GEORGETOWN UNIVERSITY

HEALTH POLICY INSTITUTE

Addressing Insurance Market Reform In National Health Reform

Statement of

Karen Pollitz, Research Professor
Georgetown University Health Policy Institute

Committee on Health, Education, Labor, and Pensions

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Mr. Chairman and Members of the Committee,

Thank you for inviting me to testify on opportunities to strengthen health insurance markets in health care reform. My name is Karen Pollitz. I direct the study of private health insurance and its regulation at Georgetown University's Health Policy Institute.

A program of health reform to guarantee universal coverage including through private health insurance will need to address several key shortcomings of private markets today. These include:

1. Discrimination based on health status and risk selection
2. Inadequate coverage
3. Affordability challenges for low- and middle-income people
4. Rising costs
5. Lack of transparency and accountability

Part of the solution to these problems will lie in strengthening and reorganizing private health insurance markets to produce the coverage results we seek. A health insurance Exchange – sometimes referred to by other names, such as "Connector" – can be established to pursue the goals of reform and to hold markets accountable for progress toward those goals.

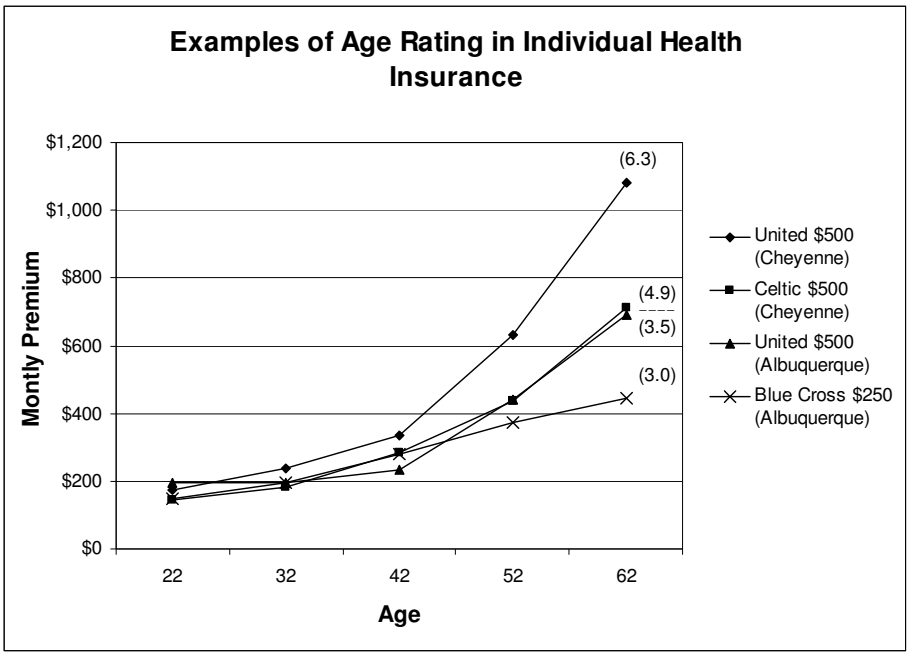
<u>Promote risk spreading and stability</u>

It has long been true that approximately 20 percent of the population accounts for 80 percent of health spending. The sickest one percent account for nearly one-quarter of health expenditures. We rely on health insurance to spread costs more evenly across the population and protect all of us from the risk that we may find ourselves in need of expensive care in any given year. Unfortunately the distribution of medical care needs creates a powerful economic incentive to avoid risk, not spread it. Discrimination based on health status is a problem for all health insurance purchasers, although most pronounced in the individual market today. Even consumers with mild conditions may be turned down, charged more, or offered a policy with permanent coverage exclusions. More expensive health conditions such as cancer, diabetes, pregnancy, will always render a person uninsurable in medically underwritten individual markets.

Risk avoidance practices continue even after coverage is issued. Last summer, the House Committee on Oversight and Government Reform studied problems relating to post-claims underwriting and rescission. Individual market policyholders who make claims in the first year of coverage may be investigated for evidence their health condition was pre-existing or not fully disclosed during the initial medical underwriting process. Claims may be denied or coverage cancelled or rescinded as a result. Although these practices are intended to protect against fraud, abuses have also been documented.[1]

Stability and long term affordability of coverage is also highly problematic in the individual market today. Typically people remain enrolled in policies for less than two years.[2] High rates of turnover result from several factors. In general, the individual market today is a residual market and unsubsidized, so participants tend to leave as soon as they regain eligibility for subsidized job-based or public coverage. However, for those who must remain longer, various market practices encourage churning or make it increasingly unaffordable to remain covered.

