The Nuts and Bolts of Health Insurance for the Aspiring Health Reformer
Alliance for Health Reform, Blue Cross and Blue Shield Association and American Cancer Society Cancer Action Network
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ED HOWARD: Welcome. My name is Ed Howard. I'm with the Alliance for Health Reform. On behalf of Senator Jay Rockefeller, Senator Susan Collins, our board of directors, welcome to this briefing on the workings of the private insurance market in the United States. We're pleased to have two partners in presenting today's briefing, the Blue Cross Blue Shield Association and the American Cancer Society's Cancer Action Network, ACSCAN.

Most of you probably know Blue Cross Blue Shield is the pre-eminent health insurance plan group in the country taken together the independent plans represented by their association; provide coverage for more than 100 million of us. The Cancer Action Network is the advocacy arm of the American Cancer Society, does a range of policy work nationally and of course, ACS has 3,000 local offices.

We're happy to have both the Action Network and Blue Cross Blue Shield as partners in today's program, which I should note is a little different from our usual briefing. Normally we will assemble a group of leading experts on a particular topic then have them lay out their positions on an important policy issue from different standpoints and that issue, as it receives attention nationally, is discussed from those different viewpoints.

But, today our goal is not to discuss what should be the policy with respect to private insurance; it's to help us understand better what is happening in private insurance. That's why we call it a primer. That's not to say that our panelists are not leading experts, believe me they are. They certainly hold different views on some important policy questions that surround private insurance, but our main purpose today is to get everybody up to speed on how insurance operates today, what its strengths and weaknesses are, and then you can be a more informed observer and participant in the policy discussions that we anticipate in the months ahead.

Before we get to our panelists, let me just make a couple of logistical notes. By Monday morning, you're going to be able to view the web cast of this session on kaisernetwork.org and then a few days after that, there will be a transcript available both there and on our web site at allhealth.org. We'll send you an email to let you know that the transcript's available. You can even get a pod cast if that's your mode of communication.

At the appropriate time, we'd appreciate you filling out a question card if you want to have a question addressed to one of the panelists or the panel in general. There are also microphones, three of them scattered around the room, you can come to ask the question in person and of course, we would love

it for you to fill out that blue evaluation sheet so that we can make these briefings as good as we can, even better than we have them now, so that you can get what you need out of them.

So if you would turn your cell phone to vibrate, turn your pager off, we're going to get started. I apologize in advance. I'm going to have to be ducking out of here before we finish this program. That's why I am sharing moderating duties with our policy associate at the alliance, Deanna Okrent who'll probably be nicer to both panelists and audience than I would be. So I'm sure you will treat her as well as she will treat you. Deanna, I wonder if I could turn to you to introduce our panel.

DEANNA OKRENT: Thank you Ed. Thank you Ed and we have four distinguished panelists with us today and we certainly appreciate their being here. I'm going to give them to you one at a time and say a few words about each as it's their turn to speak but you can find out more about them, their credentials and their careers in the packets on a page that we have for their bios.

Karen Pollitz is going to be leading off today. She's here on my right. She's a Research Professor at Georgetown Health Policy Institute and she's done some of the most powerful analysis of impact of insurance markets on Americans with illness or other health-related conditions. She's served

in senior positions at HHS and on staff of several members of Congress including the Alliance's Honorary Chairman, Senator Rockefeller. So I give you Karen Pollitz and she's going to provide an overview of health insurance in the U.S. today.

KAREN POLLITZ: Thank you Deanna and Ed and good afternoon everyone. It's a pleasure to be here. Thanks to Blue Cross and the American Cancer Society for sponsoring this. Okay, nuts and bolts of health insurance, let's start with some basics. This is very basic but very important so please everybody write this down. We buy health insurance not in case we stay healthy but in case we get sick. That seems obvious but that's a very important nut and bolt for this discussion today.

For insurance to take of us when we are sick it has to pass three tests and it has to get A's on each of them. Your health insurance has to be available to you. That means you need to be eligible to sign up for it. The premium for that coverage must be affordable relative to your income. The coverage that is provided under your policy must be adequate. That's measured by how much you are left to pay out of pocket for your care after your insurance is done paying and it has to be all of those things al of the time.

We get health insurance today, most of our coverage before the age of 65 is private coverage. Mostly we get this at work. This is probably not a surprise to anyone in this room.

Over 60-percent of us get private coverage at work. About five-percent buy it on our own but this is a snapshot. So people move around and don't be fooled by snapshots. Another nut and bolt of health insurance is you need to keep an eye on the system while it's moving.

About two million people lose their employer-sponsored coverage every month. Sometimes they're switched to other employer coverage. Sometimes they become uninsured. While only five=percent of people in any given year have individual health insurance, over a three-year period, one in four will seek coverage in this market and though we have about 18-percent of the non-elderly population who is uninsured, over a four-year period, it's more than a third of us who will experience a spell without coverage for at least a month. So our system moves all the time.

Another important concept of health insurance, the job of health insurance is risk-spreading. The reason we finance health care using insurance is because the distribution of health care spending is very uneven. On average, per capita spending on medical care in the U.S. is about $7,000 a year but almost nobody spends $7,000 in a year. Instead, most of us are healthy most of the time.

The healthiest half of us, if you lined everybody up like this graph does in order of how healthy you are, the

healthiest half of us only account for three-percent of medical spending in a year and that's only about a couple of hundred bucks per person in that category but as you move toward the left, the sickest 20-percent of people account for 80-percent of health care spending and the sickest one-percent of the population, if you go all the way to my left, accounts for almost a quarter of health care spending. So if you get that sick your medical bills may exceed $100,000 in a year.

So we use health insurance to spread that risk out, nobody could afford to pay as you go on health care. So everybody pays an average. The average is the premium and since most of us are healthy most of the time, we will pay more in premiums than we use in health care most of the time but when we get set, the money in the premium pool will be available to take care of us. That's what we need health insurance to do but it's very hard for this to happen. In fact, it's incredibly hard.

We have a voluntary system of coverage in the United States and that means people don't have to have health insurance and insurers are worried with reason that people may wait. People may not want to buy insurance when they're feeling healthy but want to purchase it when they start to get sick. We call that adverse selection and insurers worry about that very much.

Also we have a competitive insurance market and in market competition in health insurance, consumers need to worry that insurance companies will try to avoid you when you are sick.

So it will be more advantageous for insurers to not sell you coverage when you're sick or to try to drop you or not pay your claims depending on sort of what is allowed. Sometimes we refer to this as cherry picking and lemon dropping but there's definitely an advantage in a competitive market for insurers to try to avoid people who are sick or to try to avoid paying their claims. So it's very tricky. This is a very tricky thing to do in our current health care system.

Alright so let me walk through my four A's and just sort of talk about why it is that we have difficulty today finding coverage that is available, affordable, and adequate all of the time. With respect to job-based coverage, availability is primarily a problem of the fact that employer-sponsored insurance is voluntary and not all employers offer coverage.

So if you work in a job that doesn't offer health benefits, chances are you won't have job-based coverage available to you and that is, in fact, the case. Most uninsured Americans work full-time and they work for companies that don't offer them benefits.

When employers do offer benefits, however, federal law, HIPPA requires that eligibility cannot be based on your health status. So it’s never allowed for an employer to offer health insurance only to the healthy employees. That’s not the case in the individual insurance market. In most states, the individual health insurance market is medically underwritten and that means your eligibility for coverage depends, first and foremost, on how healthy you are and if you are sick or if you’d been sick, you may be turned down. That can be fixed by regulation or by other kinds of policy solutions.

A lot of states have high-risk pools, which is another place where people can have coverage available to them if they’re uninsurable in the individual market. Also some states have rules that are called guaranteed issue that require insurance companies to sell you individual policies no matter what your health status.

Availability is also important over time in not just can you buy the coverage but can you keep it. In job-based plans, people tend to lose coverage when they change jobs or when their family status changes, they get divorced from the worker, but again employers can’t take your coverage away because you get sick and you start to make claims.

In the individual market, again this isn’t always the case. Once you buy a policy and then you get sick, you may get

stuck in that policy. You have no place else to go because all the other policies in the market will turn you down. There have also been some problems with rescissions that you've probably read about in the paper where sometimes insurers will take back a policy once you make claims, if you make them in the early years.

Lots of times, this is done because they are worried that there was adverse selection and somebody bought the policy when they weren't supposed to or didn't disclose that they were sick but there also have been abusive practices where insurers have actually paid bonuses to staff to see how many policies can they take back.

Affordability, this is another challenge. Health care is expensive. There's no question about it. The price of health insurance, however, the premium doesn't always reflect the cost of health care really can be all over the map. The closest thing we probably have to a true price of health insurance is found in the large group market or in your health plans in the FEHBP.

If you look at what the FEHBP standard plan costs, the Blue Cross plan that most people buy, it's about $4,000 a year for a person, about $12,000 for a family. That's a comprehensive set of benefits and it's a broad risk pool with a few sick people and a lot of healthy people. That looks kind of

like what the average is and that tends to be a pretty stable number over time. You see that a lot although there's a lot of variation around that premium in the group market.

