



**Testimony**

**for**

**Senate Committee on Health, Education, Labor and Pensions**

**Understanding Health Insurance Premiums and  
the Need for System-wide Cost Containment**

**by**

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## **I. Introduction**

Chairman Harkin, Ranking Member Enzi, and members of the committee, I am Karen Ignagni, CEO of America's Health Insurance Plans (AHIP), which is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We appreciate this opportunity to testify on issues affecting the affordability of health insurance coverage. Our written testimony addresses the following issues:

- What our community is doing to create a bridge to a more modernized health care system;
- How premiums relate to costs;
- How premiums are evaluated at the state level;
- What is changed by the new law;
- Principles for a workable system; and
- Unmet challenges.

We hope this information will be helpful to the committee and we look forward to working with you to address the factors that are causing premiums to increase.

## **II. What Our Community Is Doing to Create a Bridge to a More Modernized Health Care System**

Our community is strongly committed to the successful implementation of the "Patient Protection and Affordable Care Act" (PPACA), and we already have begun taking important steps to lay the foundation of a health care system that rewards value, not volume. Health plans are pioneering new initiatives for improving patient care, enhancing quality, and helping enrollees receive the highest possible value for their health care dollars.

### Administration Simplification

Health insurance plans have recognized the importance of working with clinicians and hospitals to reduce the complexities of administrative transactions and improve patient care. Our primary

goal for administrative simplification has been to improve the ease with which health care providers electronically connect with health insurance plans to exchange administrative and clinical information, and simplify the system for consumers.

Through a partnership with the Council for Affordable Quality Healthcare (CAQH), our members are participating in an initiative, known as CORE, that is focused on developing a single set of operating rules to expand and enhance the standards for administrative transactions in the health care industry. The goal of these rules is to streamline and automate the claims payment cycle by encouraging interoperability between health plans and providers. This goal is being achieved through a phased approach that results in a reduction in administrative costs and time.

The CORE collaboration started in 2005 and approximately 115 entities are now participating. Participants include health insurance plans, providers and provider groups, health IT companies, standard setting organizations, federal and state agencies, and other health industry trade associations.

Once the CORE initiative is fully implemented, the operating rules will enable all administrative transactions to be performed electronically. All parties will be able to exchange information in a consistent, predictable manner – ensuring that clinicians have the information they need on any patient, covered by any insurance, when they need it. This is comparable to the standards work that was done to allow banks to offer ATMs to consumers. This initiative also lays the groundwork that will enable the administrative simplification provisions of the new law to work.

### Physician Portals

Building on the development of common standards, AHIP and the Blue Cross and Blue Shield Association (BCBSA) are working with our members in New Jersey and Ohio where state-based initiatives have been launched to simplify the flow of information between health plans and physicians' offices. These initiatives allow physicians to use a single web portal to conduct electronic transactions with all of the health insurance plans that insure their patients, helping them to streamline and fully automate key office tasks. The lessons learned from these initiatives, including feedback from physicians, will be applied to future administrative simplification efforts as health insurance plans work to help physicians improve customer service for their patients and reduce personnel and billing costs for medical practices. Savings potentially could reach hundreds of billions of dollars as the entire health care system achieves

efficiencies through similar moves to automation and consistent business practices. For consumers, the operating rules and the physician portal will enable the seamless exchange of health information without the hassles of clipboards and repetitive requests for information.

### Payment Reforms

Health insurance plans also have implemented innovative payment models to reward quality and promote evidence-based health care using clinical guidelines that are equivalent in some respects to aviation protocols. When properly applied, evidence-based clinical guidelines allow doctors to do what they were trained to do while reducing the chance of undertreatment, overtreatment, and mistreatment. A 2006 *New England Journal of Medicine* article reported that at least half of the nation's health insurance plans, representing 80 percent of all enrollees, included some pay-for-performance incentives in their provider contracts. For patients, this progress means greater safety and improved outcomes. For providers, it means being recognized and rewarded for practicing to the highest professional standards.

Health insurance plans are committed to engaging physicians, hospitals, and other health care professionals in the design and implementation of payment reforms. Our members also are working with various stakeholders to make performance measurement more consistent. We urge the committee and policymakers to assess these efforts and consider building upon the PPACA initiatives to ensure a system-wide approach to delivery reform.

### Reducing Preventable Hospital Admissions, Readmissions, and Emergency Room Visits

Reducing preventable hospital admissions, overall readmissions, and emergency room visits has become an important national priority for both quality improvement and cost control. Health plans are advancing this goal through a variety of initiatives that transform patient experiences with care. These include:

- Information and support programs for patients transitioning from hospital to home;
- Medical home innovations that expand patients' access to primary care and support primary care physicians with multidisciplinary teams of medical, behavioral health, and social service professionals;
- Case management to help patients at high risk of hospitalization access all of the medical, behavioral health, and social services they need;
- Home medical visits for patients who have difficulty reaching the doctor's office;

- Programs to help frequent emergency room users connect with quality care on an ongoing basis; and
- Initiatives to align end-of-life treatment plans with patients' preferences.

