

**Testimony of**

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on behalf of  
America's Health Insurance Plans**

**Before the**

**U.S. House of Representatives  
Committee on Education and Workforce  
Subcommittee on Employer-Employee Relations**

*Examining Innovative Health Insurance Options for Workers and Employers*

**June 24, 2004**

## **I. Introduction**

Good morning, Mr. Chairman and members of the subcommittee. I am Rick Remmers, Chief Executive Officer of Humana-Kentucky/Indiana/Tennessee. I am here today to testify on behalf of America's Health Insurance Plans (AHIP). AHIP is the largest health trade association in the country, representing over 1,300 companies that provide health benefits to over 200 million Americans. I appreciate the opportunity to provide information to the subcommittee on the new products and services that health insurance plans have developed to meet the needs of employers.

I will focus my remarks on the following four areas:

- Trends in the employer group market
- Innovative health insurance plan strategies to assist workers in using their premium dollars
- The special needs of small employers
- Regulatory challenges to meeting employers' needs

## **II. Trends in the Employer Group Market**

More than 161 million Americans receive private health care coverage through the workplace. Despite rising health care costs, the overwhelming majority of employers continue to offer coverage: in 2003, the offer rate ranged from 65% of smaller firms with 3 to 199 workers to 98% of larger firms with more than 200 workers. Employers paid an average of \$2,900 a year for single coverage (84% of total premiums) and \$6,700 for family coverage (73% of total premiums). The percentage of premium paid by employers has been steady since 2000, rarely varying by more than one or two percentage points from one year to the next.<sup>1</sup>

Though workers have experienced a rise in deductibles and copayments – for example, the average annual in-network deductible for a worker in a Preferred Provider Organization (PPO) plan rose from \$251 in 2002 to \$275 in 2003<sup>2</sup> – most have experienced no other types of reduction in their benefit packages. Most employer-sponsored health plans continue to offer their workers generous benefits, including comprehensive coverage for prescription drugs and preventive services. Moreover, the percentage of workers with a choice of health plans has remained relatively stable, at 62%.<sup>3</sup>

Nonetheless, employers and workers rightly remained concerned over cost trends. In a recent survey of employers, 25% said they expected to increase employee contributions, and 23% said they would pass on more costs by making changes to the health plans they offer their workers.<sup>4</sup>

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<sup>1</sup> Kaiser Family Foundation/Health Research and Educational Trust. (2003). *Employer health benefits: 2003 annual survey*.

<sup>2</sup> *Ibid.*

<sup>3</sup> *Ibid.*

<sup>4</sup> Gunsauly, C. (2003, December) Employers stay committed as costs soar. *Employee Benefit News*.

These are short-term strategies. Employers and workers need additional solutions that will help them control their health care costs. Health insurance plans are developing additional solutions through:

- Consumer choice products—to give workers options for using their purchasing clout in the marketplace.
- Disease management, wellness and education programs, and pay-for-performance—to give workers with chronic conditions more services, and opportunities to stay healthy, and to align reimbursement with providers’ performance, higher quality, and ultimately more cost-effective, health care.
- Information transparency—ensuring that consumers have cost and quality tools that will help them make choices that are right for them and for their loved ones. These tools allow consumers to compare providers on price and performance.

### **III. Responding to Employers’ Needs with Consumer Choice Products**

Health insurance plans have developed a spectrum of “consumer choice” products that give workers the incentives and the tools to become better consumers of health care. By giving workers more control over funds allocated for their health benefits, workers will be more engaged in how they spend their money. This is especially true once a worker becomes more educated about the actual cost of health services.

Consumer choice products are available in at least three basic designs:

- Products designed around tax-advantaged spending accounts – such as Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs), or Flexible Spending Arrangements (FSAs) – and a low premium (high deductible) health plan.
- Products designed around tiered networks of providers.
- Products designed around structured choice, where workers “build their own” plans after their employer has chosen a core set or level of benefits.