So when insurers set the price of policy, that reflects what's covered and who's covered. In the individual market, the array of premiums that are available is unbelievable. If you tried to plot it on a graph, it would look like a snowstorm. They're just all over the place. So I found a policy just the other day I was looking at that's for sale in Cleveland. It's $40 a month but only if you're 25, only if you're in perfect health, and it doesn't cover very much, $10,000 deductible, no mental health, no maternity care, no prescription drugs, just kind of unbelievable.

At the other end of the spectrum if you're older, my age, and trying to buy coverage and you're not in perfect health, I mean I've talked to insurers and actually done studies where quotes are over $2,000 also for a policy that doesn't cover very much. So it changes.

This also can be fixed. It can be regulated. We have something called community rating that just says to insurers you have to charge the average. When you do that, the variation goes away. So you don't get policies anymore that cost $40 a month but you also don't get policies that cost $2,500 a month

or at least you shouldn't if you're regulating in a very comprehensive way.

If you look in the state of Massachusetts, which has adopted guarantee issue and also community rating, the average cost of an individual policy in that market is running, there are a range of policies anywhere from three to $500 a month. That's a lot of money relative to what people can afford. So that state also addresses affordability through subsidies.

If you are below poverty, your premium is zero per month in Massachusetts. If you're up to 200-perent of poverty, you won't pay more than about $100 a month. So we can address affordability first by stabilizing rates and then secondly by subsidizing them.

The affordability of coverage also changes over time. So again, beware of the entry rate, the teaser rates, what have the sub prime mortgage crisis, what has that taught us? You need to look at what happens to rates over time and without regulation, rates can grow very dramatically.

In the individual market, the Consumer Reports wrote a story this year about somebody who bought a policy way back in 1980 at $25 a month and today, his premium is $4,300 a month. So you need to follow what happens at renewal.

In the group market, insurers can change in the absence of regulation. They can change premiums dramatically at renewal

based on the experience of the group. That's not allowed in the individual market in most states but it doesn't need to be allowed because again, people get stuck. They get stranded in policies and if they can't move then that policy just becomes a policy of sick people. You can see how dramatically the rates can change over time.

Adequacy is another important thing. There's no point in buying cheap health insurance if it doesn't cover anything because then if you get sick, you're going to end up selling your house to pay the medical bills anyway.

So the underinsured medical bankruptcies, these are problems primarily of the insured. So we need to keep an eye on whether the coverage that health insurance provides is adequate. Coverage is generally comprehensive in the group market although this certainly can vary. In the individual market, there are many threats to adequacy; again policies with very, very high cost sharing that don't cover important benefits like maternity care and mental health care, chemotherapy, and so forth.

People will also change the adequacy of plans. People and employers will change the adequacy of plans over time to try to moderate those premium increases over time but again. This turns out to be a kind of false tradeoff because if you

get sick, anything that you saved in the premiums, you are going to spend on out-of-pocket medical bills.

Alright, I've worked in this field for almost 25 years and that makes me a newbie because health reform has actually been on the agenda in the United States for almost a century. It was Theodore Roosevelt who was the first President, presidential candidate who ran on a platform of comprehensive coverage and he lost. So we have been not reforming the health care system for a very long time.

In the 25 years that I've been doing this, I've observed that health reform debates often will turn on big, important, political, philosophical issues like what should be the role of government and should we have single payer or should we have a choice of plans? Do we believe in markets or d we believe in regulation?

These are all absolutely very important questions that need to be addressed and debated but often I find while we are debating those lofty questions, we lose track of the nuts and bolts and that is how do we get health insurance to do what we want it to do, which is to finance our health care when we are sick.

So I would encourage you, as you are preparing for health reform, as you are analyzing health reform proposals, maybe drafting your own for your boss, to keep your eye on the

four As and use these to evaluate any reform proposal. If you want single payer that is available, affordable, adequate, fine, you can do that. If you want a private market that competes to offer available, affordable, adequate coverage all the time, you can do that too. The state of Massachusetts has shown us that you can do that too. It doesn't really matter. Just keep your eye on the four As. Thank you very much.

DEANNA OKRENT: And thank you [applause]. Thank you Karen. We're going to now hear from Patrick Ryan. It's okay to call him Pat he said. He is a Senior Actuary with Wellmark Blue Cross Blue Shield Plans serving Iowa and South Dakota. So Pat has come a long way to be with us here today. His responsibilities there at Wellmark include making prices and other actuarial recommendations for the small group and individual markets. He has a decade's worth of actuarial experience in the heath insurance field and I give you Pat Ryan.

PAT RYAN: Thanks and I must admit I'm excited to be here. I spend a good portion of my time behind a computer analyzing data and crunching numbers in an effort to convert that to information that we can use to understand what's happening in the past and also predict what we think will happen in the future. So it's always nice to get out and share my findings with others who are equally interested in

understanding a little bit more about the market in place today.

So I guess to start off here, I want to start with our market. This is consistent with the slide that Karen had. Basically, in one word to describe our market, it's disproportionate and disproportionate in the sense that a very small number of people generate a very large number in amount of costs. What that creates is kind of a dynamic that I kind of made up myself. I don't know if you're going to find it in any textbook but it's kind of a volatility of averages I guess the best way to describe that is just considering a population of disproportionate, two disproportionate members, one person has zero claims. The other person has $100 in claims.

The average claims for that population is 50 and if you have a proportion of population, you'd have a person maybe with $49 of claims and a person with $51 of claims. Their average is also $50. So both populations have the same amount of average claims but the impact of those populations and the impact of the average claims of those populations is significantly different when you lose somebody or when you add somebody.

If you lose the lowest cost member then the disproportionate population, the average cost increases significantly from $50 to $100 in that case where if you look at a more proportionate population, it only goes from the $50

to the $51, which is a much more small, much more controlled. So there's a higher volatility when you look at the averages, when you're working with the disproportionate population in a market that we're dealing with with health insurance today.

So just to look at some of the buying, some of the characteristics of our sicker individuals and this is probably not surprising to most of you but sicker individuals or high-risk individuals tend to be sicker. They also tend to be older unfortunately. It happens to all of us and they basically have chronic conditions that need to see certain specialists and need to have certain benefits in place.

So that's what's important to them in their purchasing decision. It's less about the premium they're paying. They know they're going to get that back in some way or another but it's more about the access to providers and what not that they have.

On the flipside, your healthier population tends to also be younger and they also tend to think they're invincible. They have less sensitivity to managed care tactics. They don't ever think they're going to be sick. So access isn't as important to them as really the cost of what they're buying is. Mainly they basically don't want to pay for something that they're not going to use. Getting back to the earlier slide, there are a lot of healthy individuals and a significant

amount; basically 20 to 25-percent of people don't turn in a claim all year.

A lot of these people are paying some fairly high premiums in exchange for being healthy and that's their reward for it. So that's kind of the mindset of those people. They're just looking for the lowest price product that they can find. That's what we, as insurers, try to do in order to accommodate that.

Basically this next thing leads to adverse selection. That was brought up also by Karen and really in simplest form, you start with that disproportionate population and you can do a couple of things. You either add to a share of high-risk individuals, which tips the scale and causes that average cost of the entire market to go higher by a significant amount. That usually drives another decision making process by those people who aren't turning in any claims to opt out of the market and when that happens, the average cost then tilts a little bit more and causes a further cycle of costs spiraling higher and higher. That's something that's not good. We're going to see an actual real world example of that here coming up.

Another, to a smaller degree, something that can cause adverse selection is just allowing people to pick and choose certain benefits for their situations that make the most sense to them. That also causes cost increase as well.

A couple of strategies that insurers do, it is basically to try to attract the lowest cost individuals to keep the lowest cost, the price of insurance as low for everyone as possible and that's obviously attracting the healthy individuals by trying to get them something as price appropriate as possible while also using the excess funding that you'll still generate from them to spread over towards funding for the higher cost individuals.

So it's just a matter of finding that sweet spot of charging the appropriate premium that can still attract the young individuals, the healthy individuals to pay for the excess claims that are needed for the higher cost individuals.

Also in some markets that have high-risk pools, underwriting is also used in order to also attract the healthier individuals and give an option for the less healthy individuals to opt into the high-risk pools, which are then funded by a broader-based mechanism and allow the individual market, the rest of the individual market, to remain unharmed.

There we go. I want to get to the real world example here. This is our data. This is our individual market data. We're looking at individuals with single policies that are 19 and older. We're allowed to charge a different rate based on your age. So as you can see, our younger ages pay a lower rate

and that attracts them into the market and our higher aged people pay a higher rate.

Basically the next column over, the $267 reflects kind of an average rate, if we had to charge everybody the same rate regardless of age, gender, or what not, we would charge everybody $267 for the same and that's assuming everybody here is still there tomorrow.

So that's basically going to cause some processes for the younger people to look at and compare what they're currently paying and what they're going to be paying the healthier individuals are going to be making choices and several of them will be making choices to go find coverage elsewhere or basically opt out of the insurance market altogether.

Basically when that happens and we lose more healthy people, the $267 average rate goes to $301 and that's for the volatility of averages comes into play again. You're losing your proportion of healthy members. The average swings significantly and so it creates a volatile environment where the average premium increase is significant.

