medical expenses, Gov. Deval Patrick wants to cap insurance rate increases for those in the individual and small group market at 4.8%, not the 8% to 32% increases the companies have requested for the coming premium year.

Last week, two of the state's biggest health insurers were threatened with fines of as much as $5,000 a day, plus another $1,000 for each consumer who was unable to buy insurance at approved rates from the insurer, if they did not comply with the governor's directive.

How long will these non-profit insurers be able to stay in business if the government forces them to continue to pay benefits that exceed the premiums they are allowed to collect? Three of the four major health insurers in Massachusetts showed operating losses for 2009. If their rates are capped, they say they'll be forced to cut payments to health providers, putting further pressure on doctors and fragile hospitals.

In their complaint filed against the state last week, the major health insurers in Massachusetts say they could collectively lose more than $100 million – "losses that will deplete their individual reserves, weaken their financial stability, and in some instances threaten their near-term solvency."

And the law's distortions don't extend just to health insurance: Some Massachusetts safety-net hospitals that treat a disproportionate number of lower-income and uninsured patients are threatening bankruptcy. They still are treating a large number of people without health insurance, but the payments they receive for uncompensated care have been cut under the reform deal.

Private sector innovation

Many of the problems the country is facing involving health costs could be addressed by encouraging much more competition and empowering consumers to have greater control over decisions involving their care and coverage. In a truly competitive market for insurance where consumers had more power over spending decisions, price transparency and a larger choice of options would drive out insurers who price their products exorbitantly.

Unfortunately, the lack of competition in health insurance in many states limits the options for coverage, over-regulation drives up costs, and our structure of financing health insurance gives consumers little power to make choices.

While health care is different than other sectors of our economy and requires special consideration, there are many areas where consumers can and want to have more control over their health care choices. The evidence I will describe below shows that competition could work if we were truly to engage consumers as partners in getting better value for their health care dollars. The private sector has demonstrated that it can get health costs under control, particularly where companies have provided new structures to allow consumers to become engaged.

Employer innovations

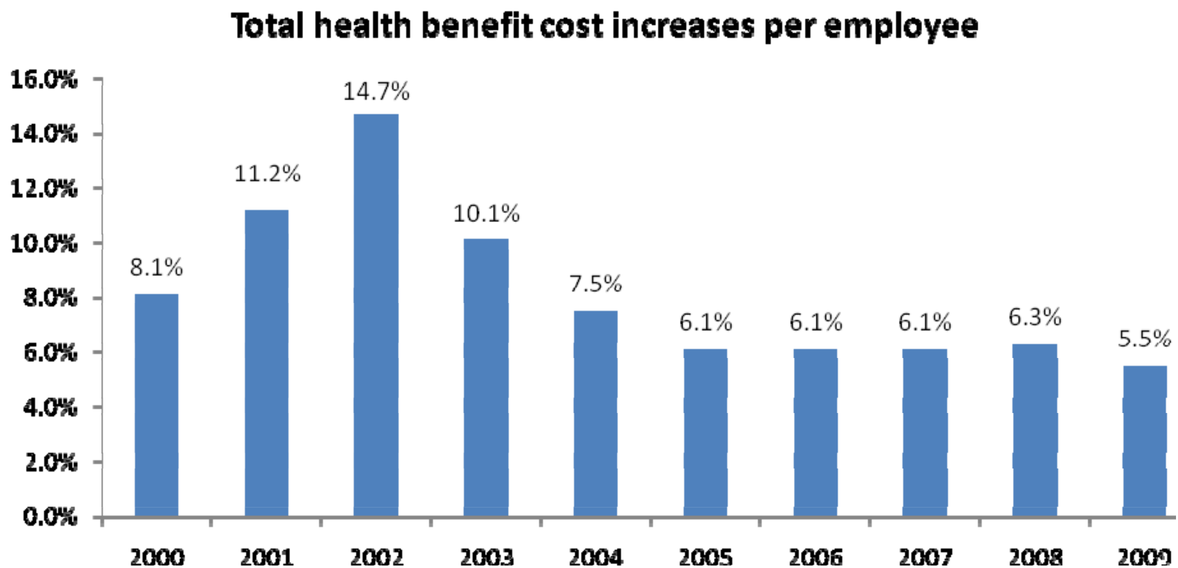
Many leading employers are working to get better value for spending on health care and health insurance for their employees in order to shape their health insurance offerings to fit their resources and workforces. A few examples:

