

A Real-World Perspective on Health Insurance Coverage

Testimony of Mr. Vip Patel

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To Subcommittee on Health of

U.S. Senate Health, Education, Labor, and Pensions Committee

March 12, 2002

Introduction

Chairman Kennedy, it's an honor to address a lifetime advocate for the poor and disadvantaged. Many of us rejoiced to see you recognized at the State of the Union Address for your bipartisan leadership on the education issue. May you receive more such recognition for bipartisan leadership on the issue of the uninsured.

Senator Frist, a brilliant and compassionate heart-lung surgeon, you've saved many lives. May you have accelerated success as you compassionately work to save many more lives, nationally and internationally, through the legislative process.

Members of the committee, you are the war-torn veterans of healthcare policy, having fought many healthcare battles, perhaps right here in these chambers.

So it is with humility that I contemplate what NEW catalyst or FRESH spark I can bring to your efforts. Thank you for the opportunity to testify today and thank you for your interest in, and work on behalf of the nation's uninsured.

In Summary

The severe uninsured problem is only worsening. No one solution can solve the uninsured problem. Targeted solutions are required for unique segments of the uninsured: the Impoverished Uninsured (10 million under FPL); the Unhealthy Uninsured (two million); the Working Uninsured (25 million); the Displaced Uninsured (two million), etc. I have been advocating solutions for each of these various uninsured segments. Rather than diminishing solutions for any one segment, all avenues should be advanced today. For this hearing, I've been asked to focus on the Working Uninsured segment, representing two-thirds of the Uninsured population. The most effective approach for the working uninsured is helping them purchase their own health insurance by 1) enabling economic assistance from their uninsured employer and 2) offering economic assistance from the government. A legal solution exists to remove the barrier that prevents assistance from employers, without requiring any government budget. Government assistance through tax credits or subsidies will make a significant impact on bridging the affordability gap for many millions who qualify for, but can't afford health insurance. This conclusion is based on eHealthInsurance's primary contribution in this

testimony, real nationwide data that shows the health insurance real people currently purchase with their own money. The uninsured need results, and they need them now.

Worsening Problem Requires All Approaches

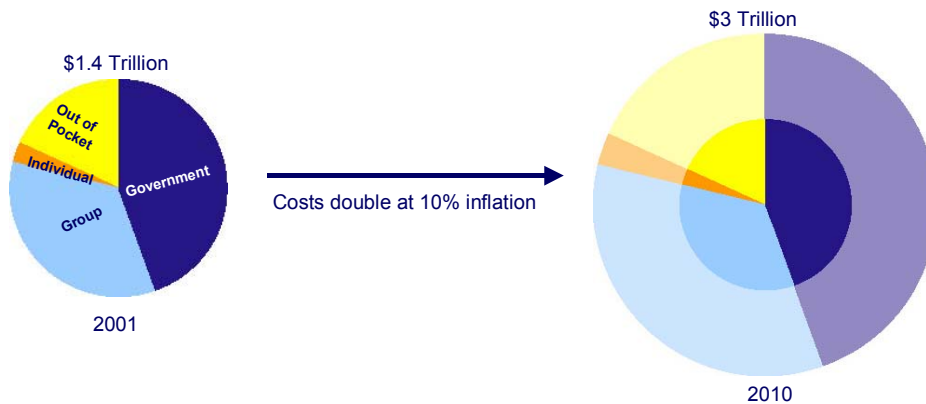
On this very day, 15 years ago, I awoke to the news that my father, Mohanlal Patel, had suddenly passed away from a massive heart attack. It took this shock to later awaken me to my own risk of heart disease. So I manically embarked on the most fashionable of diets at the time, consisting almost exclusively of carbohydrates and no fats, but it did little to reduce my high cholesterol count. About a year ago, someone encouraged me to try the new most fashionable diet that flipped the previous diet completely around, severely restricting carbohydrates. Would you believe my cholesterol plummeted? **Interesting thing about healthcare, the picture you thought you understood so clearly yesterday may be a completely different picture today.**

For decades, various leaders have been fighting proponents of 100% consumer-based, employer-based or government-based health insurance coverage. This recurring “all or nothing” mentality stems from concern that a fragmented healthcare system is inherently inefficient. Despite this, we must first face the fact that fragmentation is a reality. In 2001, America’s \$1.4 Trillion in healthcare expenses were financed 44% through government-based, 34% through employer-based, and 3% through individual-based insurance coverage, with the 18% out-of-pocket balance representing the uninsured hole in coverage.