At that point, there's a second round of decision-making process, which could attract others to opt out of the market. At that point, the rate could go up even higher to a level of $354 and then by the time you compare that to what

we're currently looking at, that's higher than what the current highest aged people are paying today at $354. So it really kind of can work against you when you lose that portion of healthy business that's currently funding claims for the less healthy people.

Basically we've seen this to a certain extent in some states that have opted for a guarantee issue and a community rate environment where they have lost people and they have seen increases in premiums and they have had carriers opt out of the market as a result of that. That last situation is bad. It's bad for the members that are paying higher premiums.

It's also bad for the insurance companies because they can't accurately price for that. They're going to lose money at the point that they charge the premium that's average for everyone and the healthier individuals opt out finding there's not enough money to pay the claims and if they prospectively expect that to happen, then more people will only opt out and basically, there will still not be enough money there to fund the claims for the higher cost individuals. At that point, at some point, they'll just have to opt out of the market because they'll never be able to accurately price that in that environment.

Getting on, I know I just have a couple of minutes here but touching on pooling, pooling's kind of a word that's used

basically it’s something that’s done in all markets. It’s done in the individual market, in the small group market, and the large group market. I think most people think of it done more in the small group market than anywhere.

Basically it’s just the process that we described earlier where we’re taking premiums, excess premiums, from lower cost groups, healthier groups, and using that money to fund higher cost groups in states, a lot of times, there are set parameters on how much they’re required to pool and that’s a good thing.

It basically creates kind of an even playing field for carriers to treat groups in the same manner and also protects the groups and individuals themselves so that carriers cannot overly rate a higher cost group and basically price them out of the market. It forces kind of that floor amount that needs to be charged to the lower cost group.

Now it also protects the group in a year-to-year basis where a carrier’s not allowed to charge an excess amount of increase for someone who had a bad year. They limit the amount of rate increases that can be applied in any given year to someone who had a bad claims experience or is expected to have bad claims experience.

I think, just to touch on briefly some, I think there’s some concepts of adding to pooling and creating purchasing

pools that could possibly lower the cost of health care and the reality is, I think, what people need to pay attention to more is it's not necessarily the size of the pool but the type of the pool that you're creating. Getting a larger pool isn't going to help you if you're not attracting the right risk to keep the overall costs down.

At this point in time, that's really the driver of costs and that's what we need to be addressing is attracting the right costs, the right people to the purchasing pools. I know I just have a few minutes left here. So I'll just get to, purchasing pools.

This is our Iowa data, again as well, and this basically, at the very bottom, the tier one through four are average risks or risks that we're allowed to rate our healthiest groups of tier one versus our least healthy in tier four. You can see that they obviously have disproportionate share of premium. If we were to rate them all the same rate again, the $454 would be the amount that we need to charge all groups at that level.

Then that would spur a decision making process for groups, particularly the groups that are healthier that are currently subsidizing the rest of the pool to consider whether or not insurance is appropriate for them and could cause several of them to opt out of the pool and then cause us to go

into our next round and once those healthier groups opt out of the pool then you're left with an average cost that's higher at $476 that will then continue to spiral out into a higher and higher level and we'll see the volatility to that extent.

So really the greatest challenge to health insurance base is just the tracking the balance pool. It's not necessarily keeping the least healthy out. I think there definitely needs to be places to accommodate those individuals but to protect the majority of the people that have the lower cost claims, I think it's important that we keep a mechanism there that is healthy that's in place that's available to them to continue to seek their affordable coverage that they need. That's it.

DEANNA OKRENT: Thank you [applause]. Okay. Thank you very much Pat. I'm sure there are questions out there. We're going to save those for the end but as they come to mind, if you would write them on those green cards, we will give you a chance to pass them forward.

We're going to turn next to Sandy Praeger. She is the Commissioner of the Kansas Insurance Department and the current President of NAIC, the National Association of Insurance Commissioners. She has direct policymaking experience too both as mayor of Lawrence, Kansas and as state legislator in both chambers. I give you Sandy Praeger.

SANDY PRAEGER: Thank you and it really is a pleasure to be here. I thank the Alliance and the Cancer Action Network and Blue Cross Blue Shield Association for the opportunity to talk about something today other than credit swaps and derivatives and CDOs and subprime mortgage-based securities. That's been dominating our insurance world here for the last couple of weeks and now we're back to the old tried and true problem that never seems to go away as Karen pointed out so effectively.

Let me just talk a little bit about the role that state regulators play in protecting consumers and remind everyone because I think it's been lost here recently in this debate about financial services and insurance regulation, insurance is regulated at the state level and has to comply with the laws that are enacted at the states.

Our national association works very diligently and has for many years, since actually 1871 when it was founded, to promote uniformity among those regulations but insurance still is very much a local-based product. It's a very personal product regardless of what type of insurance you're buying but most especially where health insurance is concerned.

State oversight deals in a number of different areas. First of all, any product that is sold in our state must be licensed by the state. So as new products come online, those new products are brought to state regulators where we review

them and determine their appropriateness for our consumers in our market place. We also make sure that fair marketing practices are employed, that people are not given misleading or inappropriate information and that's critically important.

We want the players in the market place to be following the rules and not deceiving people about the products that they're offering that sounds too good to be true product that is $89. You'd seen the facts, everything's covered, access to all providers and you think wow, that sounds too good to be true. Probably is not true. Those are the kinds of marketing abuses that we're there to guard against.

We're also very concerned about insurer insolvencies. We want to make sure when a person buys a policy and pays premium that the policy will be there for them when the time comes to file a claim. The insurance is a contract. It's a promise to pay and we're there to make sure that that promise t pay is upheld.

We also, as I mentioned, want to make sure that the products are described accurately and some of the limited benefit products that are on the market place oftentimes are, if not intentionally misrepresented, certainly if you don't ask all the right questions, you may be misled into buying something you think provides more benefit and more coverage than it actually does. We want to make sure that those

marketing and all of those marketing materials that are used in the market place have to be approved by state regulators.

We want to make sure that premiums are based on sound actuarial principles and that they do comply with our state laws. There are a variety of state laws and I'll mention some of them as I go forward. Then we're there to resolve the inevitable disputes that do arise between consumers and insurers. Oftentimes, the consumer thinks they have more benefit than they actually do. Sometimes the insurer is trying to deny a benefit that they're actually entitled to and state regulators are there to mediate those disputes and make sure that the person is getting all the benefits that they are entitled to.

Karen mentioned rescissions, that's been probably one of the more recent problems that we've seen in the market place and it's post-claims underwriting where they try to, first maybe some company will try to deny access to care because they said you lied on your application when, in fact, you maybe just didn't understand the questions on the application. That's one of our latest attempts through our national association is to work with the industry.

That's been very, very supportive of this effort to come up with standard application forms so consumers don't get misled by terminology that's difficult for them to understand

and maybe misrepresents something on the form just because they didn't understand. So we think perhaps a standard application form would help solve that problem and the industry's been very supportive of those efforts.

In the individual market, some of the state approaches to protecting persons in the individual market vary but I'm going to give you Kansas rules, which are pretty typical. Policies, there is guaranteed renewability. Policies are renewed at the option of the policyholder. However, in many cases, the rates can go up based on that pooling mechanism that Pat described.

For individuals, leaving the group market and going into the individual market, once they've exhausted their COBRA benefits, in some states, many states in fact, have the opportunity if they are a high-risk individual and are faced with a fairly large premium, have the opportunity if they've either been denied coverage or the premium quoted is much higher than the average in the market place, they can go into the state's high-risk pool.

Again, rates have to be approved by our departments. They have to be actuarially sound and they have to be able to demonstrate that these rates are actually need to be able to pay claims. I frequently tell groups we regulate for rate adequacy. We don't regulate to try to keep rates artificially

low because we would put companies out of business and that doesn't help anyone but we are there to make sure that the rates are adequate and not higher than is actually needed to pay the claims. I'm going to skip through some of these points because I want to get on so you all have time for questions.

This map shows the various mechanisms that states do employ in the individual market. The largest group there is the third one down, the high-risk pools, 32 states utilize high-risk pools to help accommodate folks with pre-existing conditions who are having difficulty buying in the individual market. Only three states, the blue states have a guaranteed issue into the individual market. That probably affords the greatest protection but it is politically very difficult to get passed at the state level.

When you have that guaranteed issues into the individual market, it does have an impact dong what it's supposed to do that's spreading the risk over the broadest range of individuals but it does when you first try to implement, cause rates to go up for a significant number of folks while they are dropped for others. It's that kind of political debate that makes it difficult to get guaranteed issue passed. Well I mentioned the high-risk pools. I'm going to skip to the next one.

In the small group market, there are varying state approaches but again I'll just talk about what Kansas has done because it's fairly typical. After the federal HIPAA Law was passed, Health Insurance Portability and Accountability Act and I'm very familiar with that because our Senator, Nancy Kassabaum was chair of the Labor Committee when that passed and some may call it the Kennedy-Kassabaum. In Kansas, we call it Kassabaum-Kennedy [laughter]. She worked really, she was a very, very dedicated Senator who worked very hard to try to solve the problems of insurance affordability.