- Safeway chief executive Steve Burd has become an evangelist for wellness incentives in the company's health insurance arrangements. In the first year after these plans were introduced, the company's health costs went down 11 percent. "If you design a health care plan that rewards good behavior, you will drive costs down," he said.[9] The company shared its cost savings with employees, cutting their costs by 25 percent or more. Safeway introduced a program called Healthy Measures that encourages employees to get health assessments and provides support and incentives for responsible health behaviors. Safeway also covers the full cost of recommended preventive care.[10]
- Target offers its employees a range of health insurance choices. One Health Savings Account option costs them as little as $20 a month, and Target contributes $400 a year to health spending accounts for individuals and $800 for families.[11] "We've seen, and national research supports, that team members make more cost-conscious decisions when they participate in a consumer-based plan," according to John Mulligan, Target's vice president for pay and benefits. "These plans engage our team members in a decision-making process that gives them greater ownership and control of their health care dollars." The company offers its 360,000 employees Decision Guides to help them compare price and quality and estimate their costs, plus access to wellness programs, a nurse hotline, and other support tools.[12]

- Wal-Mart offers dozens of health plan options to its employees, one with premiums as low as $5 a month. For this, employees receive a $100 health care credit, more than 2,400 generic drugs available for $4 a month, and major medical coverage with no lifetime maximum that starts at $2,000 – basically the moment they step into a hospital. Employees can choose to pay higher premiums for lower deductibles and more comprehensive coverage.[13] For $62 a month, employees can choose a $500 deductible policy with a $100 health care credit and no lifetime maximum on their insurance coverage.

- Whole Foods' CEO John Mackey toured the country talking to employees about health benefits options. Afterward, employees voted to switch to new account-based health plans with higher-deductible insurance coverage. Whole Foods deposits up to $1,800 a year into a spending account for each employee, with Mackey pointing out that this is not charity but part of the employee's compensation package. If they don't spend the money on medical care, it rolls over and the company adds more the next year. Some workers have as much as $8,000 in their accounts.[14] Whole Foods saves money and still covers 100 percent of its employees' health insurance premiums.

These companies and many others have worked extraordinarily hard to find the delicate balance between getting health costs under control and continuing to provide coverage that satisfies their workers. There simply is no way that a benefit or cost structure dictated by Washington could achieve these same results. Maintaining ERISA protection is crucial to allowing companies to continue to innovate.



Source: Mercer's National Survey of Employer-Sponsored Health Plans; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April) 1990-2009; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April) 1990-2009.

As this chart shows, employers held cost growth to 5.5 percent in 2009, the lowest increase in a decade. The use of wellness and health management programs increased as large employers found these tools to be very helpful in holding health costs down.[15] It is crucially important that implementation of the new health reform legislation provide incentives for employers and health plans to continue these innovative approaches to controlling health costs.

New health care financing options

Several new private sector health coverage options are available to companies and individuals such as Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs).

HSAs permit individuals to combine health insurance with a tax-free health spending and savings account. The account is used to pay for routine health care expenses, such as doctor's visits, for services not covered by insurance, and to create a cushion to pay premiums in lean economic times. The high-deductible insurance policy covers larger medical expenses such as hospitalization and surgeries. Federal law also allows the insurance contract to cover preventive care, such as cancer screenings.

Eight million Americans had health insurance that qualifies holders to open HSAs as of January 2009.[16]

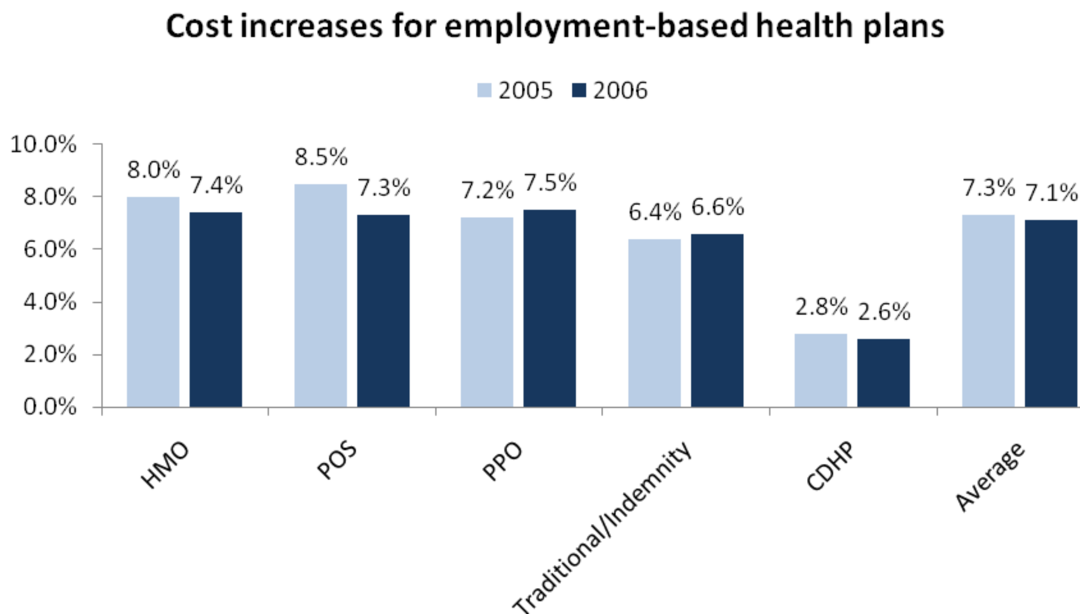
The older sisters of HSAs, Health Reimbursement Arrangements, were created via a regulatory interpretation in 2002 to give employers more flexibility in structuring health coverage for their workers. HRAs operate much like HSAs but can be offered only through the workplace. They are generally account-based plans accompanied by health insurance. While the money in HSAs is truly portable to the employee or individual holder, access to HRA funds is generally restricted after an employee leaves a company. But HRAs give employers more flexibility in shaping their benefit packages, including providing incentives for prevention and wellness activities.

