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**COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS**

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Mr. Chairman:

Thank you for the opportunity to testify before your committee today about a very important aspect of the conduct of the market for private insurance in Indiana and the United States. I am Co-Director of the William S. and Christine S. Hall Center for Law and Health at the law school and also Co-Director of the Consortium for Health Policy, Law and Bioethics, an IUPUI Signature Center. Both the Hall Center and the Consortium are engaged in research, scholarship and education on health law and policy.

It is clear that the United States health care sector is in trouble. The major means of financing health care products and services – health insurance – is broken. The percentage of Americans whose health insurance is provided through employment has dropped precipitously in recent years from 80 percent of workers in 1982 to 73 percent by 1998.¹ The United States Census reports that the number of the percentage of the population covered by employer-sponsored private health insurance is 59.3 percent in 2007.² And just last Friday, The Commonwealth Fund issued a report on how the individual health insurance market was failing Americans.³

¹ J. Gruber & R. McKnight, Why did Employee Health Insurance Contributions Rise? *J. Health Economics* (2003);22:1085.

² C. DeNavas-Walt, B.D. Proctor & J. C. Smith, Income, Poverty, and Health Insurance Coverage in the United States: 2007 (Current Population Reports, Aug 2008), available at <http://www.census.gov/prod/2008pubs/p60-235.pdf> (visited Jul. 23, 2009).

³ M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families, The Commonwealth Fund, July 2009, available at <http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2009/Jul/Failure-to-Protect.aspx> (visited Jul. 24, 2009).

From 2006-2008, the Indiana University Health Reform Faculty Study Group,⁴ with funding from the State of Indiana, analyzed Indiana's health care sector and developed proposals for reform.⁵ The information on Indiana presented in this testimony was developed by this Study Group from published national and Indiana data. I served as Co-Director of this Study Group.

The Crisis Today in Indiana and the United States

The situation with private health insurance coverage in Indiana is not unlike other states. Indiana's uninsured population is composed principally of working adults and its ranks are growing.⁶ On any given day, Indiana has approximately 561,000 uninsured residents. This number has expanded faster than the national rate each year since 2000. Sixty-two percent of the uninsured are between 18 and 64 with incomes below 200 percent of the federal poverty level (i.e., \$40,000 for a family of four). Of note, Indiana has higher per capita expenditures compared to other states and an age-adjusted mortality rate 6.2 percent higher than the national average, with notably excess mortality in diabetes and cancer.⁷ Further, Indiana falls way below other states in important public health status measures like obesity and tobacco use.⁸

Between 2001 and 2005, Indiana experienced an 8.8 percent drop in employer sponsored coverage – one of the sharpest declines among all states.⁹ In 2006, only 34 percent of Indiana firms with fewer than 50 employees offered health insurance to their workers, lower than the 43 percent who did so nationally. Firms that do offer coverage are shifting an increasing portion of costs to their employees.

⁴ Indiana University, Indiana University Health Reform Faculty Study Group, available at <http://www.healthcarereform.iupui.edu/> (visited Jul. 24, 2009).

⁵E. Wright & M. Foddrill, A Framework for Health Reform in Indiana: Draft for Public Discussion (Center for Health Policy, Indiana University School of Public and Environmental Affairs, 2009), available at <http://policyinstitute.iu.edu/PubsPDFs/framework%20recommendations.pdf> (visited Jul. 23, 2009).

⁶ P.J. Seward, A. Holmes & E. Wright, *The Uninsured: Indiana's Rising Healthcare Dilemma* (Center for Health Policy, Indiana University School of Public and Environmental Affairs, 2009), available at <http://policyinstitute.iu.edu/PubsPDFs/Uninsured.pdf> (visited Jul. 24, 2009). (Data in this paragraph are from the cited source. Data in this paragraph are from the cited source. Citations of original sources have been omitted in this document but are available in the Study Group Report. Also some sentences presenting data are taken directly from the report.)