The requirements in the small group market really have afforded some good protections. There is guaranteed issue. Everyone is offered coverage. There's guaranteed renewability and limits on pre-existing condition exclusions and all of those are good consumer protections.

Again, Kansas like other states, has adopted the NAIC small group premium rate model log, which where claim experience from small employers are pooled together. Pat addressed that and the premium variations that are based on health status are very limited. Let me just quickly go through the guaranteed issue.

All small groups must offer coverage to all small employers regardless of the employee's health status and they must accept all eligible employees. You can't underwrite any

individual in that small group and you can't exclude them from coverage based on age, sex, and health status. These policies are guaranteed renewables. They must allow the small employer to renew coverage including coverage for all of their employees.

There are limits on pre-existing condition waiting periods. They can impose a maximum of a 12-month waiting period for employees with pre-existing health conditions when they first join the small group but then going forward, you can move from health plan to health plan, small employer group to small employer group, and that pre-existing imposition cannot be imposed again.

When we look at the pooling, 27 states use rules that are similar to our 1993 NAIC model and basically it says that in that pool, you cannot rate the healthy group, you cannot charge them a premium that is less than 25-percent of the average in the market place and you can't rate the unhealthy group more than 25-percent of the average in the market place.

I can tell you when I was in the Kansas legislature when we adopted our rating rules in Kansas and it was a real numbers game. We had to demonstrate to our legislature the winners and losers as we impose these rate restrictions but absent the rate restrictions, there are those unhealthy groups do get priced out of the market. The rate restriction and

community rate or rating bans has been one way of trying to stabilize in the small group market.

I know I'm out of time so I think I'll just hopefully, we can address some of the remaining and you have the slides, we can address some of the remaining issues in the question and answer [applause].

DEANNA OKRENT: Thank you Sandy and thank you for being conscious of the time. We do like to afford, give the audience the time for their question and answer period and you will get to cover some of those points later.

We're going to turn now to Steven Finan, our final panelist. He is an Associate Policy Director for the American Cancer Society. Steve's an economist with a history of service in the executive branch and here on the Hill. Specifically he recently finished a stint at the Treasury Department where he was one of few who understood how the Trade Act tax credit could be made to work. So I give you Steven Finan.

STEVE FINAN: Thank you and good afternoon. I am with the American Cancer Society Cancer Action Network, which is the advocacy partner of the American Cancer Society. Traditionally the two organizations have focused on particular concerns of cancer but a few years ago, the organizations realized that if they were to meet their goals reducing the incidence mortality of cancer, they would not be able to do it unless there was a

fundamental change in the health care system and with that, the national board made the decision to actively engage in the broader health care reform debate.

In deciding how to proceed, they looked at how we would go about doing it. To make a long story short, they adopted a set of principles, which not entirely coincidentally, are the four As that Karen put up there, availability, advocacy, affordability, and administrative simplicity.

What I want to do is give you the cancer perspective on the current health insurance system. We operate a national call center in Texas, which provides a variety of cancer services but one of them is what we call HIAS, the Health Insurance Assistance Service, which helps people who have or have had private insurance find new coverage. We started this program in April of 2005 and we are about to log our 20,000th case. So we do have some perspective on this.

I want to walk you through the four A's and how it works for cancer patients. Let me start with adequate health insurance, by that we mean it ensures timely access to the full range of evidence-based health care services including prevention in primary care, necessary to maintain health, avoid disease, overcome acute illness, and live with chronic illness. These services include the complete continuum of evidence-based

cancer care for treatment and support needs including clinical trials.

So let me give you one example of Doreen from New York. Doreen, a 57-year old former medical office receptionist was diagnosed with stage IV breast cancer in fall of 2005. The cancer spread to her spinal column, liver, lungs, and her left femur. Doreen and her husband, a retired New York City police officer, have health insurance through his retirement plan. However, the insurance plan only covered 30 outpatient visits a year, a number Doreen quickly exceeded after beginning treatment for her cancer.

Furthermore, she was unaware of limits and had made additional visits before she went of them. After she reached this annual limit, she was billed $5,000 a week for chemotherapy treatments. In less than a year, Doreen and her husband owed more than $100,000 to the hospital for treatment. Fortunately for Doreen, she had spoken at an American Cancer Society event and her story was written up in the Long Island News Day.

To make a long story short, once this became public, the insurer reversed the decision and paid Doreen’s medical bills in full. While her story turned out well, unfortunately it doesn’t work out so well for many others. Doreen’s story highlights a very serious problem that’s sometimes overlooked

in the current reform debate. Clearly having 46 million people uninsured is a very serious problem but there also is the problem of having adequate insurance coverage.

There are proposals today that would establish bare bones policies, plans with limited doctor and hospital coverage and such plans may help to reduce the number of uninsured but we cannot lose our focus on the issue of adequacy.

A partial treatment regime for a cancer patient is not acceptable. It appears that insurers are creating such arbitrary limits, as Doreen sees, as a way to control costs but unfortunately, the consumer has no way of knowing in advance about such limits. They are often buried in the fine print and virtually no consumer has the ability to read such fine print.

Let me talk about availability. By that we mean it is renewable and continuous. Availability must not be based on or constrained by actual or perceived health status or medical claims history.

Let me tell you the story of Margaret from Georgia. Margaret, age 52, had been working for a small tile and granite supply company until she was laid off in May 2008. Not only did Margaret lose her job but she lost her health insurance. About a year prior, Margaret had been diagnosed and treated for stage III ovarian cancer. Her doctors recommended Margaret have

follow-up visits every three months along with her port flushed every six weeks.

Since Margaret lost her coverage unexpectedly, none of the claims she made after her insurance was terminated in May were covered and she currently owes more than $4,000 in outstanding bills. When Margaret's employer stopped offering health insurance to employees, Margaret became HIPAA eligible but she was not aware of this protection and missed the election window.

The individual market in Georgia is medically unwritten and Margaret has received several denials for coverage. She applied for Medicaid and was denied based on her income. For Margaret, there are no opportunities for health insurance exist and unfortunately, her problem is all too common.

Affordability, by that we mean it provides everyone the ability to purchase meaningful health insurance based on his or her ability to pay. Premiums rising should not be based on an individual's actual or perceived health status or medical claims history.

Annual total out-of-pocket costs including copays and deductibles must be reasonable. Let me tell you the story of Jacqueline from Maryland. Jacqueline, 55, is insured as a dependent of her husband's employer-sponsored insurance. In August of 2005, Jacqueline was diagnosed with stage III breast

cancer. She had a bilateral mastectomy, chemotherapy, and radiation.

In addition to this, Jacqueline developed lymphoedema and had to have some of her lymph nodes removed along with physical therapy and special compression garments.

However, cost sharing for her plan became a major financial burden for Jacqueline and her husband. Jacqueline's medical bills and co-payments have almost completely depleted their lifesavings, an estimated $50,000.

Unfortunately, this is not an uncommon story. Many families like Jacqueline's are left staring at mounting bills hoping to get by without going broke. The physical and emotional strain of fighting cancer can be enormous but if you add that to the emotional toll of a financial hardship, the burden is extraordinary and insurance can and should be designed to prevent it.

Last year along, we had over 900 calls logged from people who stopped treatment in course because they could no longer pay their medical bills. Think about that, 900 people in treatment had to stop because they could no longer pay their medical bills. These were people with insurance.

The fourth A, administrative simplicity, what we mean by that requires transparency and simplicity in private health insurance products both pre and post-enrollment covering

benefits, financial liability, in terms of making claims, should be clear. Consumers must be able to compare and contrast different health insurance plans and easily navigate health insurance transactions and transitions.

Let me tell you the story of Maggie from Indiana. Maggie gave up her individual health insurance coverage after she was unexpectedly charged $4,000 in medical expenses. She had had some tests for a non-cancer condition but she did not require surgery. However, her plan included a caveat where medical tests weren’t covered unless there was surgery within 90 days.

Because of the unexpected expenses, Maggie could no longer afford to maintain her coverage and she dropped it. This confusion left Maggie uninsured when she received her cancer diagnosis two years later. Maggie was treated for bladder cancer. Her doctor advised her that she should receive regular follow-up visits after treatment.

However, this wouldn’t be possible unless she obtained health insurance again. Having already struggled to navigate the complexity of health insurance, Maggie called the American Cancer Society to examine her coverage options.

Maggie went and applied for Medicaid but she was denied. Meanwhile an individual health insurance would meet her needs. Indiana allows for medical writing, a process whereby

she would clearly be denied coverage because of her pre-existing conditions. Considering the recurrence rate of bladder cancer, Maggie was clearly a high-risk applicant. Even if she received coverage, her cancer treatments would have been excluded as a pre-existing condition.

A final option presented to her was Indiana's high-risk pool. The pool covers individuals who are denied health insurance in the individual market. However, Maggie would have faced a three-month pre-existing exclusion condition period. The monthly cost, once she received coverage, would exceed her limited means.

In Indiana, at the time, it would have been $862 per month with a $500 deductible plan. She decided the high-risk pool was unaffordable. There are two very common problems in this story that we see often.

