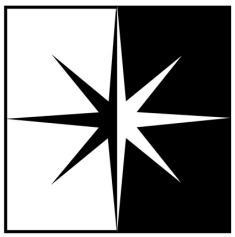

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Statement of Len M. Nichols
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Senate Committee on Health, Education, Labor, and Pensions
Addressing Insurance Market Reform in National Health Reform

March 24, 2009

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Chairman Kennedy, Ranking Member Enzi, Senator Bingaman and other distinguished members of the Committee, thank you for inviting me to testify today on this central topic of health reform and how best to organize insurance markets. My name is Len M. Nichols. I am a health economist and direct the Health Policy Program at the New America Foundation, a non-profit, non-partisan public policy research institute based in Washington, D.C., with offices in Sacramento, California. Our program seeks to nurture, advance, and protect an evidence-based conversation about comprehensive health care reform. We remain open minded about the means, but not the goals: all Americans should have access to high-quality, affordable health insurance and health care that is delivered within a politically and economically sustainable system. I am happy to share ideas for your consideration today and hereafter with you, other members of the Committee, and staff.

Insurance markets are a great place to focus on early in your inquiries. We know that having quality health coverage is literally a matter of life and death. The Institute of Medicine (IOM) estimates that over 18,000 Americans die every year because they do not have access to the timely and necessary care that health insurance affords.[1] Many of us in this room take this kind of seemingly routine care for granted, yet I know that securing access to health insurance for all is a moral obligation that many members of this committee share.

The truth is many insurance markets do not work very well for many of our fellow citizens. Small employer groups with fewer than 50 or 100 members lack bargaining power, administrative economies of scale, and the ability to self-insure. As a result, they pay very high prices for coverage.[2] Perfectly healthy and higher income individuals do satisfactorily well in the non-group market most of the time. However, those with health conditions, even fairly minor ones, often encounter carriers who refuse to sell to them at all or only at a greatly inflated price.[3] The non-group market can never work well for those with serious health conditions and modest incomes.[4]

Even large group markets are not working all that well. Large employers are increasingly focused on cost and quality issues as much as and in some cases more than everyone else. Most large employers self-insure because they concluded long ago that they were not getting value for the risk-bearing services they were buying

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[1] Institute of Medicine, *Coverage Matters: Insurance and Health Care*, (National Academies Press: Washington, D.C., 2001).

[2] The "price" of insurance is the "load," the difference between the premium paid and the amount of money paid to medical providers for health services. Individuals pay loads between 30-40%, small groups pay 25-30%, and large groups pay 6-15%.

[3] Karen Pollitz and Richard Sorian, "Is the Individual Market Ready for Prime Time?" *Health Affairs* Web Exclusive, October 23, 2002; Karen Pollitz, Richard Sorian, and Kathy Thomas, "How Accessible is Individual Health Insurance for People in Less-Than-Perfect Health?" *Kaiser Family Foundation*, June 2001.

[4] Mark V. Pauly and Len Nichols, "The Nongroup Insurance Market: Short On Facts, Long On Opinions And Policy Disputes," *Health Affairs* Web Exclusive, October 23, 2002.

from insurers. Today, many large employers just buy claims processing and provider contracting services. Furthermore, many employers actually engage in benefit design and care management efforts themselves, sometimes in concert with insurers acting as third party administrators, but often alone.

Thus, insurance markets need to be reformed – and some people must be given substantial subsidies – for us to reach the goal of covering all Americans in a sustainable way.

I will get specific in short order, but I prefer to start with a big picture perspective. To reform our health system generally and our insurance marketplaces specifically, we must re-align incentives quite profoundly. The role of policy is to set the rules so that *self-interest* is channeled to serve the *social interest*. We have not done this very well with regard to insurance regulation, either at the federal or state levels. We can do far better.

Our goal should be to create marketplaces wherein insurers who adopt socially responsible business models will thrive. The obsolete business model that has inflicted so much inefficiency and human suffering on so many is centered on aggressive underwriting and risk selection. Under this model, insurers compete to insure the best risks and avoid the sick at all costs. Americans will be much better served by rules that make it unprofitable and illegal to continue these strategies.