Next, all must concede that the battle is not for a slice of the pie, but against the foreign enemy of health care inflation. By the end of the decade, when healthcare expenses have doubled to \$3Trillion (at 10% inflation), we’ll be in a desperate effort to plug an even more massive hole in coverage, where all approaches must be called upon to help.

Since the beginning of the decade, eHealthInsurance has challenged Congressional leaders to cut the number of the nation’s uninsured in half by the year 2010. Forgive me for being so results-oriented, but I’m gravely concerned about the lack of progress, at least partially due to paralysis from this Civil War amongst various “all or nothing” approaches to coverage. Pragmatic, compassionate and humble leadership must declare, “The Civil War is over.” No matter how long one has held a viewpoint, it’s permissible and even noble to adopt a different view, particularly in healthcare, because the picture keeps changing.

U.S. Healthcare Expense Distribution



| 2001 U.S. Healthcare Distribution of Expenses | | | | |
|---|----------|---------|------------------|-------------|
| | \$ | % of \$ | People (million) | % of People |
| Government (Medicaid, Medicare, etc.) | \$ 620 | 44% | 92 | 33% |
| Private Insurance - Group & Other | \$ 479 | 34% | 134 | 48% |
| Private Insurance - Individual | \$ 48 | 3% | 16 | 6% |
| Out of Pocket (Uninsured, etc.) | \$ 253 | 18% | 40 | 14% |
| | \$ 1,400 | 100% | 282 | 100% |

Sources: EBRI, CMS, Congressional Budget Office, eHealthInsurance analysis

eHealthInsurance -- Helping Real People in Need

A significant challenge is making the uninsured aware that health insurance can be accessible and affordable. eHealthInsurance is a nationwide online marketplace, providing access to health insurance to individuals, families and small businesses. Our free service enables consumers to research a wide range of health insurance plans from multiple health insurance companies, enabling them to purchase the health insurance that best fits their needs.

Roughly a half million people per month come to eHealthInsurance. Surprisingly, 40% of the people who complete applications with eHealthInsurance state on their application that they have been uninsured for a significant period of time - yes, 40% of eHealthInsurance applicants come from the uninsured population.

Many people approach eHealthInsurance with the misperception that health insurance is prohibitively expensive, but when they see the range of health insurance options available, starting with some very low prices, many of them find they CAN afford health insurance. Of course, many more people could actually afford health insurance if the government were to provide economic assistance to overcome the affordability barrier.

The following are just a few examples of how Americans have materially improved their lives by finding affordable, quality health insurance coverage:

- Donna Johnson of Sacramento, California is a 35-year old single mom with a 12-year-old son named Paul. She works as a manicurist. Paul had asthma for most of his life. The two were without health insurance for 11 years, and paid more than \$15,000 in medical bills out-of-pocket.

“To not have health insurance, and to have either you be sick or your children be sick and have to go to the doctor, you’re scared, you’re afraid that the doctors are going to turn you away, you’re afraid the hospitals are going to turn you away because you’re not insured.”

“It’s the worst thing to have your kid in a hospital, hooked up to wires and machines and you don’t have any money to pay for any of this. I didn’t know what I was going to do.”

When she heard about eHealthInsurance, Johnson went online to see if she could get health insurance, even though she didn’t really think she could. To her surprise, Johnson and her son were approved for coverage through eHealthInsurance in a few weeks. She now pays \$225/month and is fully covered, even with son Paul’s pre-existing condition.

“I was just so overwhelmed by everything I had been through, all of the years that I had gone through without the insurance, all the money that I paid, (when I received the cards in the mail) I sat in my chair and I cried, because it was just the best feeling that I had had in a lot of years.”

“It’s awful, being uninsured. It’s horrible. You’re worried all the time. I’d send Paul to school and wonder if he is going to fall down and break his arm today or if he would be exposed to some kid with meningitis. Instead of being concerned about his health and well being, I was more afraid of what that would cost me.”

“You need the medical coverage so in case that something happens you are covered. You can concentrate on your child’s well being and not on the money.”

- Venus Campanelli of Chicago, Illinois is married, works part time, and has two children. Her husband is self-employed.

“We know now that we can afford (health insurance), we don’t have to worry about that payment every month, and say ‘Oh, my God, this is taking a big bite out of our budget every month.’”

“We got a cheaper deductible by half and the payments went down by half, for basically more coverage.”

“Especially when you have little ones, they fall, they cut themselves. My son had stitches, so (insurance) is important.”