⁷ A. Holmes & E. Wright, *The Rising Tide of Health Care Costs in Indiana* (Center for Health Policy, Indiana University School of Public and Environmental Affairs, 2008), available at <http://policyinstitute.iu.edu/PubsPDFs/The%20Rising%20Tide%20of%20Healthcare%20Costs%20in%20Indiana.pdf> (visited Jul. 24, 2009). (Data in this paragraph are from the cited source. Citations of original sources have been omitted in this document but are available in the Study Group Report. Also some sentences presenting data are taken directly from the report.)

⁸ H. McCabe, G. Steele, E.D. Kinney et al., *Public Health Programs Key to Healthy Population, Lower Healthcare Costs* (Center for Health Policy, Indiana University School of Public and Environmental Affairs, 2008), available at <http://policyinstitute.iu.edu/PubsPDFs/PublicHealthProg.pdf> (visited Jul. 24, 2009).

⁹ A. Holmes & E. Wright, *The Rising Tide of Health Care Costs in Indiana*, *supra* note 7. (Data in this paragraph are from the cited source. Citations of original sources have been omitted in this document but are available in the Study Group Report. Also some sentences presenting data are taken directly from the report.)

Individual private health insurance is one of the few options for health coverage for individuals and families who are not otherwise eligible for public health insurance programs like Medicare and Medicaid. We have reason to believe that the situation with private coverage in Indiana is not unlike the situation that The Commonwealth Fund reported nationally.¹⁰ According to this report:

Over the last three years, nearly three-quarters of people who tried to buy coverage in this market never actually purchased a plan, either because they could not find one that fit their needs or that they could afford, or because they were turned down due to a preexisting condition.¹¹

Indiana does have a high-risk pool for individuals who are medically uninsurable. The Indiana Comprehensive Health Insurance Association (ICHIA) offers four plans. The cost and benefits of these plans are summarized in the table below.¹² ICHIA policies have a pre-existing condition of three months unless waived. As demonstrated in the table, ICHIA policies are expensive and have high levels of cost sharing.

Monthly Premiums for ICHIA Insurance Plans in Rate Area 5: Marion (Indianapolis) and Vanderburgh (Evansville) Counties July 2009								
	Plan 1 Deductible: \$500 Coinsurance: 80% / 20% In-Network (no more than \$1000) 60% / 40% Out-of-Network Out-of-Pocket Maximum: \$1,500 (including deductible)		Plan 3A Deductible: \$1,000 Coinsurance: 80%/20% In-Network (no more than \$2000) 60% / 40% Out-of-Network Out-of-Pocket maximum: \$3,000 (including deductible)		Plan 3B Deductible: \$1,500 Coinsurance: 80% / 20% In-Network (no more than \$2500) 60% / 40% Out-of-Network Out-of-Pocket maximum: \$4,000 (including deductible)		Plan 4 Summary not available	
Ages	Male	Female	Male	Female	Male	Female	Male	Female
Child	\$266.59	\$304.68	\$218.72	\$249.49	\$168.55	\$191.53	\$143.04	\$162.53
19 – 24	335.54	667.72	288.93	574.27	266.83	527.23	226.43	447.41
25 – 29	343.83	667.72	298.06	574.27	275.60	527.23	233.88	447.41
30 – 34	374.96	667.72	325.46	574.27	300.76	527.23	255.22	447.41
35 – 39	420.06	667.72	363.65	574.27	334.06	527.23	283.48	447.41
40 – 44	500.66	667.72	459.27	612.87	420.49	559.98	350.52	466.79
45 – 49	616.76	733.11	567.72	671.02	520.31	611.12	433.73	509.43
50 – 54	763.07	838.32	705.43	767.06	648.25	697.62	540.37	581.54
55 – 59	957.66	971.88	888.57	890.74	818.57	811.56	682.36	676.50
60 – 64	1,159.83	1,149.36	1,076.07	1,054.35	990.31	961.41	825.51	801.42
65 +	1,347.05	1,328.77	1,243.81	1,213.78	1,138.82	1,101.91	949.31	918.54

¹⁰ M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, Failure to Protect, *supra* note 3.