Both products are helping to make health insurance more affordable and are helping companies lower their health costs. Health insurance premiums generally are lower than average because deductibles are higher, and the savings on premiums can help fund the HSA or HRA that people can use to pay for routine health expenses.

Companies that have introduced health plans with new incentives for consumers to be engaged as partners in managing health costs generally have seen lower-than-average health cost increases. Annual premium increases for employment-based coverage averaged about six percent for the last three years, down from double digits earlier in the decade.[17] The most impressive results have come from consumer-directed plans such as HSAs and HRAs.

Enrollment in consumer-directed health plans (CDHP) grew to an estimated 23 million people in 2009, up from 18 million people in 2008 -- a 27% increase. This finding was reported by the American Association of Preferred Provider Organizations and was based upon research from Mercer's 2009 National Survey of Employer Sponsored health Plans. Small employers led CDHP adoption in 2009, accounting for most of the growth among all employers.[18]

Deloitte's Center for Health Solutions found that cost of consumer-directed health plans (CDHPs) increased by only 2.6 percent in 2006 among the 152 major companies it surveyed. This is about a third the rate of increase for traditional plans.[19]



Source: "Reducing Corporate Health Care Costs: 2006 Survey," Human Capital Practice of Deloitte Consulting LLP and the Deloitte Center for Health Solutions, 2006.

Lower costs of insurance coverage

Consumer-directed health products have helped to moderate health cost increases overall.

- UnitedHealthcare found that employer health benefit costs were more than 15 percent lower in 2007 for its HRAs than for traditional PPO plans. Importantly, 85 percent of the cost savings were attributable to lower utilization costs, such as avoiding hospitalizations and greater use of generic drugs – and not from cost shifting to employees.[20]

- A Mercer study found that consumer-directed health plans delivered substantially lower costs per employee than either PPOs or HMOs in 2008. CDHP medical

plans averaged $6,207 per employee, compared to $7,768 for HMOs and $7,815 for PPOs.[21]

- In addition, health insurance that people purchase in the individual market is often more affordable than employment-based coverage. eHealthInsurance, the largest online broker for individually-purchased and small-group health insurance, found that the average yearly health insurance premium in 2009 was $1,968 for individuals and $4,656 for a family.[22]

Other benefits

In addition to moderating cost increases, HSAs also are providing new options for the uninsured. Up to 43 percent of those enrolling in HSA-qualifying health insurance were previously uninsured, showing that uninsured Americans in particular have been looking for an affordable alternative to traditional health insurance, according to Assurant Health.[23] Assurant Health's most recent data show that they have broad appeal:

- 66% of HSA purchasers are families with children
- 63% of HSA purchasers are over age 40
- 52% of all HSA purchasers have high school or technical school training as their highest level of education
- 30% of HSA purchasers have family incomes of less than $50,000

UnitedHealthcare found, based upon a survey of 300,000 HSA owners, that the average account holder had household incomes of $55,500, and 25 percent of those with an HSA had incomes of less than $39,000.[24] Changes in federal law in 2006 allowing employers to make larger deposits for lower-income workers also are apparently succeeding, since UnitedHealthcare found that they were more likely to have employer contributions in their HSAs than higher-income HSA holders.