- John Fritz, of San Jose, California was laid off from his job in 2001. He is married, with two children under the age of four.

“(My) company did offer COBRA, but with the HR person rolling her eyes saying, ‘if you really want COBRA, here it is’...but it’s bloody expensive.” The company’s COBRA premium would have been a little more than \$1200/month for Fritz’s family of four.

“When you’ve got two kids, you’ve got immunizations and who knows what else to worry about,” Fritz said.

He went to eHealthInsurance.com and found comparable coverage to his COBRA plan for only \$150/month with the doctors they wanted.

“It wasn’t three weeks before we had to put it to use when my newborn daughter got pneumonia. So that covered the costs right there.”

Real Data to Assist Policy Makers

Over the last several years, eHealthInsurance has met with Democratic and Republican leaders in the Senate, House and both Bush and Clinton Administrations. The purpose of those meetings, as it is today, has always been to bring experience and data from real people across the country to bear on discussions about how to help solve the problem of the uninsured.

In these meetings, we discovered that policy makers and influencers seeking to help the uninsured are in real need of accurate information about the expense and comprehensiveness of health insurance purchased by individuals and families. eHealthInsurance has national reach and volume, offering 10,000 different plans from 100 different insurers across the country, with licenses to sell insurance in all 50 states and the District of Columbia. This puts us in a relatively exclusive position to provide such information, since there are very few national sources of health insurance in the private market.

That leads us to some new information we would like to share with the Committee today. In January 2002, eHealthInsurance pulled a recent sample of 20,000 individual (single) sold policies from its database of customers to better understand the cost and comprehensiveness of health insurance policies purchased by individuals nationwide. The following data shows the costs of the plans actually selected and benefits received by individuals buying on the private health insurance market. The purchasing behavior is representative of what people actually choose in a health insurance plan when they pay for it themselves.

This data shows that affordable, accessible health insurance is available to many uninsured Americans. With some government assistance, many more Americans could also afford this coverage.

Premiums Within Reach Across Most of the Country

The average individual (single) premiums that consumers in this sample purchased is \$159 per-member-per-month (PMPM) (which is slightly higher than the average family policy at \$110 PMPM). On an annual basis, this individual premium amount equates to \$1,900 per-person-per-year. This amount is substantiated when compared to the average PMPMs of some of the nation's largest individual health insurance carriers. Such premiums are available to states representing 93% of the U.S. population. Almost two-thirds of the uninsured population fall in age brackets with an average annual premium of less than \$1700, which is even below the overall average of individual premiums.

| Health Insurance Premiums for Single Policies by Age Bracket | | | | | | | |
|--|----------|-----------|-----------|-----------|-----------|---------------------|----------|
| | age <18 | age 18-24 | age 25-34 | age 35-44 | age 45-64 | 65 and older (4) | all ages |
| Average monthly premium per single (1) | \$ 102 | \$ 123 | \$ 138 | \$ 182 | \$ 262 | N/A | \$ 159 |
| Average annual premium per single | \$ 1,226 | \$ 1,481 | \$ 1,658 | \$ 2,178 | \$ 3,144 | N/A | \$ 1,908 |
| % of uninsured population by age (2) | 24% | 18% | 21% | 17% | 19% | 1% | 100% |
| % of U.S. population by age (3) | 25% | 10% | 14% | 16% | 22% | 12% | 100% |

(1) Source: eHealthInsurance, Inc. 2001, 20,000 single policies across states representing 93.5% of the U.S. population