Age rating makes it difficult to afford coverage over time. Insurers typically charge people in their early sixties three to six times the premium for people in their early twenties. The slope of this age climb varies, but often age adjustments are modest for young adults, becoming more pronounced for people in their fifties and early sixties, not coincidentally, when the incidence of many high cost medical conditions also increases.



Parenthetical number by 62-year-old premium indicates multiple of 22-year-old premium
Source: ehealthinsurance.com. Quotes for male, non-smoker, March 18, 2009

Durational rating is used by many insurers to increase premiums based on the tenure of the policyholder. The predictive power of medical underwriting wears off over time; policyholders who were young and healthy when they first applied for coverage tend not to remain that way. By applying tenure surcharges, insurers encourage those enrollees who are still healthy to apply for new coverage, and resubmit to medical underwriting, in order to hold premiums down. This practice has the effect of segregating policyholders who have gotten sick, forcing their premiums even higher.

In a related practice, insurers may introduce new policies into the marketplace every few years, leaving older policies in force but no longer actively marketed. With freshly underwritten applicants diverted to new policies, the claims experience of the "closed" policies deteriorates, driving up premiums. People healthy enough to leave the closed block will do so, further escalating premiums for those with health problems who are stranded.[3]

A recent health insurance survey of family farm and ranch operators, who rely disproportionately on the individual health insurance market, found high rates of financial burden due to these kinds of market practices.[4]

How reform can help – Congress can and must change the rules of the health insurance marketplace so that insurers no longer compete on the basis of risk selection, but instead, on the basis of efficiency and customer service. All policies should be sold on a guaranteed issue basis.

Premiums should be determined based on community rating.[*] Pre-existing condition exclusions should end. Federal minimum standards for health insurance should be strengthened so that these protections apply to all types of health coverage. Vigorous oversight to ensure compliance is also essential.

Assure coverage adequacy

Under-insurance is a serious and growing problem. In 2007, 57 million Americans lived in families struggling with medical debt – a 33 percent increase since 2003 – and 75 percent of them had health insurance.[5] Policies that fail to cover key benefits, such as prescription drugs, maternity care, and mental health care, can leave people under-insured. Likewise, caps on covered benefits leave patients at risk for catastrophic medical expenses. High deductibles, co-pays, and other cost sharing are also problematic.

In an effort to offset rising premiums and stem coverage loss, the content of coverage under many health insurance plans and policies has eroded steadily. However, this strategy has proven to be ineffective. Coverage erosion leaves the under-insured in circumstances very similar to the uninsured – they forego or delay needed medical care due to costs, experience poorer quality care, and suffer financial burdens.[6]

Coverage adequacy is particularly important for patients with chronic conditions. Even modest co-pays for services can accumulate to burdensome levels for patients who need medical care and prescriptions on a regular basis. For example, a study of the effect of doubling prescription drug co-pays – from $6 to $12 for generic drugs and from $12 to $25 for brand name drugs – found that patients with diabetes, hypertension, and depression reduced use of their respective medications by nearly one-quarter.[7] Failure to properly manage chronic conditions often leads to the development of more serious and expensive medical complications. Under-insurance among the chronically ill should be viewed as a threat to public health. There is also evidence high cost sharing is exacerbating collections problems and fueling bad debt for hospitals and doctors.[8]

How reform can help - A key goal of health reform must be to ensure that all people have adequate coverage. Minimum standards for what health insurance covers must be developed and explicitly take into account what insured patients will be left to pay out of pocket when they need medical care. Research finds that when out-of-pocket spending for health care services exceeds just 2.5 percent of family income, financial pressures on families from medical bills increase dramatically. Financial burdens arise for low-income families at even lower levels of out-of-pocket spending.[9] Accordingly, the design of all health insurance plans and policies must consider the care needs of patients with cancer, diabetes, heart disease and other serious medical conditions. Coverage for care needs of people when they are healthy – primary and preventive care services and maternity care – must also be included. Cost sharing must be held to modest levels and further subsidized for low-income individuals.