First, there is the problem that Maggie and Doreen experienced where there are limits and hurdles within a plan that they learn about only after they have hit or passed them. The financial consequences can be dramatic and profound.

The second problem is the enormous complexity of rules that exist when a person needs to move around the system, high-risk pools, COBRA, HIPAA-eligibles, underwriting. It is no wonder that so many people inadvertently are unintentionally

lose coverage. The rules work for administrators but they don't work well for patients.

Last but certainly not least is the issue of cherry picking or as the insurance folks say, market segmentation. It is probably the most critical issue you will face in dealing with health care reform and both Pat and Karen have spoken to it but the reality is, as they have said, is the question is how do we spread risk in a competitive, unregulated market, insurers will necessarily try to segment risks because of a few people including cancer patients represents a high proportion of high insurance claims.

As both Karen and Pat pointed out, you've got a mere 20-percent of the population accounting for 80-percent of the costs. In a competitive market, there is no doubt that there is enormous economic pressure on an insurer to find those people and either deny them coverage or charge them substantially higher.

This heavily skewed distribution does create that problem of risk selection but the health and wellbeing of individuals is not truly an individual good. It's important for society that people be healthy and therefore we, as a society, have to decide how to spread the risk so that there can be less healthy among us are cared for.

As we, at the American Cancer Society Cancer Action Network, see every day, more and more people who most need care are being left behind. So as you move forward on health legislation in the coming year, please always keep in the forefront of your thinking, what will a reform proposal do for cancer patients? I don't say that from a selfish perspective. I say that from the perspective that if a system works for a cancer patient, it probably works for anyone with a serious medical condition. With that I will turn it back to you Deanna.

DEANNA OKRENT: thank you Steve and thank you to all our panelists for an excellent presentation of the nuts and bolts of health insurance. Now, it's your turn to and your opportunities to ask the panelists any questions that you might have.

As Ed mentioned earlier, there are three microphones in the room. The best way to get your question answered is to ask it yourself but also if you have written down a question on a green card, just hold it up and someone will come around and collect it from you and bring it up here. I see some being held up and they will be brought forward shortly.

I wonder if I might start out by asking a question actually about something that I didn't hear covered that I have heard come up, at the notion of an employer being self-insured. Some large employers are self-insured and I was wondering if

you could explain what that means for the employer, for the individual who's covered under that type of plan and is it actually insurance in a traditional sense?

KAREN POLLITZ: About half of people who had job-based coverage are covered under employer plans that are self-insured. This is something that very large employers tend to do. The distribution of health expenses that were, both Pat and I had slides on, works out kind of nicely to an average number if you have a large group of people.

So large employers with a thousand or more employees, certainly 10,000 employees, will tend to, and if they have some resources, will be able to predict with some certainty that what the average health care spending of their employees and family members will be in a year. They'll call an actuary like Pat and will say well this is what it's going to be. So they know the law of large numbers means that it'll work out to about the average.

So the employer has a choice. They can go to an insurance company and pay that average in a premium or they can just set that much money aside and say we'll just pay the claims ourselves. When they do that, they usually go out and hire an insurance company to administer the claims so it could be very difficult for people to know if you're in a self-insured plan because you're still walking around with a Blue

Cross or an Aetna card in your pocket but when the bill gets paid, it's actually your employer that's paying the bill or your employer's dollars that are paying the bill. It's not the insurance company's money.

SANDY PRAEGER: And Deanna, let me just, yes, Karen's given a great overview. We call those ARISSA pre-empted companies because the Employee Retirement Income Security Act passed in '73 or four exempts companies that are self-insured from state regulation.

So all of the calls that we get on a regular basis advocating on behalf of consumers sometimes it isn't a full-fledged complaint. It's just they don't understand. They don't know how to navigate through their health insurance claims process. We're there for those consumers if it's a fully insured state regulated plan but we are pre-empted as state regulators from advocating on behalf of patients if they're in a self-insured plan. They oftentimes don't know and Karen is exactly right.

We will sometimes get into that complain resolution process because it's an insurance card that the employee presented to us before we realized that this company is pre-empted from our regulation. That doesn't keep up from still trying to resolve the problem and oftentimes, we're able to because as I said, sometimes it's just a misunderstanding but

from a complaint standpoint, we have no authority to tell that self-insured plan that this is a covered benefit and they really ought to be paying it.

PAT RYAN: And I'd just add that to a couple of the comments there that yes, definitely it's the larger employers that are the ones that tend to have the ability to have that more predictability to self-insure and even those companies tend to even buy reinsurance, which gives them protection for the large catastrophic events so that they can't have that ability to predict what they can as well.

They also tend to subsidize their premiums significantly more, which draw all their employers in and they become more vested in what their employees are doing in terms of making sure that they do get the care that they need and that they are able to get what's needed as well.

I think another thing to point out is because they're exempt from state law and state regulation. A lot of times, they're not required to subsidize some of the high-risk pools that we're talking about earlier. Those high-risk pools tend to be subsidized usually by the insurers and the insurers basically subsidize them with the markets that they have part of the individual and part of the group markets and the rationale for the group markets is these people tend to some from group coverage.

So that's usually why they tend to be subsidized with group markets. However, the largest employers who are self-funded are exempt from that and so they're not a part of that funding process. I think that's kind of an important thing to point out because that is, a lot of times where a lot of these people come from and there's no ability to capture that.

SANDY PRAEGER: Let me just put some numbers to that from a Kansas perspective. I don't think we're that much different. Forty-percent of our market place is ARISSA pre-empted. So these are people who work for large employers who are in self-insured plans. So we don't regulate them. The premiums that they're participating in are, the company, whether it's the company or whether they're using a TPA does not participate in that high-risk pool.

Thirty-percent of our market place, a little over thirty-percent of our market place is buying coverage in the regulated market place. It's those companies, that 30-percent, that are assessed on an annual basis, the cost overages in our high-risk pool. So it does create a bit of an unlevel playing field.

DEANNA OKRENT: Well okay. I'm going to go to this question next being we're talking about state-mandated benefits. Here's a question from a slightly different perspective and perhaps it applies more in the Northeast, in

Mid-Atlantic states, where the small states are close together, but this questioner asks if someone works in Connecticut for example and has employer-based coverage, but lives in Massachusetts, which states mandates supply if they get their care closer to where they live, which would be in Massachusetts rather than in the state in which they work and in which the employer is based.

KAREN POLLITZ: Well typically, the policy is regulated where it's sold. So if the employer in Massachusetts bought the policy, it would be subject to Massachusetts' rules. Is that right Sandy?

SANDY PRAEGER: That's right.

KAREN POLLITZ: Okay.

DEANNA OKRENT: Thank you. Okay. This question is specifically for Pat and I'm going to read it directly from the card. You examined the effect community rating and guaranteed issue has had in New Jersey and Maine, and the impact community rating can have on premiums for individuals. Have you examined how individual coverage mandate would fit into the equation and then goes on to say that is, for example in the Massachusetts Health Reform Plan.

PAT RYAN: Well basically the Massachusetts Health Reform Plan is pretty new and so I think people are going to be learning as this process goes on and I think that the lower

premium amount that's currently there today in place is there as a starting point but I would expect at any community rating cycle that once you start with that average premium and then you'll see what happens from that.

You can significantly go up and maybe if they attract the right risk, it'll stay steady but I think the Maine and New Jersey plans were more picked because they have been in place for a period of time where we have been able to witness the changes in pricing to those plans and where they are today. So I think that was basically where that logic came from.

KAREN POLLITZ: Deanna, actually before I came over here I got an email. The Massachusetts model, reform model, is a really interesting one to look at. I would encourage everybody to study up on it and a new report on the first year of implementation just got posted today, if you go the Commonwealth Connector web site, there's a link to it right on the front page but it is kind of an interesting exercise in seeing if you can make the market be available, affordable, adequate always.

So we have a year of data now but this is a state that, in a year, has covered over 400,000 uninsured people. It's kind of amazing. They have said all policies have to be sold on a guaranteed issue basis. No one gets turned away because they're sick. Everybody has to be in the market, so no fair on the

adverse selection waiting until you're sick. Everybody has to be in.

There is a benefit standard. There are a range of plans that can be offered but all the plans have to cover drugs, maternity care, mental health care. They have to cover the stuff you need when you get sick. It is all community ratings. So everybody pays the same and yes, that means you only get the average. You don't get the ends but there are also very, very generous subsidies, at least for people with incomes up to 300-percent of poverty.

So the community rate for somebody in their 40s runs anywhere from $300 to $500 a month for a comprehensive policy depending on which deductible you take but the premium subsidies then make that more affordable. So they don't try to make policies affordable by having them not cover things or not covering people who need things. They go to the average kind of pooling rate and then they make it available. They have made this work. It's not inexpensive but they've covered over 400,000 people in the first year. You can sort of read about it and see the numbers in this report.

DEANNA OKRENT: Thank you. Moving through the questions and also around the country, this questioner brings up something that came up in California earlier this week and it's the MLR, medical loss ratio, and the questioner wants to know

if the panelists can speak to the downsides or merits of the use of the medical loss ratio both as a way to ensure consumers are getting what they paid for and as a way of comparing plans. Anybody want to explain medical loss ratio?