#### ***Tax-Advantaged Spending Accounts***

An example of a product designed around a spending account is the “Liberty plan” offered by Tufts Health Plan, in alliance with Destiny Health. At the heart of the Liberty plan is the Personal Medical Fund™ (PMF), an interest-earning fund to which the employer credits a fixed amount of money for the individual to spend each year on health care expenses that are subject to an annual deductible. The PMF could easily be a Health Reimbursement Arrangement or a Health Savings Account: an HRA is an employer-funded account that reimburses workers for qualified medical care expenses; an HSA is a tax-exempt trust or custodial account with a financial institution that can be funded by the employer, the worker, or both.

If eligible health care expenses are more than the amount in the PMF, then the member pays additional health care expenses within the remaining deductible. Comprehensive coverage takes care of eligible expenses above the plan's deductible. Comprehensive coverage also covers drugs for chronic illness.

Complementing the Personal Medical Fund is the "Vitality Program" of rewards for healthy behaviors. Consumers are able to earn points – the equivalent of frequent flier miles – for making healthy choices. For many people, this might include joining a health club. For others, it might include losing weight or giving up smoking. For diabetics, it might be getting regular eye exams.

A 2002 survey by Destiny Health offers an early peek into the potential of consumer choice products like the Liberty plan:

- 41% of enrollees took a more active role in well-being and physical activity
- 37% improved their preventive healthcare regimen
- 16% reduced their number of doctor visits
- 12% negotiated costs with their doctor before receiving care

These changes in patients' behavior could result in big long-term changes in cost trends. More important, it demonstrates the power of informed consumers to make healthy choices.

### ***Tiered Networks***

One example of a product designed around a "tiered" network is Aetna's "Aexcel" network of specialist physicians. Based on an analysis of clinical measures of effectiveness (such as hospital readmission rates over a 30-day period and reduced rates of unexpected complications by hospitalized patients) and use of health care resources, Aetna identifies best-performing specialists (cardiologists, cardiothoracic surgeons, gastroenterologists, general surgeons, obstetrician-gynecologists and orthopedic specialists), and places them in a new, discrete network.

Employers have the option of directing their workers to use only Aexcel physicians for the six specialties. Or employers can offer Aexcel to workers along with Aetna's broader network of specialists. If both networks are offered to a workforce, employees choosing Aexcel physicians receive a reduction in copayments or coinsurance, or a reduction in deductibles. The Aexcel network is currently available in the three markets of Dallas/Fort Worth, North Florida and Seattle/Western Washington. Aetna intends to expand this product into additional service areas and specialties throughout the next two years.

### ***"Build-Your-Own" Plans***

Two examples of the build-your-own approach are offered by Highmark Blue Cross Blue Shield and Anthem Blue Cross Blue Shield.

Highmark's BlueChoice program features interactive selection tools that allow members to indicate general preferences and receive a list of plans ranked by how well they meet those preferences. Employers choose a central benefit plan and funding level. For workers, additional plan options allow them to choose from up to 200 additional options. These interactive selection tools ensure that each worker has a health plan tailored to his or her personal situation.

Anthem ByDesign permits employers to select a core level of benefits, and workers can opt to upgrade benefits for additional cost. Employers may choose from PPO health, dental, vision, prescription, life and disability benefits. This plan gives workers more control of their choices so that they can tailor family or personal health care strategies, and become more vested in their healthcare decisions.

### ***Multiple Design Features***

As health insurance plans and employers gain experience with consumer choice plans, the pace of product innovations will increase. A number of health insurance plans – including many of those previously discussed – combine multiple design elements. For example, **Humana's SmartSelect** product, available to self-funded groups of 300 or more workers, allows employers to choose from a variety of PPO plans, some of which include a Health Reimbursement Arrangement (HRA). Using sophisticated but user-friendly web-based tools, workers compare costs and benefits, estimate their total health care spending, and customize their plan by selecting varying levels of copayments, coinsurance and premium costs, as well as prescription benefit options. By offering workers choices in a suite of benefit options from the same carrier, employers can maintain the integrity of their insurance pool to protect the coverage of both the sick and the well, the young and the aged. This suite of choices allows workers a chance to select a plan based on their own evaluation of their health care and financial needs.

**Humana's SmartSuite** plans allow workers to choose from pre-packaged plan designs including HMOs, PPOs and plans with a spending account. A comprehensive education program is wrapped around these Humana products that provide the worker with education and support on a year round basis helping them become engaged health care consumers.