While implementing these initiatives, our members have demonstrated that effective care is about personal connections. Personal phone calls from nurses, social workers, or case managers to check on patients' needs following hospitalization help patients overcome barriers to following care plans, avoid medication errors, and significantly reduce potentially avoidable hospital admissions, readmissions, and emergency room visits. In addition, patients face tremendous challenges in taking medications correctly, and these challenges have created an important new analytical and teaching role for pharmacists in the health care system.

Research findings demonstrate that these innovative strategies are working to help keep patients out of the hospital and avoid potentially harmful complications. In December 2009, AHIP released the second in a series of working papers<sup>1</sup>, comparing patterns of care among patients enrolled in two large, multi-state Medicare Advantage HMO plans and in Medicare's traditional fee-for-service (FFS) program. The preliminary results from this study are consistent with the results gathered in an earlier eight-company AHIP study<sup>2</sup> of smaller and regional Medicare Advantage plans. Based on the simple average of all 18 areas studied in all 10 companies, the risk-adjusted comparisons indicate that these plans improved health care for their enrollees by:

- reducing emergency room visits by 24 percent;
- reducing hospital re-admissions by 39 percent;
- reducing certain potentially avoidable hospital admissions by 10 percent; and
- reducing inpatient hospital days by 20 percent.

By reducing the need for avoidable hospitalizations and emergency room care, health insurance plans are not only improving the health and well-being of their enrollees – but also achieving greater efficiencies and cost savings.

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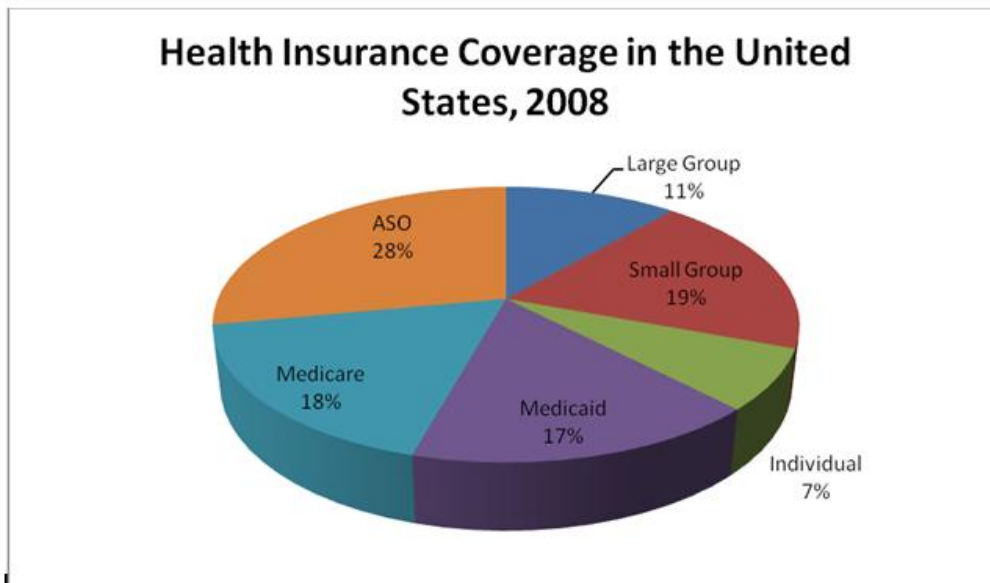
<sup>1</sup> AHIP Center for Policy and Research, *Working Paper: Comparisons of Utilization in Two Large Multi-State Medicare Advantage HMOs and Medicare Fee-for-Service in the Same Service Areas*, December 2009

<sup>2</sup> AHIP Center for Policy and Research, *A Preliminary Comparison of Utilization Measures Among Diabetes and Heart Disease Patients in Eight Regional Medicare Advantage Plans and Medicare Fee-for-Service in the Same Service Areas* (revised September 2009). See also, AHIP Center for Policy and Research, *Reductions in Hospital Days, Re-Admissions, and Potentially Avoidable Admissions Among Medicare Advantage Enrollees in California and Nevada*, (revised October 2009)

Recognizing that these preliminary findings demonstrate dramatic improvements relative to FFS coverage, we are seeking verification of these results through additional research using different data sources and risk adjustment mechanisms. We also should note that our research found that outpatient visits were roughly the same for Medicare Advantage and FFS enrollees and that physician visits for Medicare Advantage enrollees were substantially higher.

### III. How Premiums Relate to Costs

As the committee conducts its review of why premium costs are increasing, the chart below illustrates how Americans are covered today. The major focus of the health reform debate has been the individual health insurance market, which accounts for 7 percent of the insured population in the United States (or 18 million people).