SANDY PRAEGER: Sounds like an actuarial question to me.

PAT RYAN: Yes, I guess I don't quite understand it other than the requirement to require insurers to most, some states have a minimum medical loss ratio and I think that just makes sure that a certain percentage of your payments are being directed directly towards the providers in paying the claims that they should be. I think that's a good thing. It's a good consumer protection that needs to be in place.

For the states that sell individual policies and this is in place insurers, at least we tend to be much higher than that anyway, just in an effort to be as competitive as possible, insurance carriers are typically, that's one of the first things that they'll typically try to cut is the amount of administration expenses that are in place today anyway. So it's definitely a good consumer protection. It's a good place to start and I think it makes sense.

SANDY PRAEGER: And the medical loss ratio also is what a regulator will look at too to make sure premiums that are being charged are sufficient to pay claims and obviously if they get into a negative situation, we've got a problem. We

need to look at the company and figure out how to get them back on sound financial footing. So it is part of our solvency surveillance regime.

DEANNA OKRENT: Thank you and I see a questioner at the mic. Yes?

FEMALE SPEAKER: Thank you. Well first thanks for your presentations. At the National Women's Loss Center, we recently released a report on the obstacles that women face in particular when trying to buy coverage on the individual insurance market. So I was hoping you could answer questions specifically about that market.

The primary focus of our research had to do with gender rating or the practice of basing premiums based on applicant sex and we knew going into it that 40 states and D.C. allowed for this to happen. We did a systematic review of plans in each state and found that a lot of the rates, there were wide swings in variation between one plan and another.

So in one state for example, we found that a plan might charge a woman 15-percent more than a man for coverage. Then a plan in the same city, it might charge a woman 140-percent more than a man for coverage. These are the same plans and the same health status because these are not completely underwritten, just based on health status, just based on gender and non-smoking and age.

So my question is when we find such huge variations, what's the rhyme or reason behind it and how can it be actuarially sound when we're seeing such huge variations? So I guess maybe if Pat can speak about this and maybe Sandy too because I'm also interested in how a state would regulate this and find out or determine whether these are actuarially sound and what a state would do if they found that they weren't. Thanks.

PAT RYAN: Great. Thanks and that's a good point. We definitely, in both Iowa and South Dakota, we're able to rate by gender and really the type of plan plays a big part and the gender rating and we basically have two sets of factors that we use for our health plans. One set is for plans that offer maternity coverage and the other set is plans that don't offer maternity coverage.

Usually at the point of purchase, there is a selection factor again and there are definitely costs that are incurred for plans that have maternity. So the females that choose those plans are typically females who use maternity and so basically the average cost for a person who has a plan that has maternity for a female is significantly higher in those years between ages 22 and 38 than it is for a female who chooses a plan that doesn't have maternity coverage in those same years.

Basically, they are actuarially sound. We do studies just about every year to make sure that our rates are appropriate for each age and gender and typically, what we see as we see definitely a higher cost for our females in those lower ages but then that slope continues at a lower rate than the males do. In older ages, the females are actually cheaper in terms of premium. So it does catch up with what's appropriate in terms of the usage of medical services at any given point in time and it's an attempt to try to create a fairness amongst the market and assessing the costs at the time that they're needed.

KAREN POLLITZ: I have just one thing. I think this is sort of a good example of how the techno fireworks of insurance can distract us a little bit from the four A's. I have no doubt that actuaries can justify these rates because that and I don't pretend to know all of the stuff that Pat does for a living but essentially that boils down to showing that women who can get pregnant cost more than men who can't at any given age.

That is certainly true, although as a mother of two, I promise you I did not get pregnant by myself either time [laughter] and we all need to be born. So if you go back to thinking about how do we finance health care, it is certainly possible for actuaries to charge women more and to justify charging women more when they might get pregnant but if that

makes it less affordable for women to get coverage then you runt he risk that they won't be able to get the coverage to finance the health care they need when they get pregnant.

So they're sort of actuarially justified, which is the science and the math of it and then there's the question of how do we set policy to finance health care. I just urge you to remember that those are different questions. They don't need to be contradictory. They're just different questions. We should keep them separate.

DEANNA OKRENT: Thank you.

SANDY PRAEGER: Deanna, let me just comment. I frequently talk about the M&Ms of coverage and its maternity and mental health and those are the two areas if an employer has a choice to make, they will not include either of those because of the potential expense but we want health insurance to be there to cover the services that people need. And I think increasingly, we're becoming much more aware of some of the inequities that exist in our system today but those are two areas that frequently, if they can be, will be either excluded or certainly generate higher premiums if they are included.

DEANNA OKRENT: Now I have a few questions here related to information that insurance companies hold and the privacy of that information and particularly with regard to electronic health information.

So first, one questioner asks are there privacy rules governing information insurance companies get through billing and claims, which I know is a pretty standard place for researchers to get some information. So what are the privacy rules around that?

Another questioner asks if not, if there aren't rules currently governing what might be coming down the pike with regard to electronic health information, what measures you think need to be implemented to ensure responsible use of this information and then the questioner adds, and deter lemon-dropping/cherry-picking.

PAT RYAN: Well I can speak from an insurer's perspective on privacy issues and I can't tell you how much money we've spent recently in ensuring that privacy is upheld within our systems and within our electronic systems but it's definitely a lot of money and it's something that I can't even send an email out without getting it screened in some way, looking for somebody's name and looking for some sort of dollar amount or something like that to ensure the privacy of our customers is at the highest level as possible.

So we definitely take it very seriously. Our providers, at least our local providers in Iowa take it seriously and every time I go in to see the doctor, I'm constantly signing another form to ensure that my privacy is protected in that no

one else has access to my information unless I specifically grant it.

We are still currently having difficulty sharing information over the Internet and different ways that our customers would like to be able to see their benefits on the Internet or would really to see different information on the Internet. We don't feel comfortable yet with the level of security in place to grant that type of thing.

In fact, even for the few things that we have, it's a very cumbersome process to ensure that it is that member and that the member is giving us the permission to do certain functions and to show them certain things electronically. I know it's very important to us. We take it very seriously.

SANDY PRAEGER: Our department requires the top 20 insurers in Kansas file claims data with us and we get that data scrubbed of individual identifiers. It's important to be able to have that kind of information so we can see pricing trends and cost trends and do some evaluation from a quality standpoint.

I think researchers, just in general, if you're looking at population health research, you need access to good information but it is critically important that individuals' health records be protected from disclosure during that process.

Let me just give you a real life example. Our community hospital where I live is undergoing a major renovation, $45 million renovation and they're moving to private rooms and talking to folks in the community, have said you know, private rooms, why do people need private rooms?

Well first of all, insurance doesn't pay any different for a private versus a semi-private. So it isn't a cost issue but from a health care delivery system, the providers were concerned that it's pretty darn hard to keep medical information private when you've got a roommate and you're in there trying to counsel the patient. So from a medical privacy standpoint, that was one of the drivers in terms of moving to a private room just to protect the privacy of that individual patient and their families.

KAREN POLLITZ: Deanna, the last part of that second question had to do with whether privacy protects your specific exemption written into the HIPPA privacy rule is for underwriting purposes. So when you are applying for a medically underwritten health insurance policy on every application, you have to sign a form that says I hereby give you access to any and all medical records that were ever created about me anywhere.

All of those can be scrubbed during the underwriting process. They can and will be scrubbed during the re-

underwriting process if there's a post-claims investigation. The only exception for that is the one that the Congress just passed this year for genetic information and in your legislation that you passed, there is a specific end to that exemption for genetic information.

So underwriters are not allowed to ask about genetic tests. They're not allowed to look at your records about genetic tests. They are not supposed to even acquire them. At some point, as this gets implemented in the next few months, I think insurers are going to have to go back when they're looking at these standard application forms and maybe change some of those questions so that they don't sweep in with all of the rest of your medical records, that kind of information, because that is now protected even from the underwriting process and insurers are not even supposed to ask for it.

PAT RYAN: I'd like to point out maybe from a practical standpoint, as an insurer, during the underwriting process, we do use, if the member has been with us and has been in our database, we can and will use that information to help us underwrite and understand the information that was also with the application.

If there's any additional information that needs to be addressed or would like to be captured then we basically would go back to the member and ask them can you get us medical

records or can you answer these additional questions. It's not something that we proactively do. It's something that they disclose to us. So really the only information that we have and that we actually use is the information that we already have from them.

DEANNA OKRENT: Okay. Now going on a little different direction here. The questioner asks how do you feel about added fees on health insurance for those who are higher risk because of personal choices that they make such as smoking? Would this help lower costs for the risk pool as a whole?

SANDY PRAEGER: As it was mentioned earlier, these large companies that are self-insured, are doing some really creative things to address the health of their employees. They do onsite screenings. They bring health screenings right into the workplace to facilitate the health screening process. They certainly incent employees to quit smoking by providing smoking cessation. They will do body mass indexes and encourage people to get on a diet and do incentives with actual cost incentives. You can get a premium reduction and your actual costs will go down if you choose to engage in healthy lifestyles.