Experience shows that products such as these appeal to workers across a wide range of incomes. One Humana customer, an employer of 700 people with average compensation in the “high \$30s, low \$40s” and 15% to 20% of workers with average compensation in the “low \$20s,” reports that “even our workers who have more modest incomes are able to budget their finances and afford coverage through these mechanisms.”<sup>5</sup> In addition, these plans have wide employer appeal as Humana clients on average have consistently experienced single digit increases. Moreover, employers can actually limit their exposure year over year through rate cap guarantees. For example, Humana's **SmartAssurance** program limits the maximum second year employer rate increase to 9.9%.

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<sup>5</sup> Patrick B. McGinnis, Chairman and CEO, Trover Solutions Inc., Louisville, KY.

#### IV. Responding to Employers' Needs with Programs to Improve Quality

Recent major studies show that people in all parts of the United States, even in areas with outstanding medical institutions, are at significant risk of receiving poor health care. Across a wide range of communities, people received only 50% to 60% of treatments that have been determined to be the “best practices” for addressing their medical conditions. For example, less than one-quarter of diabetics had their average blood sugar levels measured regularly, and only 45% of heart attack patients received beta blockers and only 61% received aspirin. These findings are consistent with substantial research over the past several decades – including continuing research by Dr. John Wennberg and others at Dartmouth – on regional variations in care that have found shortfalls in the quality of health care delivered to Americans.<sup>6</sup>

Clearly, millions of Americans who have health care coverage through the workplace are not receiving care that is consistent with the highest level of objective scientific evidence. While the overuse, underuse and misuse of health care services have been well documented, the significant efficiencies that would result to the entire health care system have not been as well recognized:

- 30% of all direct health care expenditures are the result of poor quality and its indirect costs (e.g., reduced productivity due to absenteeism) cost a combined total of between \$525 and \$630 billion annually.<sup>7</sup>

AHIP member companies support the improvement of health care quality through the use of evidence-based medicine as the standard for health care. We support advancing health care quality and transparency to improve outcomes, eliminate errors, reduce costs, and help consumers to make informed health care choices. We should seek to control costs by informing consumers, promoting safe and effective care, offering payment incentives that reward quality, enacting sensible liability reforms, and enhancing benefits that emphasize health and wellness programs. These initiatives are happening today. They empower consumers and represent our best opportunity to ensure choice and quality while controlling costs.

Health insurance plans have developed a spectrum of programs that give physicians and patients the information, tools, and incentives to enhance the quality of care:

- Evidence-based medicine (EBM)
- Disease management (DM) programs
- Predictive modeling programs

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<sup>6</sup> J.E. Wennberg and M.M. Cooper, *The Dartmouth Atlas of Health Care in the United States* (Chicago, 1999); Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the Twenty-first Century* (Washington: National Academies Press, 2001); E. McGlynn, S. Asch, J. Adams, J. Keeseey, J. Hicks, A. Cristofaro, E. Kerr, “The Quality of Health Care Delivered to Adults in the United States,” *New England Journal of Medicine*, 348, no. 26 (2003): 2635-2645; E. Kerr, E. McGlynn, J. Adams, J. Keeseey, and S. Asch, “Profiling the Quality of Care in Twelve Communities: Results From The CQI Study,” *Health Affairs*, 233, no. 3, May-June, 2004: 247-256.

<sup>7</sup> *Reducing the Costs of Poor-Quality Health Care*, Midwest Business Group on Health in collaboration with the Juran Institute, Inc., and The Severyn Group, Inc. 2003.

- Wellness and prevention programs
- Quality recognition and incentives to reward quality

### ***Evidence-Based Medicine***

In *Crossing the Quality Chasm*, the Institute of Medicine defines the practice of evidence-based medicine as the integration of best research evidence with clinical expertise and patient values. Patient care can be enhanced through a national commitment to evidence-based medicine and transparency in the health care system. It is important that scientific research, best practices, and consumer information be applied in everyday medical practice and health care decision-making. Total health costs due to preventable adverse events (medical errors resulting in injury) are estimated to be in the range of \$8.5-\$14.5 billion.<sup>8</sup> At the low end, elimination of \$8.5 billion in medical errors would be enough for employers to insure almost 2.5 million additional Americans with quality coverage. Instead, those funds are wasted on unnecessary care.