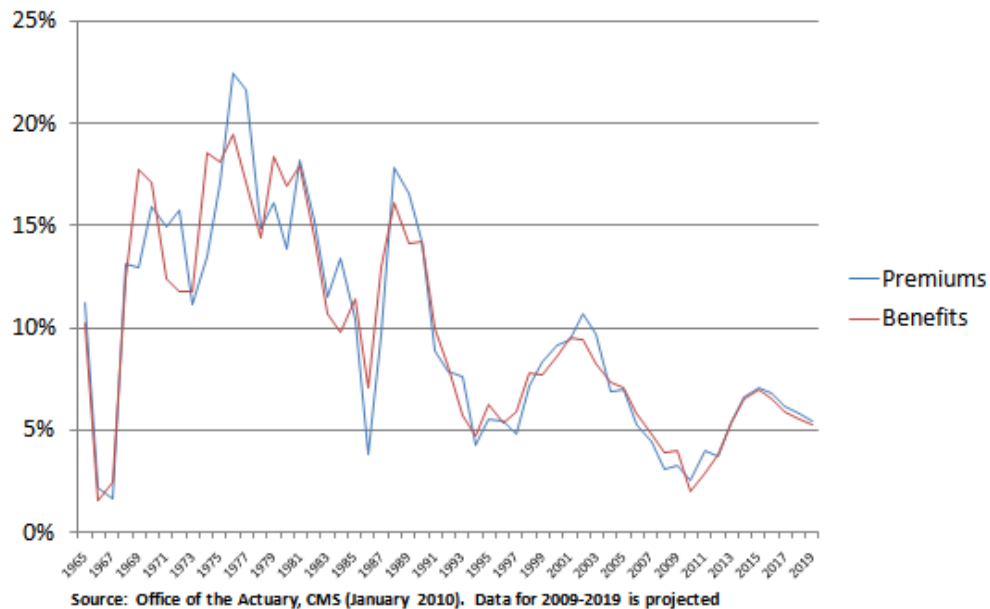
The individual market has unique challenges, including the fact that participation will continue to be voluntary until the individual coverage requirement takes effect in 2014. As a result, the risk of adverse selection is much higher in the individual market than in other markets. Indeed, with the recession, a number of individuals purchasing coverage in the individual market have

dropped coverage.

In the small group market, a different type of adverse selection has occurred, with layoffs generally affecting individuals most recently hired, small groups have become older and sicker which has been a factor in premium increases for this market segment. Rising costs, along with other factors explained below, are driving premiums in all markets.

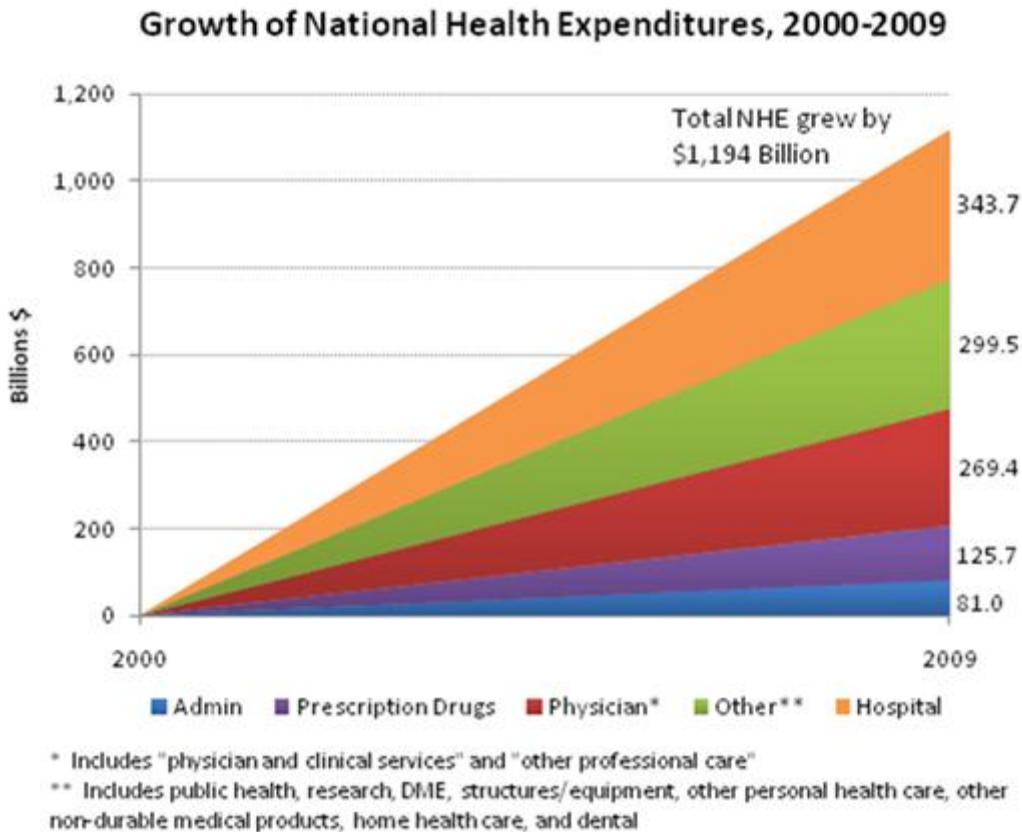
When the cost of health care services increases, the cost of providing health benefits also rises. The federal government's data on national health expenditures (see chart below) indicate that over the past 20 years (1989-2009) health benefit costs have increased by an average of 7.2 percent annually and premium increases likewise have averaged 7.1 percent annually. This trend clearly demonstrates the importance of addressing underlying medical costs through measures that achieve system-wide cost containment.

### NHE Private Health Insurance Premium vs. Benefit Growth



Furthermore, the chart below shows that the administrative costs of health plans increased much less than spending on prescription drugs, physician services, hospitals, and other health expenditures from 2000-2009. In fact, last year, the percentage of premiums that went toward

administrative costs and profits declined for the sixth consecutive year – from 13.67 percent in 2003 to 11.15 percent in 2009.