(2) Source: Health Insurance Coverage, US Census Bureau, issued Sept 2000

(3) Source: U.S. Census Bureau, Census 2000, with extrapolation

(4) Age 65 and older are covered under Medicare

Average Health Insurance Premiums by State

| State | Population | % of U.S. Pop. | Avg. monthly premium per single: all ages | Avg. annual premium per single: all ages | Average age | Guaranteed Issue (2) | Community Rating (3) |
|----------------|------------|----------------|---|--|-------------|----------------------|----------------------|
| California | 34,501,130 | 12.1% | \$ 143 | \$ 1,718 | 30 | | |
| Texas | 21,325,018 | 7.5% | \$ 143 | \$ 1,716 | 32 | | |
| New York | 19,011,378 | 6.7% | \$ 266 | \$ 3,198 | 35 | Yes | Yes |
| Florida | 16,396,515 | 5.8% | \$ 287 | \$ 3,448 | 33 | | |
| Illinois | 12,482,301 | 4.4% | \$ 174 | \$ 2,088 | 32 | | |
| Pennsylvania | 12,287,150 | 4.3% | \$ 164 | \$ 1,962 | 31 | | |
| Ohio | 11,373,541 | 4.0% | \$ 153 | \$ 1,837 | 33 | | |
| Michigan | 9,990,817 | 3.5% | \$ 161 | \$ 1,934 | 32 | | |
| New Jersey | 8,484,431 | 3.0% | \$ 203 | \$ 2,436 | 38 | Yes | Yes |
| Georgia | 8,383,915 | 2.9% | \$ 127 | \$ 1,521 | 30 | | |
| North Carolina | 8,186,268 | 2.9% | \$ 121 | \$ 1,450 | 34 | | |
| Virginia | 7,187,734 | 2.5% | \$ 148 | \$ 1,778 | 32 | | |
| Indiana | 6,114,745 | 2.1% | \$ 136 | \$ 1,633 | 31 | | |
| Washington | 5,987,973 | 2.1% | \$ 129 | \$ 1,545 | 34 | | |
| Tennessee | 5,740,021 | 2.0% | \$ 155 | \$ 1,866 | 33 | | |
| Missouri | 5,629,707 | 2.0% | \$ 172 | \$ 2,066 | 31 | | |
| Wisconsin | 5,401,906 | 1.9% | \$ 174 | \$ 2,090 | 33 | | |
| Maryland | 5,375,156 | 1.9% | \$ 166 | \$ 1,986 | 31 | | |
| Arizona | 5,307,331 | 1.9% | \$ 139 | \$ 1,672 | 34 | | |
| Minnesota | 4,972,294 | 1.7% | \$ 165 | \$ 1,975 | 31 | | |
| Louisiana | 4,465,430 | 1.6% | \$ 166 | \$ 1,995 | 30 | | |
| Alabama | 4,464,356 | 1.6% | \$ 133 | \$ 1,602 | 27 | | |
| Colorado | 4,417,714 | 1.6% | \$ 151 | \$ 1,816 | 32 | | |
| South Carolina | 4,063,011 | 1.4% | \$ 137 | \$ 1,650 | 31 | | |

| | | | | | | | |
|----------------------|--------------------|--------------|---------------|-----------------|-----------|--|--|
| Oregon | 3,472,867 | 1.2% | \$ 135 | \$ 1,625 | 30 | | |
| Oklahoma | 3,460,097 | 1.2% | \$ 133 | \$ 1,597 | 34 | | |
| Connecticut | 3,425,074 | 1.2% | \$ 153 | \$ 1,838 | 37 | | |
| Iowa | 2,923,179 | 1.0% | \$ 144 | \$ 1,723 | 34 | | |
| Mississippi | 2,858,029 | 1.0% | \$ 170 | \$ 2,038 | 31 | | |
| Kansas | 2,694,641 | 0.9% | \$ 121 | \$ 1,446 | 33 | | |
| Arkansas | 2,692,090 | 0.9% | \$ 146 | \$ 1,751 | 35 | | |
| Utah (1) | 2,269,789 | 0.8% | \$ 93 | \$ 1,117 | 28 | | |
| Nevada | 2,106,074 | 0.7% | \$ 166 | \$ 1,995 | 35 | | |
| New Mexico | 1,829,146 | 0.6% | \$ 164 | \$ 1,972 | 36 | | |
| Nebraska | 1,713,235 | 0.6% | \$ 185 | \$ 2,223 | 29 | | |
| Rhode Island | 1,058,920 | 0.4% | \$ 181 | \$ 2,174 | 32 | | |
| Montana | 904,433 | 0.3% | \$ 173 | \$ 2,073 | 31 | | |
| Delaware | 796,165 | 0.3% | \$ 165 | \$ 1,980 | 31 | | |
| South Dakota | 756,600 | 0.3% | \$ 165 | \$ 1,986 | 42 | | |
| Alaska | 634,892 | 0.2% | \$ 216 | \$ 2,592 | 32 | | |
| District of Columbia | 571,822 | 0.2% | \$ 143 | \$ 1,713 | 31 | | |
| Wyoming | 494,423 | 0.2% | \$ 128 | \$ 1,537 | 35 | | |
| Totals | 266,211,318 | 93.5% | \$ 159 | \$ 1,907 | 32 | | |