It is necessary to institute rules that will encourage insurers to: interact with enrollees efficiently, respectfully, and transparently; help us get and stay healthier; identify outstanding and efficient providers and use information tools and incentives to help them deliver better care; and, structure payments to providers so that continuous quality improvement is embedded in every care process, regardless of whether the care is being delivered in the physician's office, the hospital, or elsewhere. In other words, we want to create markets wherein insurers compete based on price, clinical value added, and consumer satisfaction, rather than on avoiding the sick and strategically denying claims.

<u>Necessary Reforms:</u>

The following reforms are necessary to create an insurance market that is accessible and affordable for all:

A new marketplace that extends the advantages of large group purchasing – large, balanced risk pools and administrative economies of scale – to all. This new marketplace or "exchange" could be organized nationally. But insurance markets, like health service markets, are inherently local. The conditions on the ground vary quite a bit across the country and even within states. For example, integrated health systems, large multi-specialty physician groups, and effective and

responsive local non-profit health plans are not as widespread as most of us would prefer. Therefore, creating several marketplaces or exchanges on a regional, state, or sub-state level (or some combination), would be preferable to a single national marketplace.

However, and this should be made abundantly clear, the most important rules that govern the new marketplace must be uniform across the country. We cannot serve all Americans well with a regulatory patchwork that reflects local lobbying disparities more than good policy sense.

The responsibility for enforcing the new insurance regulations should remain with the states. As a result of their current role, states have more functional knowledge about regulating insurance companies and of the local nuances of local markets than the federal government. However, the federal government will need to invest in back-up regulatory authority if states fail to act consistently with the intent of federal legislation.

Initially, the new exchanges should subsume today's small group and non-group markets. This will enable people who are not eligible for Medicaid (or Medicare) who work in small firms or are without access to employer-sponsored coverage to enter right away. No residual market outside the exchange should be allowed for these small groups and individuals. This will eliminate risk selection once and for all. Over time, large (currently self-insured) groups might be allowed to enter into the market, perhaps starting with state and federal employees. Care must be taken to protect against risk selection, however, so large groups should be allowed to come in only as a result of employer choice, not the choice of individual employees.

The marketplaces should be governed by a balanced, non-profit board of directors appointed by political leaders. Insurers will need to meet specific standards in order to participate. They should be required to report data (for comparative performance purposes) and abide by the marketing rules and open enrollment period policies set by the board.

Prohibit discrimination based on health status. No American should be denied coverage or charged differential premiums because of their health status or family history. To achieve this goal, the following reforms are absolutely necessary: guaranteed issue (all insurers must sell all products to all people within the exchange and outside the exchange large employers must allow all workers to join their plans at group rates), no exclusions based on preexisting conditions (once virtually all Americans are covered), guaranteed renewability (plans cannot refuse to continue covering individuals or differentially change their premium as a result of changes to health status), and modified community rating (premiums may not vary based on health status, but can vary by age, geography, and family size).

Minimum benefit package. All Americans should have coverage that protects their health and financial needs. Therefore, Congress or another authority should require a minimum level of benefits to guarantee the quality of coverage being offered in the marketplace and protect against adverse selection that could result from wide variations in product design.

The minimum benefit standard could be designed as a specific minimum benefit package or an actuarial value target. An actuarial value test, while not as effective for market competition as a specific benefit minimum package, would nevertheless preserve some flexibility for benefit and cost-sharing design and still guarantee quality coverage. If done carefully, this strategy could also protect against extreme adverse selection.

Risk adjustment (distributing payments to insurers based on differential risk profiles) will be necessary to help reduce the consequences of adverse selection as well. Insurers should also be permitted to sell supplemental products; however, these packages must be priced and described separately to allow consumers to easily compare different choices and create transparency regarding cost and value.