Additionally, as we examine issues surrounding health insurance premiums and medical costs, it is important to look at recent history, particularly the decade of the 1990s when premium growth was well below historical trend and stable for several years, contributing toward economic growth and growth in coverage. We know from this experience that health plans can hold down premiums when they are able to use care management tools to reward the delivery of high quality, appropriate and efficient care.

In today's health care system, we face new challenges – most notably, rapid increases in the unit price of medical services – that are contributing to higher health care costs. In fact, according to the 2008 National Health Expenditures (NHE) report issued in January 2010, price increases constituted two-thirds of the year-over-year increase in health spending. Specifically, of the 4.6 percent annual increase in personal health expenditures reported in 2008, price accounted for 3.1 percentage points, while 1.5 percentage points was driven by non-price factors. The NHE report



also indicated that for 2008, health insurance premiums increased at 3.1 percent, approximately one-third below the increase in total health spending.<sup>3</sup>

Further evidence of the changing impact of price increases on premium rates can be found in a February 2010 article<sup>4</sup> published on-line by *Health Affairs*. In this article, authors Paul Ginsburg and Robert Berenson (both with the Center for Studying Health System Change) noted that “providers’ growing market power to negotiate higher payment rates from private insurers is the ‘elephant in the room’ that is rarely mentioned.” To that end, the authors note that in some cases payment rates to hospitals and physician groups approach or exceed 200 percent of the amount paid by Medicare. This concern is reinforced by the following examples of unsustainable cost increases we have uncovered through AHIP research and discussions with our members:

- One AHIP member operating in a large state reported facing hospital rate increases ranging between 7 percent and 90 percent, with the average request at 29 percent.
- Another AHIP member reported that a “must have” hospital was demanding a 40 percent increase in payment and insisting on contractual terms that would prohibit the plan from sharing the facility’s quality information with consumers.
- Another AHIP member reported that a hospital in suburban New Jersey – the only hospital in its community – is demanding that health plans pay an extra 15-16 percent to compensate for Medicaid and Medicare payments that are rising by 4-5 percent less than the hospital’s costs.
- A hospital in the Northeast charges health insurance plans 50 percent more than it charges the plan owned by its own hospital system.
- Charges for a colonoscopy vary widely among three hospitals in a 20-mile radius in California – with no apparent linkage to quality – with the minimum typical price ranging between \$2,192 and \$3,786 and the maximum typical price ranging between \$2,590 and \$4,185.<sup>5</sup>

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<sup>3</sup> *Health Affairs, Health Spending Growth at Historic Low in 2008*, Hartman

<sup>4</sup> *Health Affairs, Unchecked Provider Clout In California Foreshadows Challenges To Health Reform*, by Robert Berenson, Paul Ginsburg, and Nicole Kemper, February 2010

<sup>5</sup> Based on data from Anthem Care Comparison Tool

- An August 2009 AHIP survey<sup>6</sup> of out-of-network fees found that a patient in Arizona was charged \$72,000 for lower back spinal fusion when Medicare's fee was only \$1,683; and for total hip replacement surgery, a patient was charged \$45,601 when Medicare's fee was only \$1,431. A patient in California was charged \$15,870 for cataract surgery when Medicare only pays \$638.

In the face of these exploding costs, our members are deploying the next generation of medical management tools to promote a high-value health care system, including:

- Targeting disease management services to enrollees who stand to benefit the most from proactive interventions;
- Working with primary care physicians to expand patient-centered medical homes that promote care coordination and accountability for clinical outcomes;
- Providing incentives to promote the use of decision-support tools and health information technology;
- Providing quality improvement reports for physicians to monitor their progress in managing disease;
- Offering personalized risk assessments and wellness programs;
- Encouraging electronic prescribing and consumer safety alerts;
- Providing peer-to-peer comparisons to demonstrate the appropriate use of health care services across specialists and manage the use of high-cost imaging services.

Many of the quality programs and innovative initiatives being implemented in various markets across the country by the private sector would improve the delivery of care and patient outcomes in a more timely and efficient manner if public programs were part of the local initiatives. Expanding these programs to encompass the full health care system – both public and private payers – is an important step toward identifying gaps in care, pursuing opportunities for improvement, and evaluating innovations so adoption can occur more broadly.