Not Included:

| State | Population | % of U.S. Pop. | Avg. monthly premium per single: all ages | Avg. annual premium per single: all ages | Average age | Guaranteed Issue (2) | Community Rating (3) |
|---------------|------------|----------------|---|--|-------------|----------------------|----------------------|
| Massachusetts | 6,379,304 | 2.2% | N/A | N/A | N/A | Yes | |
| Kentucky | 4,065,556 | 1.4% | N/A | N/A | N/A | Yes | |
| West Virginia | 1,801,916 | 0.6% | N/A | N/A | N/A | | |
| Idaho | 1,321,006 | 0.5% | N/A | N/A | N/A | Yes | |
| Maine | 1,286,670 | 0.5% | N/A | N/A | N/A | Yes | Yes |
| New Hampshire | 1,259,181 | 0.4% | N/A | N/A | N/A | Yes | Yes |
| Hawaii | 1,224,398 | 0.4% | N/A | N/A | N/A | employer mandate | |
| North Dakota | 634,448 | 0.2% | N/A | N/A | N/A | | |
| Vermont | 613,090 | 0.2% | N/A | N/A | N/A | Yes | Yes |

18,585,569 6.5%

Total US 284,796,887

- (1) Sample skewed young; age bands averaged
- (2) Law requires all applicants to be issued a policy regardless of health
- (3) Law requires policies to be priced independent of age and/or health

Several States Outside the Norm

In several states such as New York, uncompetitive market conditions can cause significantly higher premiums across all age brackets.

| Health Insurance Premiums for Single Policies by Age for Three Largest States | | | | | | | | | | |
|---|------------|----------------|---------------------------------------|--|--|--|--|---|----------------------|----------------------|
| State | Population | % of U.S. Pop. | Avg. single monthly premium: all ages | Avg. single monthly premium: age 18-24 | Avg. single monthly premium: age 25-34 | Avg. single monthly premium: age 35-44 | Avg. single monthly premium: age 45-64 | # of Carriers Actively Pursuing Individual Business (1) | Guaranteed Issue (2) | Community Rating (3) |
| California | 34,501,130 | 12.1% | \$ 143 | \$ 107 | \$ 132 | \$ 175 | \$ 238 | 7 | No | No |
| Texas | 21,325,018 | 7.5% | \$ 143 | \$ 108 | \$ 124 | \$ 160 | \$ 228 | 7 | No | No |
| New York | 19,011,378 | 6.7% | \$ 266 | \$ 243 | \$ 267 | \$ 282 | \$ 271 | 1 | Yes | Yes |

- (1) Number of insurance companies responding positively to offer from eHealthInsurance for expanding members in individual market
- (2) Law requires all applicants to be issued a policy regardless of health
- (3) Law requires policies to be priced independent of age and/or health

Modest Deductibles and Co-payments

Data from this sample shows that there is a clear consumer purchasing preference for lower deductibles. As shown in the chart below, greater than two-thirds of all plans purchased have a deductible of \$1000 or less, and close to half have deductibles of \$500 or less. Additionally, two-thirds of policies have office visit co-payments of \$20 or less.

| Deductible | % of Policies Purchased |
|------------------|-------------------------|
| \$500 or less | 43.5% |
| \$501 to \$1000 | 25.9% |
| \$1001 to \$1500 | 7.5% |
| \$1501 to \$2000 | 7.8% |
| \$2001 to \$3000 | 10.0% |
| Over \$3000 | 5.3% |
| Total | 100% |

| Co-Pay | % of Policies Purchased |
|--------|-------------------------|
| \$0 | 36.7% |
| \$5 | 0.0% |
| \$10 | 9.3% |
| \$15 | 9.2% |
| \$20 | 20.1% |
| \$25 | 6.2% |
| \$30 | 10.7% |
| \$35 | 4.7% |
| \$40 | 1.2% |
| \$45 | 1.8% |
| Total | 100% |

Solid and Accessible Benefits

87% of policies purchased by individuals can be considered “comprehensive” in coverage, where comprehensiveness is defined to include: Inpatient + Outpatient + Labs&Tests + Prescription Drugs (85%). Consumers purchased mainstream health insurance plan types that are relatively unencumbered with utilization restrictions (e.g., HMO gatekeepers) or non-mainstream, minimal-coverage products.

| Benefit Levels of Policies Selected | |
|-------------------------------------|-------------------------|
| Benefit Coverage | % of Policies Purchased |
| Comprehensive (1) | 87% |
| Basic | 13% |
| Total | 100% |