Subsidies. Health care costs have risen faster than wages for some time. As a result, health insurance and health care have become more unaffordable for more and more American families every day. Therefore, we will need to devote substantial subsidy dollars to make health insurance and health care affordable for all Americans. However, affordability has two dimensions – for households and for governments. Ultimately, the final definition of affordability will reflect political judgments about what households and governments can afford. This definition may evolve over time, as will delivery system efficiencies, demographic trends, and economic growth.

Reform proposals should include sliding scale subsidies for individuals and families who need help affording coverage (again, defined by the community). Subsidies could be available for both premiums and cost-sharing requirements (depending on the design of the minimum package) and made available directly or through the tax code.

We should keep in mind that the federal government already spends more than $200 billion per year subsidizing insurance through the tax treatment of employer-provided health coverage. Economists, analysts, and courageous policy makers have argued for years that the income tax exclusion for employer premium payments is both regressive and inefficient relative to other ways to subsidize insurance coverage. The current employer tax exclusion is a poorly targeted subsidy that we could and should use to make our health system both more efficient and more fair. Therefore, as we think about how to finance coverage expansion and necessary subsidies, we should remember that some of the resources we have dedicated already could be targeted far

more efficiently.

Requirement to purchase coverage. No one suggests an individual mandate because they want to "make" people buy insurance. Rather, when combined with the reforms described above, a requirement to purchase coverage is necessary to make the insurance market function efficiently and fairly. Without a purchase requirement, insurers will legitimately fear that only the sick will buy health insurance (adverse selection). That fear will produce higher premium bids, which will cost people and governments more money. Purchase requirements will guaranteed that the population seeking care represents the entire population. As a result, insurers will bid lower in a competitive context. Massachusetts has seen this happen in real life.

Once insurance is accessible (through the newly reformed marketplace) and affordable (through subsidies), all individuals should be required to purchase coverage to make sure everyone pays their fair share and reduce the costs shifted to the insured by free riders. A free rider is an individual who could afford to purchase coverage, but does not enroll. Ten percent of the uninsured make more than four times the federal poverty level.[5] Often when a free rider gets seriously ill they visit a hospital emergency room and indicate that they cannot pay for the services provided to them. Their costs are shifted to the insured in the form of higher provider prices and in turn higher private insurance premiums. Roughly 16 percent of our uncompensated care expenses for the uninsured go to people who make more than 400 percent of the poverty level.[6]

In addition, 25 percent of people eligible for public coverage at little to no cost do not enroll.[7] While these individuals are not free riders, they still contribute to the cost-shift or "hidden tax," which results in higher premiums for the insured. An individual mandate would necessitate effective outreach and enrollment efforts to minimize the number of people who are currently missed by the system and ensure this vulnerable population is taking advantage of available coverage. In the long run, this should help them get healthier and become more productive citizens.

Finally, as a condition of living in a community that helps individuals afford insurance and care, everyone has a personal responsibility to maintain their own health. Value-based design features in the minimum benefit package that encourage healthy eating, exercise, and lifestyle behaviors will help give Americans some of the tools they need to achieve this goal. In addition, part of taking responsibility for our own health includes a requirement to access appropriate health care services when necessary. This is possible only if a person is insured. Therefore, a requirement to purchase or

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[5] Kaiser Family Foundation, "The Uninsured, A Primer: Supplementary Data Tables," October 2008.
[6] Sarah Axeen and Elizabeth Carpenter, "Who Receives Uncompensated Care," *New America Foundation*, March 2008.
[7] John Holahan, Allison Cook, Lisa Dubay, "Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Need Help Affording Coverage," *Kaiser Family Foundation*, July 2007.

enroll in available coverage represents one part of an individual's personal responsibility to the larger community.

Transparency for insurers. In general, we must increase transparency within our insurance markets to engender fair competition and give consumers the information they need to make informed choices about the insurance products that are right for them. Insurers should be required to report information on the quality of care their enrollees are getting, as well as patient satisfaction indicators that will be made public by the exchanges. The Healthcare Effectiveness Data and Information Set (HEDIS) measures, which are continually updated by the National Committee for Quality Assurance (NCQA), seems like a reasonable place to start. Also, exchanges will want to help the public compare administrative efficiency by making available the ratio of premiums collected versus dollars spent on patient care. The risk profiles of enrollees will need to be reported for exchange-wide risk adjustment as well.