AHIP members are currently working with a number of medical specialty societies to develop tools to implement these principles. We believe in promoting comparative effectiveness research and the development of a national repository to identify and make public practices that translate evidence into practice.

### ***Disease Management***

Disease management (DM) programs are available to employers across the full range of product platforms, from HMOs to PPOs to newer consumer choice products. Using a variety of approaches – among them patient education materials, information on self-care management, telephone-based nurse case management and home visits – disease management programs help patients take responsibility for their own care, while working with physicians to ensure patients receive recommended care.

Virtually all health plans have implemented disease management programs. Ninety-nine percent of health plan enrollees are offered a DM or chronic care program for diabetes; 93% are offered DM or chronic care program for congestive heart failure; and 82% are offered a program for asthma.<sup>9</sup> These are conditions for which proactive and timely intervention may result in delayed progression of the disease, better health outcomes, and lower overall costs.

A study of the disease management programs offered by 10 AHIP member health plans and insurers released in November 2003<sup>10</sup> found:

- ***Asthma DM programs reduce total health care costs and show a strong return on investment.*** One evaluation compared the cost of care for people with asthma with costs for the rest of the health plan population. In the year before the DM program was implemented (1996), the cost of care for people with asthma was 2.4 times that of the rest

<sup>8</sup> IOM, *To Err is Human*, 1999, Executive Summary, p. 1.

<sup>9</sup> American Association of Health Plans (2002). 2002 Annual Survey of Health Plans. Publication pending.

<sup>10</sup> American Association of Health Plans/Health Insurance Association of America, *The Costs Savings of Disease Management Programs: Report on a Study of Health Plans*, (November 2003).

of the plan population. This number declined to 2.1 in 2001. The difference in pharmacy costs for patients with and without asthma declined from 4.5 times that of the rest of the plan population in 1996 to 3.6 in 2001. Another evaluation of a health plan's asthma program found that for every dollar spent on the program, the savings ranged from \$1.25 to \$1.40.

- ***DM programs for congestive heart failure reduce ER visits and inpatient admissions by one-third.*** A DM program for commercial and Medicare patients with congestive heart failure reduced emergency room visits and inpatient admissions by 33 percent. Given the high costs associated with emergency room visits, this finding has significant cost saving implications.
- ***DM programs for lower back pain provide a strong return on investment.*** A DM program for commercial HMO and commercial self-insured plan members with lower back pain found that for every dollar spent on the program, costs were reduced between \$1.30 and \$1.50.
- ***Diabetes DM programs reduce per-member, per-month costs, inpatient days, inpatient costs, and total costs.*** One health plan that implemented a DM program for Medicare and commercial members with diabetes found that total per-member, per-month costs for diabetes patients enrolled in the program were 33 percent less than costs in a control group. Another plan found that its diabetes DM program for commercial HMO members and employer self-insured plans reduced total inpatient costs by 14.4 percent; reduced inpatient days by 6.9 percent; and reduced total costs by 6.4 percent during a one-year period. The plan estimated that for every dollar spent on the program, it saved between \$1.75 and \$2.00.
- ***DM programs for multiple chronic conditions provide a major return on investment.*** Health plans' DM programs often address multiple chronic conditions, including diabetes, coronary artery disease, asthma, and congestive heart failure. An evaluation of a plan with a multi-condition DM program for its Medicare, Medicaid, and commercial members found that for every dollar spent, it saved \$2.94. Preliminary analysis of the program also found a net savings of \$.90 per-member, per-month. A similar program that another health plan established for commercial HMO and employer-self insured members found that the program saved between \$2.25 and \$2.50 for every dollar spent.

An example that illustrates how disease management can be integrated into a consumer choice plan is offered by Lumenos. Employers who contract with Lumenos encourage at-risk patients to enroll in DM programs by adding \$50 to \$100 to their health reimbursement account (HRA) if they agree to take a health risk assessment. Then, at the worker's request, the results are sent to a personal health coach who helps the member manage his or her health more effectively.