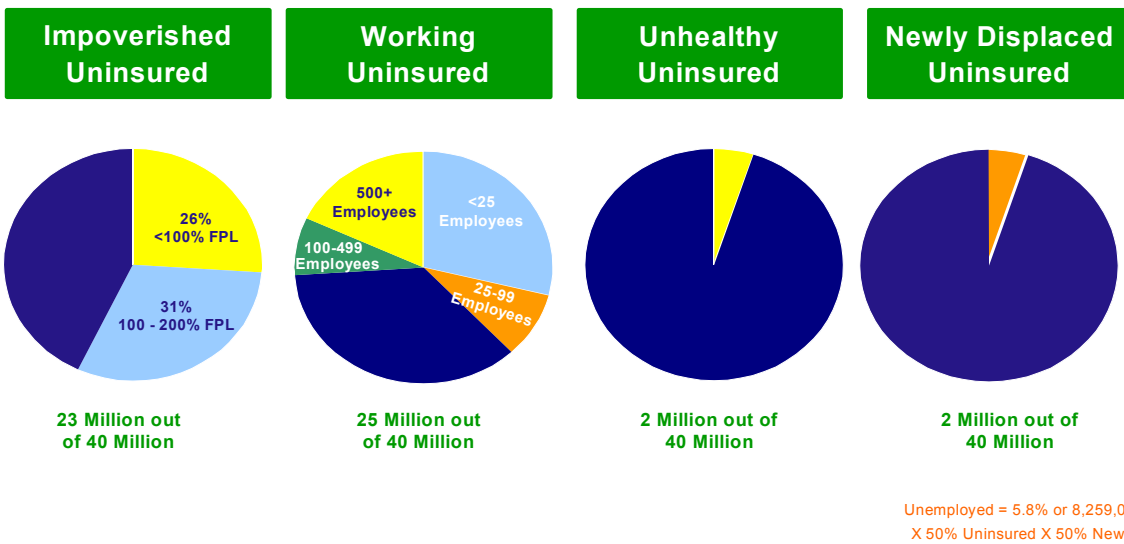
| Product Choices by Individual Customers | |
|---|-------------------------|
| Product Type | % of Policies Purchased |
| PPO | 78% |
| HMO | 10% |
| Indemnity/Other | 11% |
| Total | 100% |

(1) Comprehensive = Inpatient + Outpatient + Labs&Tests + Prescription Drugs (85%)

Targeted Solutions for Unique Segments of the Uninsured

In order to be effective in addressing the uninsured issue, we must identify realities of the various segments of the uninsured population. I find it helpful to distinguish between the impoverished uninsured, working uninsured, unhealthy uninsured and newly displaced uninsured or displaced workers. They all require approaches unique to their population. Let me be clear. No one solution will solve the entire problem. Additionally, in a healthcare system that is currently fragmented, any proposal will have inefficiencies -- but doing something well is better than doing nothing perfectly.

Uninsured Challenge by Segment



Today, I'm here to help provide real market data and experience, showing ways that Congress can help the uninsured get the coverage they need. At eHealthInsurance, we seek to accelerate and make efforts across all uninsured segments, and avoid unproductive efforts of diminishing potentially viable solutions.

The two largest segments of the total uninsured population are the impoverished uninsured and the working uninsured, with some overlap between the two. The impoverished uninsured segment consists of roughly 10 million individuals below 100% of the Federal Poverty Line (FPL) and another 12 million at 100-200% FPL. At slightly higher numbers we find the working uninsured, or 25 out of 40 million individuals¹. The largest portion of this uninsured population is found among small businesses with less than 25 employees.

¹Sources: Kaiser Family Foundation, Center for Risk Management and Insurance Research, Urban Institute 1999:

The smaller yet no less critical significant segments of the total uninsured population include the unhealthy uninsured and newly displaced uninsured, both comprised of approximately 2 million out of 40 million individuals. As the focus of the overall hearing today is the broad set of uninsured, it is helpful to identify solutions across all segments.

The Impoverished Uninsured

For the 23 million individuals classified as impoverished uninsured, I was surprised at the number of people living at 100% below the FPL that aren't covered by Medicaid. Perhaps Medicaid ought to be available to all individuals under the FPL to guarantee health care coverage to the poorest of the poor.

Furthermore, I am eager to work with states to simplify SCHIP eligibility checking with an online approach that we call "Inline with What's Online." Since 2000 I've been on a quest to respond to a challenge from Senator Wyden to eHealthInsurance to help discover ways to improve SCHIP enrollment, since we are experts in health insurance distribution. We're just now starting to make some headway in discovering how SCHIP eligibility can be determined through online data at the federal level. The Treasury Department is cooperating, and a CRS study is underway. But today, with massive budget deficits at the state level, these noble efforts seem to get an ambivalent response. In California alone we're facing a \$17.5B deficit, and the emphasis seems to be shifting from how to insure more kids and their parents to how to fund those currently in the Medicaid program. In Senator Bingaman's state of New Mexico, I understand there is a multi-billion-dollar shortfall just to finance Medicaid for current recipients in the upcoming fiscal year.