Other private insurance options

Many other employers are offering innovative programs to help their employees get and stay healthier and spend health care dollars wisely. They are offering incentive programs to encourage employees to get health assessments to detect problems early and health coaching to help those with chronic illnesses better manage their care. These companies generally work in partnership with health plans to design the consumer-based products, manage the finances, educate employees about using them, and provide wellness programs and support for employees with chronic conditions. Price transparency is an important element in their success.

For example, in 2005, Aetna launched a program that offers a range of consumer-support tools to help patients find physicians, compare costs and quality, and get personalized

information about medical conditions and treatment. Its personalized search engine provides health information tailored to patients' individual needs.[25]

The results show this patient engagement works. Aetna is following health care claims and utilization of 1.6 million members of its Aetna HealthFund consumer-directed plans. Four years of evidence show sustained savings, more patient engagement in managing health, and greater utilization of preventive services. Employers who offered an Aetna HealthFund plan lowered their health care spending trend and saved money through all four years with the plan, across all Aetna products they offered.[26]

Aetna studied its members to identify the keys to successful implementation and found the keys were *greater* spending on preventive care, including wellness programs, focusing on employee communication and education, and carefully structuring benefits packages with appropriate levels of employee responsibility.[27]

Many companies are offering turnkey solutions to health plans and employers. U.S. Preventive Medicine, for example, offers employers packages of services they can tailor to fit the needs of their workforces for preventive care services.[28]

In addition, a galaxy of websites has evolved to offer everything from treatment information to diet advice. EverydayHealth has just surpassed WebMD as the most-visited site for medical information, and new sites appear every day to help patients find the best doctors, the lowest cost medicines, and the most cost-effective diagnostics.

Lower drug costs

Competition, primarily from greater use of generic drugs, helped to moderate prescription drug spending. Drug prices increased 2.5% in 2008, compared to 1.4 percent in 2007. This is slower than the 4.1% average annual rate of growth between 1997 and 2007 and less than the overall rate of medical inflation.[29] Part of the reason is increased use of lower-cost generic drugs, but private competition over drug pricing in the Medicare Part D program also contributed. And retail establishments also have engaged in private price wars. In 2006, Wal-Mart began offering 30-day supplies of several hundred generic drugs for just $4. Competitors quickly followed suit, with some even offering to fill prescriptions for antibiotics for free.

There also has been active engagement by pharmaceutical companies in creating programs for low-income and uninsured people to obtain their products at little or no cost. Pharmaceutical companies have made significant investments to develop, expand, and promote patient assistance programs like Together Rx Access, Pfizer Helpful Answers, Partnership for Prescription Assistance, and many others. New private partnerships, like the Asheville Project and the Ten Cities Challenge, also have been created to help patients with chronic illnesses, including diabetes, get the medicines and counseling they need to manage their diseases.[30]

Care delivery

Private health care firms have responded to consumer demand for more convenient, accessible medical care. For example:

- TelaDoc offers its customers telephone consultations with physicians from wherever they are, anytime of day, 365 days a year. The average patient gets a call returned by a doctor in less than 40 minutes, and the cost per call is just $35 – a fraction of the cost of an emergency room visit. TelaDoc physicians also use electronic prescribing to minimize errors and keep a record of patients' medications.[31]

- There also has been an increase in the number of low-cost walk-in medical clinics like RediClinic, Take Care, and MinuteClinic. There are now more than 1,180 retail clinics nationwide.[32] They are usually located in malls or chain stores and are typically staffed by nurse practitioners working in conjunction with local doctors and hospitals to diagnose and treat common illnesses. They are open seven days a week, before and after work, and prices are a fraction of emergency room charges.

  These clinics use Mayo Clinic and Cleveland Clinic protocols to diagnose and treat a range of routine health problems, from allergies and bronchitis to poison ivy, ear and bladder infections, and strep throat, usually for a fraction of the cost of hospital emergency rooms. Wal-Mart found that about half of the people visiting its in-store clinics were uninsured and did not have other sources of care. Wal-Mart partners with local hospitals and doctors' groups to create the clinics in many areas, but it insists that all of them create electronic health records for every patient that are accessible at any other clinic in the chain.

- Specialty hospitals owned by physicians are showing the value of focused care in delivering high-quality, efficient care with greater patient satisfaction and better health outcomes.

- Physician practices also are innovating to become more consumer-friendly. Some are freeing up an hour or more a day for same-day appointments. Others are working with employers to staff on-site clinics so employees can see a doctor without taking time off work.