How well are such DM programs working? DM's success in promoting safe and effective care and improving health outcomes is well-documented by successes such as Geisinger Health

Plans' 20 percent reduction in claims costs for patients in a diabetes DM program.<sup>11</sup> DM's success in saving employers money is evidenced by the findings of an AHIP study. The results of this study indicate that patient outcomes improved for enrollees in DM programs. Additionally, these individuals had fewer hospital admissions, fewer emergency room visits, and lower health care costs. These evaluations suggest that the real savings for consumers, health insurers and plans, purchasers and consumers are in the range of 5% to 33%.<sup>12</sup>

### ***Predictive Modeling***

An actuarial rule-of-thumb is that 5% of workers generate more than 50% of a health plan's costs. Predictive modeling is a technique that health insurers and plans may use to identify at-risk and chronically ill patients. These programs help patients uncover inconsistencies in care, identify potential health risks and focus on best practices for their care. Through analysis of demographic, medical, laboratory, and pharmacy data, predictive modeling can identify high-risk patients and identify individuals at future risk, before the onset of an adverse condition. Patients benefit and health care costs can be reduced.

For example, Blue Cross Blue Shield of Michigan incorporates predictive modeling into its disease management programs, focusing on identifying candidates most likely to respond to interventions. Humana uses predictive modeling to advise employers on the types of disease management programs that would offer the greatest benefit to their workers. Workers benefit from coverage that meets their needs and tools that allow them to take charge of their own care needs and remain productive members of the workforce. Employers also may benefit from reduced costs and improved employee satisfaction.

### ***Wellness and Prevention Programs***

Wellness programs offer another effective strategy for increasing employee awareness of health concerns, preventing illness and disability, and increasing productivity. Examples of such programs to empower consumers include:

- **PacifiCare** offers employers a new free-of-charge voluntary program, *HealthCredits*. It rewards members who participate in nutrition, exercise and life-skills management programs with points, which translate into rewards, discounts on health-related items and even enhanced benefits or lower health insurance premiums and copayments. *HealthCredits* can serve as a motivational tool for workers who have the opportunity to see their health insurance and premiums decrease through more active participation in their healthcare.
- **United Healthcare** offers an interactive website for health plan members to: 1) order prescription drugs and over-the-counter medications online, ask a pharmacist questions about medications, and identify adverse drug interactions; 2) access clinical and other information about specified health conditions; and 3) set up a "my health" account, which

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<sup>11</sup>Ibid.; J. Sidorov et al, "Does Diabetes Disease Management Save Money and Improve Outcome?" *Diabetes Care* 25 (2002):684-689.

<sup>12</sup>Ibid.

tracks medical and medication history and provides tools to promote wellness, prevention, and prescription drug compliance.

### ***Quality Recognition and Incentives to Reward Quality***

AHIP member companies have been leaders in the movement of realigning payments to providers with the delivery of safe and effective, high-quality care: an approach known as pay-for-performance. Through a variety of programs, health insurance plans are identifying and rewarding high performing physicians, medical groups and hospitals, and giving consumers incentives to these providers.

- **CIGNA HealthCare** recognizes participating physicians and hospitals who have met certain quality criteria in its online *Provider Excellence Recognition Directory*. Physicians are recognized for being certified by the National Committee for Quality Assurance (NCQA) for providing high quality diabetes or heart/stroke care. Hospitals are highlighted for meeting the Leapfrog Group's three patient safety standards (e.g., Computer Physician Order Entry systems, Intensive Care Unit Physician Staffing, and Evidence-based Hospital Referrals). Such recognition provides consumers with valuable information about providers and allows them to make informed choices of physicians and hospitals.
- **Anthem Blue Cross and Blue Shield** is one of the first health benefits companies to collaborate with hospitals on an extensive hospital quality program that includes increased reimbursement based in part on quality measures. The program has been successful in improving the quality of care and outcomes at participating hospitals for all patients, not just Anthem members.

Anthem's Hospital Quality Program began in Ohio in 1992 with the quality reimbursement component added in 2002. The program evaluates quality of care provided in its network hospitals based on quality indicators (such as care provided for coronary services, obstetrics, breast cancer, asthma, joint replacement surgery, emergency departments, patient safety and accreditation status). Since its inception, this program has made statistically significant improvements in the care delivered to Anthem members in areas such as neonatal mortality rates, the use of beta blockers after heart attacks, and patient safety. Hospitals convene and share best practices. This Midwest program has been extended across all Anthem regions. These programs incorporate a payment system to recognize and reward physicians and hospitals for improved health care quality, patient safety and clinical results, such as reduced infections or medical errors. The programs measure a broad set of metrics that are based on best practices and developed in collaboration with participating hospitals and specialty medical societies.