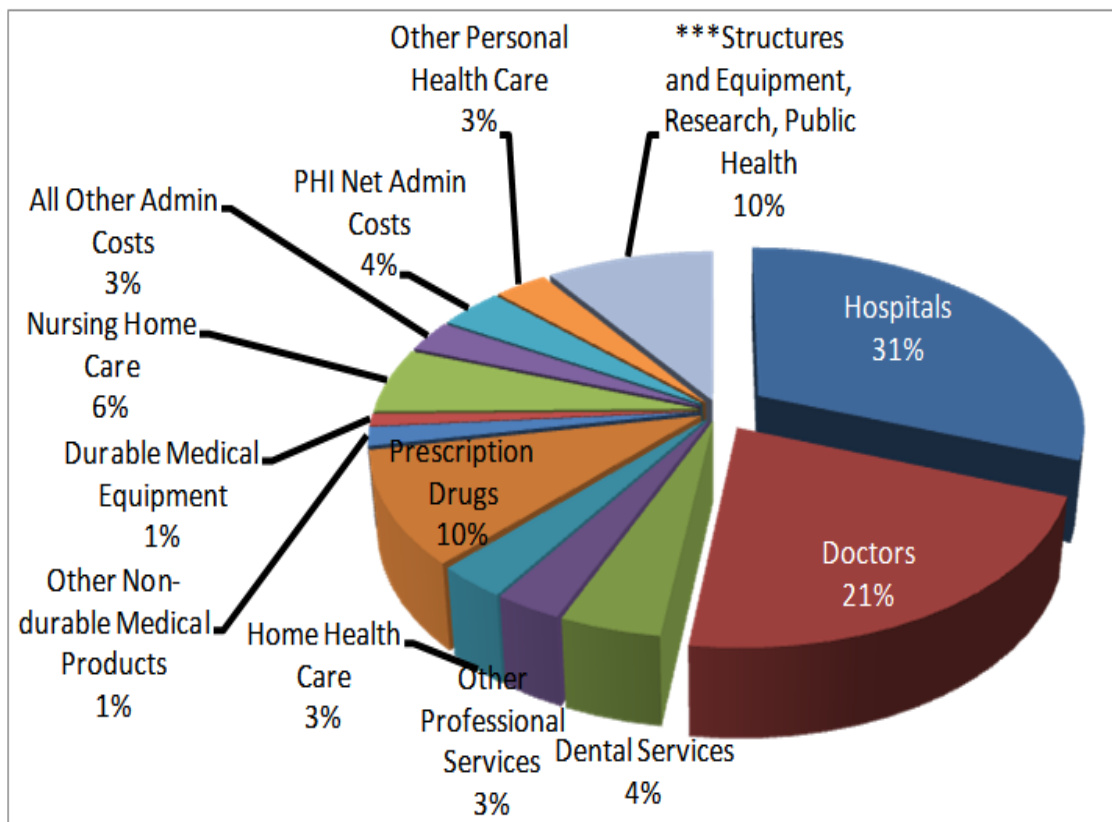
While our members are taking aggressive steps to address the cost crisis, a discussion of premiums needs to look at all components of expenditures. The chart shown below, based on

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<sup>6</sup> AHIP, *The Value of Provider Networks and the Role of Out-of-Network Charges in Rising Health Care Costs: A Survey of Charges Billed by Out-of-Network Physicians*, August 2009

annual national health expenditure data published by the Centers for Medicare & Medicaid Services (CMS), indicates that the costs associated with health insurance – including plan profits and administrative costs – account for only four percent of all national health expenditures. The other 96 percent of costs can be attributed to hospitals, physicians, pharmaceuticals, home health care, and other components of health care spending.

## Components of National Health Spending



Source: CMS National Health Expenditure Data, Projections for 2009

## How Are Premiums Built?

Health care costs are impacted by a number of direct cost drivers including:

### **Factors Affecting Premiums**

- Price per service
- Utilization of services
- Adverse selection
- New medical technology
- Cost-shifting
- State insurance taxes and fees
- Assessments for high-risk pools
- Regulatory compliance
- Aging of the population
- Unhealthy lifestyles

- **The price per service** (as discussed in detail above) is the cost charged by medical providers, such as doctors, hospital and pharmacies, for a particular service. The amount providers charge varies greatly, according to the provider's location, how the group is structured and organized, and how many other providers are located nearby. Lack of competition and shortages of health care providers are significant factors in a number of markets where consolidation among hospitals and other providers is increasing costs and health plans are facing higher rate increases from hospitals and medical groups with dominant positions.
- **The utilization of services** refers to the amount of medical services that are used. Increased utilization drives costs higher.
- **Adverse selection** is what occurs when less healthy individuals stay in the market while healthy individuals and families drop coverage. Moreover, at a time when many small businesses are financially strained because of the weak economy, our members are observing

that some companies with young, healthy workforces have stopped offering coverage. Another related trend is that as it becomes more difficult for employers to continue offering coverage, some are forced to reduce the portion of the premium they cover and increase employee cost-sharing. In response to these decisions, more employees – usually those with below average health costs – are declining to participate. The net impact of these developments is that some employers may find it less viable to offer coverage or costs may rise as the remaining risk pool is more heavily weighted with older, less healthy persons, resulting in higher average costs per enrollee for those who maintain coverage.

- **Cost shifting** occurs, from public programs to private payers, as a result of reimbursement rates that Medicare and Medicaid pay to hospitals and physicians, which often fail to cover the cost of providing health services. According to a December 2008 Milliman study<sup>7</sup>, an average family of four already pays a hidden tax of more than \$1,700 annually on their premiums because Medicare and Medicaid significantly underpay hospitals and physicians, compared to their actual costs of delivering medical care. To offset these inadequate payments, providers pass on higher costs to individuals, families and employers in the private sector. Additional cost-shifting results from uncompensated care provided to the uninsured. According to a May 2009 Families USA study<sup>8</sup>, the cost-shift associated with uncompensated care adds more than \$1,000 annually to family premiums.
- **State fees and taxes, assessments for high-risk pool programs, and the costs of complying with regulatory requirements** also contribute to the cost of health insurance coverage. As we discuss below, the “Patient Protection and Affordable Care Act” includes a number of provisions that regardless of their public policy merit will ultimately increase the cost of coverage.