The Unhealthy Uninsured

The segment of unhealthy uninsured represents those individuals with preexisting health conditions that cause insurers to deny them coverage. The Heartland Institute²⁽¹⁾ estimates that 2.5 million Americans (1% of the U.S. population, or 5% of the uninsured) with severe health conditions (e.g. AIDS, juvenile diabetes, etc.) cannot find health insurance within an employer-sponsored health plan, a government-sponsored health plan or in the individual market. As I learned more about our health care system, I discovered high-risk pools which are functioning in 28 states to offer guaranteed access for these "uninsurable" individuals. High-risk pools subsidize the premiums for high cost individuals while causing little or no economic disruption to the market. Yet the greatest challenge for these plans is severe under-funding. Perhaps the federal government should assist those states struggling under the financial burden of high-risk pools. And perhaps the federal government should be active in helping these pools to develop in the remaining states.

The Working Uninsured

Today I've been asked to comment more specifically on the working uninsured, representing two-thirds of the 40 million uninsured, by focusing on two solutions: helping the working

²⁽¹⁾ Conrad F. Meier, *Heartland Policy Study* No. 78, "How to Implement Kassebaum-Kennedy: A State Legislators Guide to the Health Insurance Portability and Accountability Act of 1996," The Heartland Institute, March 25, 1997, page 3.

uninsured purchase their own insurance through 1) economic assistance from their uninsured employer, and through 2) economic assistance from the government.

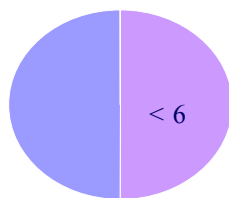
Economic Assistance from Uninsured Employers

Current regulations cause insurers to reject individual health insurance applications for employees receiving assistance from an uninsured employer. Small businesses that can't afford to purchase or administer a group plan should be allowed and encouraged to reimburse employees to purchase an individual policy.

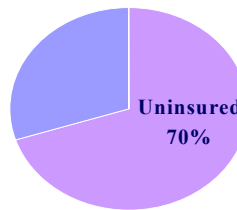
According to the U.S. Census Bureau, 95% of businesses have less than 50 employees, and more than half of U.S. businesses have less than six employees. Consistently, surveys show that the majority of these businesses are uninsured. The National Federation of Independent Businesses has over 600,000 small business members. In a 1997 survey of their membership (conducted by Gallup), results show that 70% of companies with less than 6 employees do NOT offer health insurance². This coverage level is likely to be even smaller today.

Small Employer "Group" Coverage is Challenging

Majority of U.S. Businesses
Have less than 6 Employees



If Less than 6 Employees
Most have No Group Plan



Affordability Barriers

- Requires 50 – 100% of Premium
- Profits Uncertain Year-to-Year
- Premiums Rise Annually

Supply Barriers

- Largest Carriers Dropping out of Small Business Markets (nothing to buy)

Administrative Barriers

- Plan Selection & Enrollment
- Premium Payments
- Adds/Changes/Complaints
- Termination
- ERISA

Small businesses often do not have the resources to hire a full-time benefits administrator to select and manage a health plan. Most health plans require a minimum of 50% employer contribution to the premium cost for a group plan, which is more than most small employers can afford. Both President Bush and Congressional leaders have embraced the goal of improving access to private health insurance for employees of small businesses as an important public policy objective.

² Source: National Federation of Independent Business, survey by the Gallup Organization 1998.

Many of these same small businesses that cannot afford to arrange for a group health plan for their employees could afford and would be willing to provide partial reimbursement to employees to purchase health insurance in the individual market.

However, federal agency interpretation of insurance law, as expressed in a Health Care Financing Administration (HCFA) Program Memorandum of November 2000 (relying on the Department of Labor definition of an “employee welfare benefit plan”) appears to classify a scenario where a small business reimburses employees to defray the cost of individual health insurance as a “group plan.” As a result, health insurance issuers in the individual market will deny applications from individuals who receive partial reimbursement from their employers, fearing regulatory repercussions.