- **Empire Blue Cross Blue Shield** is working with several of its large employer customers – IBM, PepsiCo, Xerox, and Verizon – to provide bonuses to hospitals that implement two of the Leapfrog Group standards: Computer Physician Order Entry (CPOE) and Intensive Care Unit (ICU) staffing. As of December 31, 2002, 53 hospitals in the plan's service area had completed the voluntary Leapfrog Group hospital survey and self-certified the status of CPOE and ICU staffing at their facilities. Bonuses were paid under the program to 29 hospitals during 2002.

- **Harvard Pilgrim Health Care** has a Provider Network Quality Incentive Program which includes support for medical directors and clinical practices, a Quality Grant Program and an Honor Roll program that publicly recognizes outstanding physicians. Another component of the Provider Network Incentive Program is a *Rewards for Excellence* program that recognizes and rewards the exemplary performance that local quality efforts achieve. Harvard Pilgrim has identified a subset of key HEDIS performance measures where effective clinical interventions have been identified and/or where current levels of performance – nationally, regionally, and within Harvard Pilgrim – are less than clinically optimal. Harvard Pilgrim offers its providers financial rewards for achieving excellent levels of performance in the defined target areas. In 2003, Harvard Pilgrim rewarded 55 out of 66 eligible practices.
- In California, the **Integrated Healthcare Association**, including health plans and insurers, physician groups, and health care systems, is implementing a state-wide *Pay for Performance* initiative. Participating health insurance plans include Aetna, Blue Cross of California, Blue Shield of California, CIGNA HealthCare of California, Inc., Health Net, and PacifiCare Health Systems. A common set of performance measures will evaluate physician groups in six clinical areas, patient satisfaction, and information technology investment (e.g., electronic medical records or computerized physician order entry of medications) and financial incentives will subsequently be awarded based on the physician groups' performance. A public scorecard will be available in September 2004 and initial payouts are expected in June 2005.

## V. Recognizing the Special Needs of Small Employers

No discussion of employers' needs is complete without considering the special needs of small employers. Small businesses with fewer than 50 workers – three-fourths of all U.S. private establishments, employing nearly one-third of the private sector workforce – are much less likely than large firms to provide health coverage for their workers. Almost all larger employers offer health insurance coverage – more than 95% in 2003. But only 80% of employers with fewer than 50 workers offer coverage. And among the smallest of small employers, those with fewer than 10 workers, only 55% offer health insurance coverage.

Affordability is the most important reason for small employers not to offer coverage. For small employers that did offer coverage in 2003, the average amount spent on single premiums was approximately \$3,000 a year; on family premiums, approximately \$8,500 a year.

- In 2002, nearly 80 percent of employers not offering health benefits reported that a major or minor reason for not offering them was that their business could not afford to offer such benefits, up from 69 percent in 2000.
- In addition, 68 percent reported that revenue is too uncertain to commit to offering a health benefits plan, up from 56 percent in 2000.
- Complementing the problem of affordability is the relatively low wage structure of small businesses. For example, average hourly earnings for businesses with fewer than 100

workers are only 62% of the average hourly earnings for businesses with 2,500 workers or more.

In response, health insurance plans have developed products that are specifically tailored to the needs of small business. For example, Blue Cross of California (Wellpoint) sells FlexScape, a product for firms with two to 50 workers that offers an array of PPO and HMO options. Depending on price, benefits vary from basic catastrophic to comprehensive packages with a range of deductibles and coinsurance levels. First available in April 2001, FlexScape now has more than 800,000 enrollees.

When the state of Florida passed a law loosening restrictions on what insurers can charge for co-pays, deductibles and other out-of-pocket expenses, Blue Cross Blue Shield of Florida made four types of plans available to employers with 50 workers or less. These BlueCare plans have higher costs for consumers when they seek service, but the premiums are about 10% to 20% less than the lowest cost plan available.