Optional reforms:

The reforms described above could achieve satisfactory performance from a market comprised exclusively of private health insurance plans. Yet, I admit that there are few real-world examples that prove this kind of system would function as anticipated, though reforms in Massachusetts are making great strides. (Since Massachusetts remains a work- in-progress I will not analyze it in detail in the written testimony but will gladly discuss my impressions of what we know so far in the hearing itself, or later). While my personal views lead me to believe that private insurers alone could enable our new marketplace to deliver excellent performance in the future, I understand profoundly that many advocates and citizens are skeptical that regulations or contracts will be able to ensure that private insurers actually comply with all reforms for all people.

Several leading reform proposals recommend allowing consumers to choose between public and private health plans. Therefore, it is worth exploring how to design an insurance marketplace wherein private and public plans can compete fairly.

Public plan. Let me be crystal clear: if the playing field is level, it is possible for public and private health insurance plans to compete and deliver value for consumers without distorting the insurance market. This policy question should not create an impasse or stall reform efforts.[8]

Fair competition, however, will require separating the oversight of the public plan from that of the managers of the marketplace or exchange(s). It will also require that

[8] For further information on my thoughts about a competing public plan, see: Len M. Nichols and John M. Bertko, "A Modest Proposal for a Competing Public Insurance Plan," *New America Foundation*, March 2009.

all rules of the marketplace – benefit package requirements, insurance regulations, and risk adjustment processes – apply to all plans equally, whether public or private.

More than 30 state governments offer their employees a choice between traditional private health insurance products and a plan self-insured by the state. This experience combined with historic competition between public and private plans in both the Medicare program and California Public Employees Retirement System (CALPERS) serves as proof-of-concept: plans operating with politically appointed managers can compete with plans run by private managers if the rules of engagement are structured properly.

Again, state employee plans offer an excellent model for how we could structure a choice of a public health insurance plan. More than 30 state governments offer their employees a choice between traditional private health insurance products and a plan self-insured by the state. In the case of the self-insured product, the state or a third party administrator (TPA) negotiates provider contracts and performs administrative functions. While the state may pay a TPA (usually the resident "Blue" plan) to handle some tasks, the plan is publicly owned and the state bears the insurance risk. If claims outpace premiums in a given year, the state pays and is at risk for the difference. Likewise, if the TPA collects more premiums than it pays out in claims, the surplus dollars are usually allocated to a premium stabilization fund or remain with the state's general revenues. Neither the TPA nor the state plan's managers profit from stinting on care. This credible reassurance seems to be what most advocates for the choice of a public health insurance plan seek.

Therefore, I believe the type of public plan I describe above can achieve many of the goals of public plan advocates, while preserving fair and effective market competition, negating the risk of excess cost-shift, and avoiding any kind of inevitable progression toward a single payer health system. Yet, this approach will require us to systemically address delivery system reforms that can deliver more value and lower cost growth trajectories over time. But that is a subject for another day.

Conclusion

Insurance market reforms are an essential part of re-making our health system into one that works for all Americans in the 21st century. Comprehensive health reform must also include efforts to improve quality and reduce cost growth. But the foundation of a *health* system must be coverage. Without coverage, tens of millions of Americans will never have access to appropriate care and health-enhancing interventions.

There is a compelling collective interest in making sure coverage is a reality for all Americans: the economic loss we suffer as a result of the uninsured exceeds the cost

of covering everyone.[9] Also, we must cover all Americans to allow the information system and quality innovations that we desperately need to work successfully. Therefore, making insurance markets work for all is a crucial step on the road to real reform, the kind of reform your committee has long sought and that our nation desperately needs. I hope this testimony is useful and I remain, as always, eager to answer any questions.

[9] Health Policy Program, "The Case for Health Reform," *New America Foundation*, 2009.