#### **IV. How are Premiums Evaluated at the State Level**

States generally have the authority to examine and regulate rates, either through a specific grant of authority or through their authority to regulate unfair practices. This authority meets states’

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<sup>7</sup> Milliman, *Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid and Commercial Payers*, December 2008

<sup>8</sup> Families USA, *Hidden Health Tax: Americans Pay A Premium*, May 2009

obligation to assure that not only are consumers charged fair premiums, but also that insurers remain solvent and are able to pay future claims.

Rates must be adequate to cover the costs of medical care utilized by insured members, and administration of health insurance services (enrollment, customer service, claims processing, care management and quality review, etc.). Additionally, rates must be adequate to assure that health plans remain solvent to meet the promises of paying claims, and meeting customers' expectations by having adequate reserves on hand to meet those obligations.

Insurance regulators want premiums to be:

- Financially sound – able to pay claims and costs, and allow insurers to remain solvent;
- Fair and reasonable – in relation to the benefits offered, thus ensuring value for consumers; and
- In compliance with the rules – incorporate states' consumer protections embodied in states' rating rules and standards.

Before offering any product to consumers, virtually every state requires the policy form and the related rate structure to be filed prior to sale. These requirements apply to both individual and small group health insurance policies. The vast majority of states regulate small group rates by way of requiring an actuarial certification that the insurer is in compliance with the rate band requirements that are the law in most states. And every insurance department has the authority to conduct market conduct exams to assure compliance.

Health insurance premiums tend to be more actively monitored than other lines of insurance. The majority of states have some form of "file and use" standards for health insurance premiums for rate changes. What this means is that insurers must file rates prior to use, with approval deemed after the expiration of the review timeframe (generally 30 to 60 days), to allow the regulators time to discuss questions or concerns they have about the filing – which includes actuarial and trend data supporting the requested rate change – with the plan.

Prior approval states are challenged to meet timeframes of review, often taking significantly more time than the timeframes for "file and use" rates – sometimes taking more than a year to finalize review of rates. This is exacerbated by the states' own financial challenges – budget cuts throughout the nation have reduced state government budgets and staff. The National

Association of Insurance Commissioners has noted<sup>9</sup> that prior approval “can be a very labor intensive and expensive process” because it adds costs and delays to the system, which creates unintended consequences for consumers. We also have seen an increasingly political approach taken in these reviews with efforts to cap rate increases, without taking into account all of the factors that premium rates reflect.

Capping rates only delays the increase needed and compounds the subsequent increases. Regulators who establish artificial caps on premium rates that do not reflect the underlying components place health plans in jeopardy of weakened financial conditions, creating larger fluctuations in premiums and needless volatility for consumers.

## **V. What Changes Under the New Law**

The debate leading up to passage of health care reform ultimately became framed as a need for insurance market reform and greater regulation of health plans, creating legislation disproportionately focused on health plans, which make up *only* 4 percent of national health expenditures, and doing little to address the underlying drivers of health care costs, which have a substantial affect on premium increases.

The extent of this new regulation is illustrated in the chart on the following page. As the illustration demonstrates, the new legislation affects every part of health plan operations, will add new layers of regulation *on top of* the regulatory framework that already exists at the federal and state levels. A second chart appended to our statement illustrates the full impact of this point. What is necessary now is not further legislation aimed at only 4 percent of the health care system, but broader consideration of the other 96 percent.

The point of these charts is to illustrate how the new law has capped health plan administrative costs and profits and regulated every part of health plan operations. In addition, the medical loss ratio (MLR) provision called for in the new law already serves as a direct form of rate regulation. While great care is required in implementing this provision in order to avoid significant disruptions in coverage and instability, particularly in the individual market, during the period

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<sup>9</sup> Letter from NAIC CEO Dr. Terri M. Vaughan to Chairman John Dingell, February 23, 2010



## Impact of Health Reform on Health Plan Operations

### New Regulations on Operations

*Caps on Medical Loss Ratios*  
PHSA  
Sec. 2718

*Prohibitions on Lifetime Limits*  
PHSA  
Sec. 2711

*Regulated Annual Limits*  
PHSA  
Sec. 2711

*Guaranteed Issue*  
PHSA Sec.  
2702

*Guaranteed Renewability*  
PHSA  
Sec. 2703

*Premium Rate Review*  
PHSA  
Sec. 2794

*No Preexisting Condition Exclusion or Discrimination*  
PHSA  
Secs. 2704 & 2705

*Regulation of Waiting Periods*  
PHSA  
Sec. 2708

*New Federal Appeals Process*  
PHSA  
Sec. 2719

*Regulation of Grandfathered Plans*  
PPACA  
Sec. 1251

*No Health StatusRating*  
PHSA  
Sec. 2701

*Regulation of Rescissions*  
PHSA  
Sec. 2712

*Quality Reporting Requirements for Coverage & Provider Reimbursement*  
PHSA  
Sec. 2717

*Standards for Health Data and Information Systems*  
PPACA  
Sec. 1104

### New Regulations on Product Design

*Required Essential Health Benefit Package*  
PPACA  
Sec. 1302

*Required Preventive Services*  
PHSA  
Sec. 2713

*Required Uniform Summary of Benefit and Coverage Documents and Standard Definitions*  
PHSA  
Sec. 2715