The opportunity for consumer choice products and HSAs is especially promising in the small group market. Though only 3% of firms with 1,000 or fewer workers offered a consumer choice health plan in 2002, the number is sure to rise as health insurance plans introduce new products. When HSAs became effective on January 1, 2004, companies that had previously offered Medical Savings Accounts – among them Blue Cross Blue Shield of Minnesota and Assurant Health (previously known as Fortis Health), and UnitedHealth (through its Golden Rule division) – immediately began offering HSAs to small groups. Other companies, such as American Medical Security Group and HealthPartners, immediately began designing HSA-compatible products for availability later in the year.

However, health insurance plans can not, on their own, solve the problem of affordability for small employers. Therefore, as Congress crafts legislation aimed at improving access to health care coverage for small employers and their workers, we urge you to consider the policy proposals recently issued by AHIP's Board of Directors. These proposals would directly address the problem of affordability through a program of individual and employer tax credits.

### ***Tax Credits for Individuals***

Roughly 15 million uninsured individuals and families—about 34% of the uninsured overall—with incomes ranging from 150% to 300% of poverty lack health care coverage and are not eligible for public programs. About 50% of these individuals work for small businesses that employ fewer than 100 workers.

To improve affordability, AHIP believes the federal government should provide an advanceable, refundable tax credit that allows for variations in such factors as family size and age. Federal funding for this tax credit could be established through annual allotments, just as funding is currently set for SCHIP.

For eligible individuals with access to employer-subsidized coverage, the credit could be used to subsidize the cost of the employee contribution. Not only would this initiative make coverage more affordable for workers, it would also increase the number of small employers offering coverage. Employers would see tax credits as a way to reduce the price of insurance for

workers, which would induce some employers, especially small employers with high concentrations of low-wage workers who are eligible for the credit, to start to offer coverage.

### ***Tax Credits for Employers***

To enhance the effectiveness of individual tax credits, the federal government should also aim targeted tax relief at small employers with total gross receipts below a certain level (e.g., \$100,000). Such employers who buy coverage for their workers should receive a tax credit to offset a part of the employer's premium contribution for workers earning between 150% and 300% of poverty. Credits would be determined on a sliding scale based on the number of workers: the very smallest businesses, those with fewer than 10 workers, would receive the largest credit because those businesses have the lowest offer rate. Federal funding for this tax credit could be established through annual allotments, just as funding is currently set for SCHIP.

## **VI. Regulatory Challenges to Meeting Employers' Needs**

On a variety of fronts, health insurance plans are working hard to give employers a range of new health care choices. Unfortunately, many states have over the years created a regulatory environment that slows health insurance plans' efforts. It is an environment that fails to serve consumers and employers by simply layering regulatory requirement over regulatory requirement. The result:

- Lack of uniformity of laws, regulations and interpretations from state to state.
- Dual—and frequently inconsistent—regulation by state and federal regulators.
- Absence of regulatory coordination from state to state.

We would like to provide the committee with some examples of how the lack of uniformity in the insurance regulatory system is affecting the development of Health Savings Account (HSA) products.

### ***First-Dollar Benefit Mandates***

Under the statutory language authorizing HSAs, the low premium health plans that accompany HSAs cannot provide first-dollar coverage, *except* for preventive care. Recent guidance from the Treasury Department defines preventive care as including:

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals.
- Routine prenatal and well-child care.
- Child and adult immunizations.
- Tobacco cessation programs.

- Obesity weight-loss programs.
- Screening services.

However, some states have first-dollar coverage mandates for benefits that may not fit the definition of preventive services. For example, New Jersey requires that hospital service corporations, health service corporations and group health insurers cover screening by blood lead measurement for children and *any necessary medical follow-up and treatment* for lead poisoned children, without application of a deductible. Pennsylvania requires that all health policies cover medical foods for the treatment of certain nutritional and metabolic diseases that require careful dietary supervision (e.g. phenylketonuria) without application of a deductible. And in North Dakota, group health plans must cover the first five hours of mental health services without application of a deductible.

### ***Speed-to-Market Approval Times***

Every state requires that health insurance plans make form or rate filings before selling a new product in the individual or small group markets. The faster states approve those filings, the faster the speed-to-market of new products for consumers and employers.