Therefore, continuing to require that individual health insurance policies that are partially reimbursed by small employers to be deemed a “group plan” under federal law is effectively closing off an opportunity for employers to assist their employees in obtaining health insurance – resulting in no insurance being issued in most cases.

I believe there are three potential avenues to address this problem.

- (a) First, HCFA should explore the possibility of re-issuing a Program Memorandum which indicates that it will not automatically deem an individual policy which is partially reimbursed by an employer as a “group plan,” particularly if the situation involves a small business which has not previously offered group health coverage to its employees;
- (b) Second, because the November 2000 HCFA Program Memorandum relies on the Department of Labor’s (DOL) definition of an “employee welfare benefit plan,” the DOL could amend the regulation determining the definition of an “employee welfare benefit plan” to specifically exclude an individual health insurance policy which is partially reimbursed by an employer; and
- (c) Lastly, Congress could amend the Health Insurance Portability and Accountability Act (HIPAA) to state that an individual health insurance policy, which is partially reimbursed by an employer, shall not be deemed a “group plan.” This could be limited to groups under a certain size where most of these groups are uninsured.

Economic Assistance from the Government (tax credits or subsidies)

Should Congress accept the offer of \$89 billion, proposed in President Bush’s budget, to help the uninsured with tax credits? A delay could mean the budget disappears. As the hockey pro Wayne Gretsky once said, “You miss 100% of the shots you never take.”

Specifically, tax credits will work for that portion of the population where the credit is large enough to cover the specific shortfall between someone’s ability to pay and the price of health insurance. They don’t work in cases where the gap is too big or an application is rejected due to the health of the applicant. For many years I’ve enjoyed being a Big Brother for Jesus and Orlando in East Palo Alto, California. Tax credits might not have helped Orlando’s nine-person family, living in a single bedroom apartment, with an unemployed father. But they might have helped Jesus, with two siblings and both parents working.

eHealthInsurance's primary contribution to this debate is the data on what people actually pay for health insurance today. As far as I am aware, eHealthInsurance has released the only statistically significant premium data (20,000 real policies), which is nationwide, state-by-state information, of actual policies sold -- not hypothetical quotes.

The analysis shows the average price of a single health insurance policy was \$159 per month or \$1900 per year. More than two-thirds of policies sold had less than \$1000 deductibles, and 87% of the policies included inpatient and outpatient benefits, labs and tests, and in most cases, prescription drug benefits.

So what does the data mean for the uninsured? Consider the person between the age of 25 and 34 whose average premium is \$1658 per year. If the government offered a \$1000 credit under the Bush or REACH proposal, the balance they would need to pay is \$658 per year, or roughly \$50/month. That means two-thirds of the uninsured (those 34 and younger) could get a policy for that \$50/month balance. Similarly, 80% of the uninsured (those age 44 and younger) could get a policy for the balance of roughly \$100/month. With the recently passed House proposal where the government pays for 60% of the premium, all brackets through the pre-Medicare ages of 64 could be covered with a balance close to \$100/month.

| | age <18 | age 18-24 | Age 25-34 | age 35-44 | age 45-64 | 65 and older (4) | all ages |
|--------------------------------------|----------|-----------|-----------|-----------|-----------|------------------|----------|
| Average monthly premium per single | \$ 102 | \$ 123 | \$ 138 | \$ 182 | \$ 262 | N/A | \$ 159 |
| Average annual premium per single | \$ 1,226 | \$ 1,481 | \$ 1,658 | \$ 2,178 | \$ 3,144 | N/A | \$ 1,908 |
| Balance required after \$1000 credit | \$226 | \$481 | \$658 | \$ 1,178 | \$ 2,144 | N/A | |
| % of uninsured population by age | 24% | 18% | 21% | 17% | 19% | 1% | 100% |
| Uninsured population at or below | 24% | 42% | 63% | 80% | 99% | 100% | 100% |

eHealthInsurance Inc. Data – 2/02

Every day people approach eHealthInsurance with the misperception that health insurance is prohibitively expensive, but when they see the range of options, starting with some very low prices, many of them find they can afford health insurance. Of course, many more people could actually afford health insurance if the government were to provide economic assistance to them.

Conclusion

Real people are desperate for real solutions. eHealthInsurance's primary contribution to solving the issue of the uninsured is contributing real data from the real world that points to solutions that can be immediately effective. Our data and analysis shows that programs to help the working uninsured would have immediate and substantial results. Potential solutions for the working uninsured exist that require no budget, and solutions exist that take advantage of funds currently in the President's budget. All avenues should be advanced. The uninsured need results and they need them now.