*Required Emergency Room Services Coverage*  
PPACA  
Sec. 1301

*Required Dependent Coverage*  
PHSA  
Sec. 2714

*Required Coverage for Approved Clinical Trials*  
PHSA  
Sec. 2709

*Federal Standards for 'Qualified' Health Plan*  
PPACA  
Sec. 1301

### New Required Fees and Taxes

*40% Excise Tax on High Cost Plans*  
IRC  
Sec. 4980I

*Annual Fee on Health Insurance Providers*  
PPACA  
Sec. 9010

*Pass-Through of Manufacturers' Fees*  
PPACA  
Secs. 9008 & 9009

*Limitation on Deduction for Compensation for Health Insurance Executives*  
PPACA  
Sec. 9014

*Risk Corridor Payment Adjustment System*  
PPACA  
Sec. 1342

*Payment for Reinsurance Program for Individual Market*  
PPACA  
Sec. 1341

*Fees to Fund Comparative Effectiveness Research*  
IRC  
Secs. 4375, 4376, and 4377

*Tax Treatment for Certain Health Organizations*  
PPACA  
Sec. 9016

\* Requests for comments for these consumer protection provisions were issued in the April 14, 2010 Federal Register.

Note: There are many provisions within the PPACA which, although not explicitly granting the Secretary of a federal agency regulatory authority, will require the federal agencies to issue regulations pursuant to its general regulatory authority. We are also aware that conforming regulations will likely be issued across several federal agencies.

Note: PPACA is the Patient Protection and Affordable Care Act as amended by the Health and Education Reconciliation Act of 2010; PHSA is the Public Health Services Act as amended by the PPACA; and the IRC is the Internal Revenue Code as amended by the PPACA.



prior to the creation of the exchanges, the MLR provision needs to be viewed in tandem with the new premium review provisions also in the law.

The new law requires the HHS Secretary and the states to work together to establish a process for the annual review of “unreasonable increases” in premiums and requires public justification and disclosure prior to the implementation of the increase. In addition, the legislation establishes a grant program that will provide the states the assistance they need to implement these requirements.

Implementation will require that these terms be defined, with the opportunity to do so in a way that ensures a consistent standard of review throughout the country, takes into consideration all of the factors that drive premiums and must be considered in order for rates to be considered actuarially sound, and provides transparency on all of these factors to improve public confidence in the process. Advancing the principle of transparency should also entail steps to focus similar attention to the rates in other health care sectors. As noted above, virtually all states have the authority to examine rate increases to ensure that they are actuarially justified, and implementation of the grant program along with the requirement that all states conduct an annual review in conjunction with the Secretary will work to ensure that there is a rate review process across the country.

The net effect of these provisions is that health plan spending as it relates to administrative costs and profits is capped, and that “unreasonable increases in premiums” will be reviewed annually, with the important caveat that the term “unreasonable increase” needs to be clearly defined in relation to actuarial soundness lest this standard encourage an arbitrary process of review that diverts attention from the real issues driving health care costs.

Looking further down the road, the new premium tax and the high-value health plan tax will further increase the cost of coverage in future years.

#### Cautionary Tales from Massachusetts and California

Massachusetts and California provide high profile examples of a public discussion about insurance rates entirely delinked from an examination of the factors driving these rates.

In the case of Massachusetts, a comprehensive and in-depth report from Attorney General Martha Coakley recently reported two findings: that the market leverage of providers was leading to higher prices, without any noticeable difference in quality; and that increases in the price of health care services had caused most of the increase in health care costs – not utilization.

Nonetheless, state regulators have placed arbitrary caps on premium increases without taking these factors into account. By focusing just on regulating premiums, the policymakers in Massachusetts are missing an opportunity to bring increases in underlying medical costs under control. Thus, even if policymakers force premiums down through legislative action, individuals, families and employers, as the *Boston Globe* correctly notes, will still “confront ballooning levels of reimbursements for providers.”

The situation of provider consolidation leading to higher premiums is not unique to Massachusetts. In fact, the *Health Affairs* article we mentioned earlier, authored by Robert Berenson and Paul Ginsburg, analyzes the affect of providers' growing market power and using this power to negotiate higher payment rates from private insurers in California. Berenson and Ginsburg cautioned that “provider dominance could offset some or all of the potential of reforms to lower premiums through increased efficiency in delivery.” While there has been considerable discussion of specific premium increases proposed in California, there has been little national discussion about the implications of the findings in the *Health Affairs* article and how these factors might be a root cause of the reported increases.

Capping premium increases without looking at the underlying components is similar to capping the prices auto makers can charge consumers, while allowing the steel, rubber, and technology manufacturers to charge the auto makers whatever they want. This will lead to financial instability throughout the system. What has occurred in Massachusetts is a politicization of processes related to premium review and approval, creating benchmarks for review that do not reflect the underlying cost drivers. Setting arbitrary caps on premiums does nothing to cure the root causes of health care price increases, according to a 2004 study<sup>10</sup> done for the California HealthCare Foundation. Similarly, a February 2010 Milliman report<sup>11</sup> makes the point that “simplistically limiting premium rate increases to some predetermined inflation index fails to recognize the fundamental elements involved in setting health insurance rates, and would likely have severe consequences within a short period of time.” These serious consequences involve

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<sup>10</sup> California HealthCare Foundation, *Should California Regulate Health Insurance Premiums?*, March 2004

<sup>11</sup> Milliman, *The Difficulty of Legislating Premium Rate Increases*, by Jonathon Shreve, February 2010

significant long term risks for health plan solvency, competition in the market, and the availability of coverage choices.