¹¹ *Id.*

¹² Indiana Comprehensive Health Insurance Association, On-Line Health Plan.Com, available at <http://www.onlinehealthplan.com/> (visited Jul. 24, 2009).

Indiana families are really feeling the strain of costly health insurance and health care services.¹³ By 2001, average personal spending on healthcare for Indiana families exceeded the expenditures that they spent on food, housing, or transportation. About a quarter of nonelderly families spend at least 10 percent of their pretax income on health care. Nearly half of all personal bankruptcies in Indiana are due to medical expenses.

Insurer practices of rescission or post claim underwriting that are the subject of this hearing can be particularly devastating for Indiana consumers. Consumers are virtually uninsurable after the rescission of a health insurance contract as indicated in insurer testimony at the June 16th hearing. Their only recourse is to obtain insurance through employment, which may be out of the picture if they are ill. Or they can enroll in one of the ICHIA plans that are quite expensive as indicated above. They are only eligible for Medicare if they are determined to be disabled and exhaust a two year waiting period. They are only eligible for Medicaid if they spend down to Medicaid income and resource levels, which are quite low in Indiana. (Of note, Indiana does not have a Medicaid Medically Needy program.) They are only eligible for Indiana's Healthy Indiana Plan if they meet that program's restrictive eligibility requirements, including participation in a medical savings account program.

Historically, Indiana residents have been subject to insurer practices of rescission, post claim underwriting and other practices that have ultimately denied private health insurance to seriously ill individuals. In the 1990s, with funding from The Robert Wood Johnson Foundation and the National Multiple Sclerosis Society, we at the Hall Center and colleagues at Indiana University documented the extensive problems that Indiana residents had with all types of private health insurance coverage.¹⁴ In another study of the working poor's attitudes toward health insurance coverage in Indiana, focus groups of the working poor clearly indicated that private coverage with high cost-sharing provisions and lack of coverage of prescription drugs among other items was not worth purchasing given their limited resources.¹⁵

¹³ A Holmes & E Wright, *The Rising Tide of Health Care Costs in Indiana*, *supra* note 7. (Data in this paragraph are from the cited source. Citations of original sources have been omitted in this document but are available in the Study Group Report. Also some sentences presenting data are taken directly from the report.)

¹⁴ See N. Swigonski, E. Kinney, D. Freund & T. Kniesner, *Unfinished Business: Inadequate Health Coverage for Privately Insured Seriously Ill Children*, *Children's Health Care* (2001);30(4):219; K. Stroupe, E. Kinney & T. Kniesner, *Chronic Illness and Health Insurance-Related Job Lock*, *Journal of Policy Analysis and Management* (2001); 20(3):525; K. Stroupe, E. Kinney & T. Kniesner, *Is There Evidence for Health Insurance-Related Job Lock When a Family Member is Chronically Ill?* *Journal of Health Policy, Politics and Law* (2000);25(2): 309; E. Kinney, D. Freund, M. Camp, K. Jordan & C. Mayfield, *Serious Illness and Private Health Coverage: A Unique Problem Calling for Unique Solutions*, *Journal of Law, Medicine & Ethics* 190 (1997); 25(2-3):190; E. Kinney & S. Steinmetz, *Notes from the Insurance Underground: How the Chronically Ill Cope*, *Journal of Health Politics, Policy and Law* (1994);19(3):633.

¹⁵E. Kinney, M. Tai-Seale, J. Greene, R. Murray & W. Tierney, *Three Political Realities in Expanding Coverage for the Working Poor: One State=s Experience*, *Health Affairs*, (1999); 18(4):188.