Now it's interesting because I've seen some, we have had some health plans apply for product approval and they're offering things like frequent flyer miles and discounts at hotels using the old American, I guess, if you create an

incentive that hits the pocketbook, maybe it will promote better and healthier habits.

These incentives are there to just get people to come in annually for a physical. If you do that then you get a reward. So there are some creative things that are being used out there to encourage healthy lifestyles.

STEVE FINAN: If I may address that question as well, we have certainly considered that question. We're as opposed to smoking as anyone but yet we have decided that we do not support the policy of having higher rates for smokers. The rationale is that as bad as smoking is, people who smoke tend to have more serious health conditions and they need to get better. To get better they need to use the medical system.

So our concern is that if you start having punitive measures for smoking or overweight or things, you may actually be keeping out or discouraging exactly the kind of health care you want to get better. So it's a very tricky game. It's very easy to say smoking's bad or being overweight is bad and you should lose weight but the reality is it's not always that easy. If you penalize them. You may keep them out and keep them away from the very thing that they need to get better.

PAT RYAN: Yes and I have to agree, it is a slippery slope that you're facing because you definitely want to reward people for doing the right thing and that gets back to my

slides earlier. You want to make your population better not necessarily and incent behaviors that will make it better, not necessarily encourage things that only causes cost to go to a higher level.

So some of the wellness programs, I know that we're coming out with, try to encourage that preventive behavior regardless of your lifestyle habits to try to incent people to see the doctor more often, to kind of catch things on the front end and then as well, several of our larger employers in particular and even us have engaged in wellness types of screenings and encouraged us basically scored us and some of the scores, I have to admit, I don't agree with.

I didn't pass the BMI test and I got knocked eight points for that and I still am trying to figure that out but [laughter] they're trying to do the right thing and hopefully these things will get fixed as we go. To your response, our tobacco users, they'll get knocked points on the scoring system for being a tobacco user but then they could have that weight if they attend smoking cessation programs and try to do the right thing to change their lives now.

The same thing for other people who have other chronic conditions who get knocked in their scores if they show some sort of value or some sort of improvement that they're trying to change their behaviors, either a letter from their doctor or

something then they'll get credit for that back in their premium and even if they have a low score and they improve their score, it's not necessarily only giving credits to people who get the very good scores. We're giving credits to people who are improving their scores or showing that they're doing the right thing.

So that's a very important part of that wellness aspect, I think, that needs to be incorporated. I think it's a good thing to do. It's just that you need to have the right things in place to make it work for everyone and give everyone a reason and a chance to make things better and to lower the cost for everyone.

KAREN POLLITZ: Deanna, just in case this doesn't come up, I'm going to use this as an opportunity to inject something that I have, I think is so important and I've mentioned the mental health parity issue. We had a group in Kansas City, Mid-America Business Coalition on Health and they're the large employers.

They're sort of like the business health roundtable, who were looking at their costs and trying to determine, they did a claims evaluation of their employees and where the dollars were going, thinking that if they were going to do disease management, it would probably focus around cardiovascular disease or something like that.

They were very surprised to find out there was more lost productivity and more claims experience related to depression. So they undertook an aggressive program on treating and helping their employees cope with depression. So I just bring that up because so often we think of mental health services as something that is, it's expensive and it's isolated and yet when you do claims evaluation, you realize there are a lot of comorbidities that go along with depression.

So this group of large businesses in Kansas City started a real aggressive outreach with their employees to deal with employee depression and I've seen, I think, some pretty good turnaround in terms of days lost from work and then some of the other things that go along with it, high blood pressure, hypertension, some of the things that go along with it. So I just wanted to get that plug in. it's kind of a hot topic here in Washington right now.

DEANNA OKRENT: And I think actually it leads into this question, which part of it has already been answered but this questioner is trying to understand high-risk pools a little bit better and whether they can be used to some advantage with regard to or instead of spreading risk across all individuals. I'll read it straight from here so that I'm not misinterpreting what the questioner's looking for.

It says high-risk pools face significant challenges including exorbitant premiums and enrollment caps. From a financial point of view, what are the pros and cons to individuals, the state, and insurance companies of concentrating the highest insurance risks in one pool, the high-risk pool, instead of spreading the risk across all individuals. As I said, you've kind of answered part of that but is there some place further to go with it?

PAT RYAN: Well I think part of it is just definitely the larger base you can spread that high-risk pool subsidization for the better and the nice thing about, at least I think we're part of the way there because the high-risk pools are currently, at least spread across not only the individual markets but the group market and then whatever the state may choose to chip in as well.

So at least in some ways that's better than just concentrating only to the individual market and buried on the backs of those people because again, these people didn't come from individual markets necessarily. They came from group markets, large group markets, and self-funded markets. I think there's an opportunity to possibly get the self-funded groups as well to be able to chip in and spread the cost to keep the overall costs down.

STEVE FINAN: I'd like to add that the theory of high-risk pools is good but in practice, it doesn't appear to be working. There are only 200,000 people in the 32 high-risk pools that exist today. That's not a whole lot of people. There's no real good number on what constitutes high risk in part because it can vary so much but as Karen found some years ago, several years ago in a study that she had done, she found people being rejected in the individual market for things like asthma, hay fever. Are those high risks? So what is a high risk but even if you get into a high risk, by definition they require subsidies and where's that money coming from?

The fact is there's enormous pressure on high-risk pools to keep people out or to otherwise limit coverage because it's so expensive. So it we're going to go that route, in theory it works but it means somebody's going to have to come up with a whole lot of money to help those people get by because a high-risk person, and this is based on actual cases I can cite, a high-risk person is someone with cancer who even has had coverage in an unregulated market can look at premiums of $70 to $100,000 a year. That's what it can be.

So if we're going to isolate those people, okay, but let's give them adequate coverage and realize it's going to cost money. Somebody has to pay for that.

SANDY PRAEGER: We're exploring another option in Kansas, which can sort of indirectly address the high-risk pool problem and it's patterned after the Healthy New York program and that's where in the small group market especially you provide a reinsurance mechanism for the high-risk individuals in your group plan and you essentially subsidize those high-risk individuals by spreading the risk over everyone in the small group market.

Healthy New York, I think, has had a pretty good success rate in providing this kind of an approach. What it does is give rate predictability and stabilizes the rate for that small group so you're not experiencing fluctuations based on the health status in that small group market.

That may, over time, keep more small employers in the health insurance market place because it's many of those small employers, when they drop coverage, putting their employees out into the individual markets, those employees with high-risk conditions are the ones that experience the most difficulty.

So if we can do more to stabilize that employer-based coverage in the small group market, we may at least keep some of those individuals from going from being forced into those high-risk pools but again, those high-risk pools are expensive to Steve's point. I think the numbers bare that out. I'd seen

200 recently. I saw 300 so I guess it's somewhere between 200 and 300,000 in those state high-risk pools.

KAREN POLLITZ: Just keeping in mind again that graph of the distribution of health expenses, if you take high-risk pools to their logical extreme, you can have all of the money in the high-risk pools and then a lot of people outside but it's not, remember, sick and healthy isn't us versus them. It's now versus when.

So for that to stay stable, the healthy people who are outside, when they get sick, they're going to have to come into the high-risk pool too and you're going to be kind of slinging people around back and forth depending on how healthy they are in any given year.

So it's a perfectly fine model if you follow it to its logical extension. You're going to end up with a single payer public program. I mean that's kind of how it's going to end up or you'll end up with what you have today, which is a fiction of a high-risk pool. You'll have a lot of programs out there that look like they're providing a safety net but in fact, people can't get into them.

The questioner mentioned enrollment caps, in fact, I think we're only down to one state that has an enrollment cap in their high-risk pool. They don't need them. Trust me, they don't need them. They set premiums that are prohibitively high.

They set $10,000 deductibles, and my favorite, they'll exclude from coverage the very pre-existing condition that made you eligible for the pool in the first place.

So when people show up and say okay, I'm ready for the high-risk pool and then they hear all that, they walk away. They don't sign up. So you don't need an enrollment cap and that's the worst way of approaching high-risk pools. I think we need to make up our minds.

PAT RYAN: I think maybe we need to blueprint our Iowa high-risk pool plan because we don't have the enrollment caps and we do offer plans, we do have a $10,000 deductible plan but we also have lower deductible plans as low as $1,500 deductibles, cost sharing at an 80/20 level and comprehensive or basically lifetime maxes that go up to as many as $3 million.

So they're actually as comprehensive as several of these benefit plans especially the lowest one is as comprehensive as what our plans we sell in the individual market. They offer minimal health benefits and a lot of the things that should be offered and preventive visits as well. The prices there are definitely higher than what they would pay in the individual market. They're required to be set at 150-percent of the average premium. I think they range anywhere

from $200 to $400 or something like that for that plan anyway for a single individual.

So they definitely are higher but they do offer that comprehensive coverage and we haven't seen the caps and the limitations that may be offered in other states that may have the problems so.

KAREN POLLITZ: But how many people are in that pool?

PAT RYAN: Basically this is a new pool. We had I think, 3,500, in our basic and standard pool. Now they've opened it up to, there's a third party administrator. I don't have an enrollment count on that but yes, it's a small number of people but it should be a small number of people because getting back to your slide, it's a small percentage of the population to begin with.