## **VI. Principles for a Workable System**

*States Are the Appropriate Venue for Review:* The expertise and resources for considering rates lies at the state level and state standards and processes are at the core of the country’s regulatory system for safeguarding solvency as explained above. As such, the new health care reform law recognizes that states properly serve as the primary regulators for health plan activities, subject to new and consistent federal standards impacting a wide range of activities, including annual rate review.

States are responsible for establishing solvency requirements for health plans to operate across the country and have long developed and maintained an underlying system and structure of regulation that has helped to protect the public – even in the face of extremely challenging economic times – from significant incidences of health plan insolvency. Indeed, one of the most important protections states provide consumers is to ensure that health plans maintain financial stability to ensure that beneficiaries can receive benefits. Health plan solvency also is important to providers, who rely on insurers having the financial wherewithal to pay claims.

Separating financial solvency from rate review, as would occur if rate review occurred principally at the federal level, would create a significant risk of financial instability. At the same time, federal rate review would do nothing to address the underlying factors driving health care costs.

*Actuarial Soundness:* It is essential to maintain and protect the critical link between the creation of premiums and “actuarial soundness,” that is, the development of rates that are reasonable in relation to the benefits provided and that ensure solvency, taking into account factors such as the underlying medical costs and trends facing a particular health plan, adverse selection, benefit plan changes, and demographic changes in the population covered. We are committed to working with the NAIC to ensure that actuarial certifications that accompany rate filings are required to be prepared in accordance with generally accepted actuarial principles, that the

components of rate increases are clearly presented, and that states undertake a review of underlying cost trends and provider consolidation.

*Transparency:* To increase public confidence, information should be disclosed about rates and their composition, without undermining competition, and we are taking the steps described below to support this objective. Parallel requirements should be imposed on other health care sectors with respect to their rates and associated underlying components that highlight both the utilization and unit cost-related elements of those charges.

The new law adds to an existing regulatory structure that places primary enforcement authority with the states, but that gives the federal government the authority to step in if a state is not substantially enforcing federal standards. How these new provisions are implemented will be an important determinant of whether new regulations and requirements improve confidence with respect to the operation of health plans without increasing costs, reducing choices, or creating solvency issues throughout the system. The real question, therefore, is not whether additional legislation is needed to further address the operation of 4 percent of the health care sector as a percentage of total spending, but whether policymakers will now broaden their focus to address sectors accounting for the remaining 96 percent of our health care system.

*Allowing Implementation to Proceed:* There are significant provisions in the “Patient Protection and Affordable Care Act” that should be given time to be implemented and evaluated.

### **Additional Steps Health Plans Are Taking**

Following a meeting between Secretary Sebelius, the President, NAIC leadership, and the CEOs of five health plans, the Secretary on March 8 addressed a letter to the company representatives asking them to make information on rates and rate increases transparent. She requested that these companies publicly display information regarding, among other things:

- the drivers of rate increases;
- the number of individuals impacted by rate increases;
- the estimates on medical costs and utilization increases and the assumptions behind them;
- explanations of what the companies are doing to control premium increases; and
- medical loss ratio information for each premium increase.

The companies all agreed to accept the challenge to make information regarding premiums, cost drivers and premium increases transparent in a way that would be meaningful and understandable both to health plan enrollees and to policymakers, and to work with the NAIC as they do so. A detailed template is under development for explaining the factors that go into premiums, the factors that go into premium increases, and the steps companies are taking to control costs and increase quality. To ensure that this information is complete and informative, we are working with company actuaries from a broad array of health plans of all sizes and models as well as the insurance commissioners.

## **VII. Unmet Challenges**

To succeed on a long-term basis, health reform ultimately must include bolder steps to achieve system-wide cost containment. We believe this can be achieved with a more comprehensive effort to reduce the rate of increase in costs, better alignment of public and private sector payment reform efforts, and broader medical malpractice reform. Perhaps most important, we believe that efforts to reduce costs are complementary to our nation's effort to improve quality as policymakers attempt to drive greater value in the delivery of care. Focusing only on premiums and not the components that are driving premiums makes little sense.

In California, a similar effort was made to cap prices charged by energy distributors and ignore supplier costs, leading to "brownouts" and reduced service for consumers. Health plan enrollees may face a similar outcome if Congress attempts to reduce the soaring costs of medical care by regulating premiums. The current situation in Massachusetts offers important lessons about the significant disruption that can occur if a premium review process disregards the linkage between the components driving premiums and the premiums themselves.

## **VIII. Conclusion**

Thank you for this opportunity to testify. Our members remain strongly committed to working with the committee to ensure the successful implementation of the new health reform law, while also working to slow the growth of underlying medical costs to make health insurance more affordable.



# SUMMARY OF HEALTH INSURANCE PLAN REGULATION