Some health insurance plans were immediately ready on January 1, 2004 to sell low premium health plans to accompany HSAs because those companies already had received state approval to sell low premium health plan policies. Other health insurance plans, however, had to file new policy forms in various states. AHIP has conducted a survey to ascertain how quickly states are approving new forms.

As of May 13, 2004, health insurance plans responding to the survey reported filing 136 policy forms for individual and group low premium health plans in 31 states. In 15 of those 31 states, two or more health insurance plans filed forms.

- Eighty-three forms have been approved, generally within 40 days or less.
- However, 53 forms remain pending, some for more than 100 days.

In the 15 states where two or more health insurance plans filed forms: two states approved all forms in 20 days or less (SC, VA); six states approved all forms in 40 days or less (AL, AZ, IL, NE, OH, OK); and the remaining seven states approved some forms, but left other forms pending.

Illinois and Indiana offer a good example of the lack of uniformity in the state approval process for low premium health plans. As of May 6, four companies have filed policy forms to sell low premium health plans to small groups in Illinois: one was approved in six days, the others were all approved in 36 days or less. The same four companies filed policy forms for low premium health plans in Indiana: one was approved in 75 days, and the other three are still pending, the longest for 80 days.

**Status of Company Filings for Low Premium Health Plans  
in Illinois and Indiana as of May 6, 2004**

<b>Company</b>	<b>Illinois</b>	<b>Indiana</b>
A	Approved in 6 days	Approved in 75 days
B	Approved in 36 days	Pending for 32 days
C	Approved in 14 days	Pending for 80 days
D	Approved in 30 days	Pending for 70 days

As these examples show, under the insurance regulatory system as it exists today, it is virtually impossible to craft a compliance system that works across state lines. It is extremely difficult for health insurance plans to standardize and streamline their operational systems if those systems need to be re-calibrated for each state in which they do business. Health insurance plans have no choice but to pass on these costs to consumers and employers.

**VII. Conclusion**

America’s Health Insurance Plans and its member companies are committed to developing consumer choice products, such as Health Savings Accounts, that give employers and their workers new and innovative health benefit options. However, it is important that policymakers take into consideration the compliance obligations imposed on health plans and insurers by federal and state laws. We have identified several areas where Congress and the federal government can take action to expand HSA opportunities for employers and consumers.

- *Coordination of HSAs with FSAs and HRAs*—The Treasury Department has released guidance limiting the coordination of HSAs with employer-sponsored flexible spending arrangements (FSAs) and Health Reimbursement Arrangements (HRAs). Legislation should give individuals the ability to choose between using their FSA, HRA or HSA to pay for qualified medical expenses.
- *Allowing Roll-Over of FSA Funds*—We strongly support legislation to allow the roll-over of up to \$500 in unused FSA funds each year – or the transfer of that money into the individual’s HSA – to deal with the problems of the current “use it or lose it” rule for such arrangements.
- *Using HSAs to Pay Health Premiums for Early Retirees*—“Early retirees” are penalized because they cannot use their HSAs to pay for health insurance coverage, including employer-provided retiree coverage. Legislation should allow HSA funds to pay the cost of health insurance coverage for individuals who retire before age 65.
- *Using HSAs to Pay for Medicare Supplement Coverage*—Individuals age 65 and older may use HSA funds to pay the cost of Medicare-related coverage – except for Medicare

Supplement premiums. Legislation should allow the use of funds from the account to pay for Medicare Supplement premiums.

- *Allowing Funding of HSAs after Age 65*—Individuals who are Medicare-eligible may no longer fund an HSA, although they can use the money in the account for qualified medical expenses. Legislation could allow individuals to put money into an HSA after age 65.

Finally, we are most appreciative of the commitment that Chairman Oxley and Chairman Baker of the House Committee on Financial Services have shown to advancing a reliable, uniform system of regulation for insurers, and we have been talking with them about our members' priorities. As the experience with HSAs indicates, one of the top issues meriting regulatory consideration is speed-to-market.

These strategies will help America's health insurance plans transform coverage and care options tomorrow in ways that will streamline and strengthen the employer-based system, rather than merely burdening it with added complexity and costs.

Thank you Chairman Johnson, and other members of the subcommittee, for the opportunity to appear before you today.