KAREN POLLITZ: Right but in all the states, it's a way smaller percentage than you would suggest from that group. If you thought it was picking up the sickest one-percent of the individual market then these pools should be about one-percent of the individual market and they're not that big. They're tiny.

STEVE FINAN: But to go back to Karen's point on her graph earlier on and Patrick had the same number, if you have five-percent of the population with 50-percent of the cost and to find that five-percent as your high-risk, okay. That means

50-percent of the dollars are going to go to your high-risk pool. We're not there and figure out how you're going to get there and if you go, say the top 20-percent is our high-risk and that would not be unreasonable, that's 80-percent of your costs.

Virtually your whole system is high-risk and that's how you get to the logic of what Karen said. You're moving towards a single payer system.

SANDY PRAEGER: Our high-risk pool in Kansas covers about one-half of one-percent of the population.

DEANNA OKRENT: Thank you. That sounds like that got everyone involved on that question and given the challenges in a high-risk pool strategy, if we could call it that, this questioner says well what consumer protections are there in the current system to allow folks to either get out of a quote, bad policy or an inappropriate policy that isn't meeting their needs, or get coverage or payment on claims that this questioner says should have been paid.

Now maybe they're getting into the rescission question that we didn't say too much about but are there some consumer protections in that situation?

PAT RYAN: Well I guess first to speak on rescission, I know that our company definitely treats it very seriously. I think rescission's important from a certain standpoint that you

obviously have to have something there for individuals to understand that they need to answer the questions to the best of their ability and not be trying to hide something.

Now to that extent, we're not, at least our company doesn't go after, we're not looking for an excuse to pay claims and that's, I think, sometimes the perception of the big, bad insurance companies get is that we're trying to prevent from paying claims.

We basically take only, we only look at the blatant cases and actually the number of cases we've looked at in our, since the first of the year, I think, is about 15 cases where rescission may have been an issue or rescission may be pending. I don't think we've actually rescinded all of those claims and that's over 10,000 people that came in to begin with. So it's a very small number that we're looking at. It's very blatant situations that may have been covered.

We're actually changing our policies so that we're not the only ones looking at this. We are having an independent attorney and an independent medical provider to also help us or help the appeal process or help the member and us understand whether or not there was a valid condition that was present at the time that was not disclosed that would have caused them to possibly to have opt into the high-risk pool or something like that.

So it’s not something that we’re necessarily using to screen from not paying claims other than to protect the rest of our consumers that are currently in the pool who are playing by the rules and who are wanting to keep their health care costs down. It’s an effort to protect those people and those populations as well so.

SANDY PRAEGER: One aspect of the consumer protection that we employ in our departments is when a consumer has been denied treatment for whatever reason, of course, we look at it. Oftentimes, the denial is based on well it’s an experimental procedure. So we ask for documentation.

Of course the consumer has to go through an internal appeals process with the company but they have the right then to come to us and we can convene an external appeals process where we bring in a panel of experts to look at and evaluate whether it is, first of all, medically necessary.

Then secondly, is it really classified as experimental or what does the medical literature show, what is the evidence-based documentation that, I think, Steve referenced evidence-based medicine.

In probably the ten years that our process has been in place, it’s been about 50/50, 50-percent of the time the consumer wins and 50-percent of the time, the decision of the insurance company is upheld. So that external appeals process

and we have an expedited 72-hour if we're really dealing with lifesaving treatments that need to be imposed.

I think just having that process in place encourages the right decision to be made in the first place especially if the company feels they're on shaky ground in denying it. They know we have the ability to go in and evaluate and advocate on behalf of that consumer getting the care they need and want.

KAREN POLLITZ: I think it's important to remember that most of these problems that we worry about only happen to people who are making claims. So these don't happen to healthy people who aren't making claims.

When you're really sick, this can be such a bummer to hear from your insurance company they're not going to pay for your surgery or they think something is experimental. Sometimes it happens to healthy people. I went through a nightmare last year.

My daughter broke her elbow in a soccer game and the insurance company wouldn't pay the claim. They said I had to send it worker's comp. I had to fight them for a year to get them to pay the claim and unfortunately for them, I was healthy and mad and so I got that to happen but when I had cancer 12 years ago, my hospital bill, after having it preauthorized, kicked out and wasn't paid.

When that happened to me, I just sat down on my kitchen floor and started to cry because I thought, oh my God I'm going to die of cancer and my kids aren't going to have a house. I didn't have the energy for a long time to do anything about it other than to just be very sad.

So I think we need to know more about the problems that go on in health insurance than we do now. Sometimes we argue about the incidence of problems and these are knowable numbers. We could have much more transparency, much more disclosure, much more reporting of how many claims get filed and how many get paid immediately within 30 days and how many get pended because there's some problem with it and how many get denied? Why is that and how many by diagnosis and we could look, I think, a lot more carefully at what's going on to see really what are the problems and how big are they.

Then I think we could try to make some, I think, appeals are important and an absolutely important protection but I think we also need a system that's much more idiot-proof than it is because when you're sick, there's just, you can't always mount an appeal.

I had the research I've done on external appeals also showed that consumers win about 50-percent of the time but that's just the small number of consumers who get all the way through the appeals process. The other finding in my research

is 90-percent of people who get denied never get to the end of the appeals process. It's just too complicated and they're not up for it.

So I think we need to find ways to make coverage simpler, much more understandable to people, much more automatic. It's never going to be simple because health care is complicated and expensive but I think we need to really kind of focus in on the perspective of the patients when we start to design these kinds of improvements to make coverage work better.

DEANNA OKRENT: Well we're just about out of time. I'm going to give each of our panelists an opportunity to have a final word but while they're doing that, please remember the blue evaluation forms and pull those out of your packet and fill them out if you will and when it is time to leave, please drop them off at the table outside there. I believe there's a box for them. So I'm going to start on my right and give each of the panelists an opportunity for a final word.

PAT RYAN: Alright, thanks and I think we have had a great discussion today in just understanding a little bit more about our health care system. It's a very complicated system that we have in place today. I think all of us will admit it's not bulletproof. There definitely are holes in it but there are also a lot of good things that happen to day and there are also

a lot of good parts about it where people are getting the coverage.

There are a lot of success stories where people are getting covered and people are able to afford the coverage they have. So with what's in place today, I think it's important to understand that there are good things happening and that a massive reform change not only brings out a massive lists of unknown.

But I think it's important to also understand what those unknowns could be and focus on maybe some of the problems and issues we have today and work to mend those as well as we can as well as be in it for everyone because I think everyone up here agrees that all of us believe that everyone should have access to health care.

Affordability is definitely a part of that access. It's not just the access itself. So I think to work towards those goals together is important for all of us to consider so.

KAREN POLLITZ: I'll just go back to my A's and keep your eyes on the patients. Beware of getting lost or distracted by averages or percents. If someone tells you something in health insurance is working for 80-percent of people, you haven't heard enough.

You need to know how the system works for people when they are sick and you need to watch it over, not just an

instant but over a period of time because people move around. Their life situations and circumstances change and their health status changes. We need to make sure that we can always, always, always be protected so when that sudden and awful thing happens that we need our insurance for, it'll be there for them.

I think the model laid out by the state of Massachusetts is a very important one. There certainly are others to look at but this is happening in real time right under our noses and we've got a state that has really kind of tried to get its arm around its market place to make everybody, really insist that everybody participate, make sure that the market behaves in ways that are reasonable and then gives people the means and the wherewithal to participate.

I think that's something that we are doing now and I hope we can do more of it for everyone in all the other states very soon.

SANDY PRAEGER: Well I want to thank everyone for this opportunity. I think we've had some very valuable insights shared today. I just want to remind everyone that neic.org, our national association web site, has a wealth of information about all lines of insurance but especially health insurance at the web site.

It’s referenced in the notes that you have in front of you, a white paper on health insurance, Health Innovations Working Group information, which is a group of departments across the country who have done some innovative things.

So there’s information about some of the innovations that are going on in health insurance at the state level. Hopefully we’re going to get through this economic crisis and we’ll be able, in the next Congress with new leadership from the White House, be able to meaningfully address some of the issues that have to be addressed from a health insurance standpoint. It can’t be solved just at the state level. It needs to be a partnership with our federal partners and advocacy groups.

I’m a believer that access to health is a right in this country. We’re the wealthiest nation on earth. We all should have access to good, affordable health care services. We’re not there yet. So the work still remains and let’s see, when was it that Theodore Roosevelt was doing this? Has it been a century or do we, see we still have a chance to get it done in a century.

KAREN POLLITZ: We’re not the Cubs yet.

SANDY PRAEGER: Thank you all.

STEVE FINAN: And thank all of you. I’ll just make it very simple. Health insurance should be about health. We don’t

do it well enough now. We need to do it better but as you get into this very complicated thing, I think the four A's are a very valuable way to think about it. Is it available? Is it adequate? Is it affordable and is it administratively simple? Thank you.

DEANNA OKRENT: And please join me in thanking our panel for what they've shared on the nuts and bolts [applause].

[END RECORDING]