- Hospitals are experimenting with new ways to ease crowding in their emergency rooms, visited by an estimated 119 million patients in 2006. There are more than 8,000 walk-in urgent care facilities nationwide staffed by practicing physicians. Inova Health System and Shady Grove Adventist in the Washington, D.C., area and dozens of other hospitals nationwide are opening free-standing emergency facilities to treat everything from lacerations to heart attacks and gunshot wounds. Patients are seen faster, and if they need to be admitted, they are transported by ambulance to nearby hospitals.[33]

- A growing number of physicians are experimenting with innovative medical practice design,[34] including direct medical practices. Physicians, generally internists or family practitioners, contract directly with their patients to offer a medical home, providing medical care, consultation, and coordination with specialists for a fixed fee. The fees range from $60 to $15,000 in some practices, but generally cost about $1,500 a year.[35] Other physicians are bypassing insurance and simply posting prices for medical services. They find they can charge patients much less because they save on the administrative overhead of insurance billing.

- Health Advocate, a Pennsylvania-based company, helps consumers find the right doctor for their ailments, work with insurance companies on coverage, and manage other administrative headaches. This service helps consumers, via call centers, who are being given more responsibility to navigate the world of health care and health coverage.[36]

Unfinished agendas

I commend you and the many other members of Congress for working toward the goal of expanding access to health coverage for the uninsured, modernizing our health care delivery system, and trying to provide relief for private and public payers to rising health costs.

The challenges are enormous. Millions of Baby Boomers are aging into Medicare, putting new pressures on the system. The costs of public programs threaten to squeeze out other public services provided by federal and state governments. Millions of people continue to lose their health insurance when they lose or change jobs (and I believe the coverage of many workers is actually threatened by PPACA.) But the cost of health care and insurance coverage continue to be at the center of the health reform debate. I think the evidence shows that private sector initiatives and genuine competition offer the best hope of helping consumers and taxpayers with health costs.

The path forward

Addressing the needs of 300 million Americans for better quality care at more affordable prices requires modernizing our health sector to become more efficient and innovative. It is not possible to expect that one piece of legislation could be written carefully enough to accommodate these needs and also continue to provide a platform for future innovation to enhance the quality of medical care in the future.

The medical profession is moving toward patient-centered medicine, with micro-targeting of treatments tailored to the individual genetic code of individual patients. Advances in medical science demand that progress must continue without being blocked

by regulatory obstacles and restrictive payment systems. This continued innovation is vital to progress in health care.

While we face major problems with cost and access to coverage, the evidence shows that careful reform which respects the diverse needs of our population is crucial. As the examples I have offered here show, competition can work in public and private programs and force the system to be more responsive to consumers. By properly structuring incentives and creating a climate friendly to this innovation, Congress could put us on a path to uniquely American health care solutions. As I believe the evidence shows, competition works, even in health care, and offers the best solution for the future.

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[1] Therese M. Vaughan, CEO, National Association of Insurance Commissioners, letter to The Honorable John Dingell, February 23, 2010.

[2] Congressional Budget Office, "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act," Letter to the Honorable Evan Bayh, November 30, 2009, at http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.

[3] PricewaterhouseCoopers, "Potential Impact of Health Reform on the Cost of Private Health Insurance Coverage," October 2009, at http://www.politico.com/static/PPM116_pwc2.html.

[4] James Capretta of the Ethics and Public Policy Center writes in *Kaiser Health News*, April 8, 2010: "The risk of cost overruns is even higher at the federal level than in Massachusetts. The Congressional Budget Office projects just 17 million people will be getting subsidized insurance through the state-based exchanges in 2016. But the population with incomes between 100 and 400 percent of the federal poverty line--roughly the group targeted for subsidized coverage--is more like 130 million people. CBO assumes the vast majority of low- and moderate-wage families will stay in job-based plans with no additional federal help. But what if they are wrong? Employers are already looking for ways to shed as much of their health care bill as they possibly can onto taxpayers. If 30 or even 50 million Americans end up in the exchanges, federal costs will soar."

[5] Steve Davis, "Four key health reform provisions that will affect health insurers this year," April 5, 2010. AIS's Health Business Daily.

[6] Congressional Budget Office, "The Budgetary Treatment of Proposals to Change the Nation's Health Insurance System," May 2009.

[7] Robert J. Blendon, Tami Buhr, Tara Sussman, and John M. Benson, "Massachusetts Health Reform: A Public Perspective From Debate Through Implementation," Health Affairs 27, no. 6, October 28, 2008, at http://content.healthaffairs.org/cgi/content/abstract/27/6/w556.

[8] Kay Lazar, "Short-term customers boosting health costs," *Boston Globe*, April 4, 2010. http://www.boston.com/news/local/massachusetts/articles/2010/04/04/short_term_customers_boosting_health_costs/

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