Strategies for Reform

As noted in the Supplemental Memorandum that was prepared following the hearing before this committee on June 16, 2009, there is considerable controversy over the legality of the practices of rescission and post claim underwriting. The Supplemental Memorandum presents information on statutes and court cases across the states that address insurer rescission of individual health insurance contracts.

Ostensibly, as the Supplemental Memorandum points out, the Health Insurance Portability and Accountability Act (HIPAA) prohibits insurance companies from rescinding or otherwise discontinuing individual insurance coverage unless there has been fraud or intentional misrepresentation of a material fact by the applicant or policyholder. HIPAA states that a “health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual” except if “the individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.”¹⁶

However, as explained in the Supplemental Memorandum, insurance companies do not necessarily follow the above quoted HIPAA provision in rescission situations. Rather, they could correctly maintain that rescission of a policy is different than non-renewal. In contract law, the consequence of rescission is that the rescinded contract never existed in the first place.¹⁷ Cancellation and non-renewal apply to an existing contract.

The Problem of Adverse Selection. Rescission and post claims underwriting are one way that an insurer can address adverse selection that exists in a voluntary individual private health insurance market. Insurers in this market suspect that the people are purchasing individual private health insurance policies on a voluntary basis only because they are sick or have reason to believe that they will become sick. The problem of adverse selection could be solved with a legal mandate that all people get insurance. The joint health reform that the three House Committees just reported out does have such mandates.¹⁸ Nevertheless, it is important to address problem of rescission and post claims underwriting in the interim.

The National Association of Insurance Commissioners, comprised of state insurance regulators, has developed principles of health reform that include a mandate for health insurance coverage. These principles also require that health reform address the problem of adverse selection:

¹⁶ Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1998 (codified as amended, Public Health Service Act § 2742, 42 U.S.C. § 300gg-42).

¹⁷ H.R. 3200, America’s Affordable Health Choices Act, 111th Cong., 1 Sess. (2009).

¹⁸ See J.W. Stempel, *Law of Insurance Contract Disputes* (1998 & Supp. 2002); E.A. Farnsworth, *Contracts* § 9.3 (3rd Ed. 1999).

Avoid Adverse Selection. Any program that grants consumers the choice between two pools with different rating, benefit, or access requirements will result in adverse selection for one of the pools. Likewise, setting different rules for different plans within the pool or allowing consumers to wait until they get sick to purchase insurance, without penalty, can have adverse consequences on the pool. Any reforms must be carefully constructed to ensure the long-term health of the market. *We can support guaranteed issue and elimination of preexisting condition exclusions for individuals to the extent that these reforms are coupled with an effective and enforceable individual purchase mandate and appropriate income-sensitive subsidies to make coverage affordable* [Emphasis supplied].¹⁹

H.R. 3600, America's Affordable Health Choices Act. In my view, H.R. 3600 does much to address current problems with individual private health insurance coverage, with long term and genuine health reform.

However, H.R. 3600 could do more in the interim. Specifically, H.R. 3600 treats rescission of the insurance contract as a non-renewal of the contract. As explained above, rescission and nonrenewal are not the same legal concepts. Rescission voids the insurance contract altogether and from the start, while cancellation and non-renewal terminate an existing contract.

To be effective, H.R. 3600 should explicitly address the practices of practices of rescission and post claim underwriting for individual health insurance contracts. Possible reforms would be the imposition of time limits on which insurers could rescind an insurance contract. Other reforms, included in H.R. 3600, are a higher evidentiary standard for intentional misrepresentation and mandated external review of decisions to rescind. Another reform would be to prohibit the practice of post claims underwriting altogether or after a brief time period.

Thank you.

¹⁹ National Association of Insurance Commissioners and the Center for Insurance Policy and Research, *Principles of Health Reform* (2009), available at http://www.naic.org/topics/topic_health_care_reform_principles.htm (visited Jul. 24, 2009).