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[*] As an alternative, some have suggested modified community rating that would allow premium adjustments for age but not health status. Because income generally increases with age, it is argued, age adjustments would be more equitable. However, income does not rise nearly as fast with age as do health insurance premiums. For example, median household income at age 55 is only 30% higher than for age 25. By contrast, under age rating, a 55-year-old's health insurance premium could be surcharged by a factor of 2 to 5. If modified community rating is adopted and income equity is a goal, premium subsidies will need to reach farther up the income scale for individuals as they age. Age rating is also problematic because age strongly correlates to health status. The incidence of many chronic conditions increases steadily with age. As a result, age rating will tend to disproportionately surcharge premiums for people with heart disease, cancer, and other conditions. If age rating is permitted, at a minimum, its impact on affordability of coverage for the chronically ill will need to be closely monitored.

A condition of insurer participation in a health insurance Exchange must be the offering of policies that meet minimum coverage standards. The elimination of substandard coverage options will not only address the problem of under-insurance, it will reinforce risk spreading. When all policies provide adequate coverage, people will not sort themselves by risk status across plans that offer widely varying levels of insurance protection.

Assure affordability

Overwhelmingly, the uninsured lack coverage today because they cannot afford it. Most uninsured have incomes below twice the federal poverty level. Significant assistance is needed to make coverage affordable. As just discussed, artificially depressing premiums by offering substandard policies will not help.

Affordability must be measured against the cost of comprehensive coverage. Job-based group health plans offered by large employers today suggest one benchmark for the likely cost of adequate coverage. Such plans currently cost approximately $4,800 per year for self-only coverage and $13,000 for family coverage.[10]

How reform can help - Subsidies are essential to make coverage affordable for millions of uninsured Americans. Defining affordability will certainly entail some subjective judgments. However, economic studies of consumer spending suggest health insurance may be affordable for middle income families as long as premiums do not exceed 4 to 8 percent of household income, with lower affordability thresholds for lower income families.[11] A similar standard has been adopted by the state of Massachusetts in determining its premium subsidies and affordability index, and as a result, subsidies for both premiums and cost sharing are available for individuals and families with income to 300 percent of the poverty. Residents with income to 500 percent of poverty are ineligible for subsidies but may receive a waiver of the requirement to buy health insurance on grounds of affordability.

Cost containment

Since 1999, employer-sponsored insurance premiums have more than doubled, well outpacing inflation and the rise in earnings.[12] In 2007 total national health expenditures reached $2.2 trillion, or more than $7,400 per capita and more than 16 percent of GDP.[13] All indications are that unless we take action through health care reform, health spending will continue to rise at levels beyond what families, employers, and taxpayers can afford.[14]

In today's private health insurance markets, competition between carriers does not help control costs. Quite the opposite, data show there is a high degree of concentration among insurers, with just a handful of carriers accounting for the majority market share in most states. Insurers have not used their market power to negotiate favorable provider rates or otherwise control costs as might be expected; rather, they've passed on health care costs to consumers while increasing profitability at the same time.[15]

How reform can help - Health insurance markets can be better organized to generate new forms of competition and more effective cost containment strategies. First and foremost, once all policies meet standards for comprehensive coverage, it will be easier for consumers to shop on the basis of price prompting insurers to behave more cost effectively.

As is the case in Massachusetts, the Exchange could also be given authority to negotiate with health insurers over premiums and to exclude the least efficient and effective carriers from participation. The Exchange might also adopt minimum loss ratio targets, adopt standards for broker commissions, and institute other expectations of efficiency to lower health insurance administrative costs.

Importantly, a public health insurance plan option should also be offered to heighten competitive pressures to contain costs. A public health insurance plan can substantially influence market innovation by investing in new approaches to disease management or more effective use of information technology. Such innovations should be freely shared with other insurers so they could adopt them at lower cost. A public health insurance plan also could induce other insurers to be tougher price negotiators with providers.

The issue of a public health insurance plan option has prompted concern that it would constitute unfair competition with private insurance companies, and might even result in the elimination of private insurers over time. However, experts suggest a different outcome seems as or more likely because a public health insurance plan will face other unique constraints. In particular, health care providers have been formidable in their exercise of political pressure to oppose payment rate cuts under Medicare, as evidenced by Congress' vote to prohibit Medicare from negotiating prescription drug price discounts under the Part D program. While a public health insurance plan will likely enjoy some cost advantages over private insurers, political constraints will prevent it from exploiting those advantages.[16]

In addition, it is important to remember how private insurers have benefited from public programs by shifting costs to them. Thanks to Medicare, the private market no longer finances most medical care for the elderly and disabled, nor for patients with ESRD and ALS. Medicaid eligibility categories now include women with breast and cervical cancer who are under-insured for this care. Three-fourths of states have opened high-risk pools for uninsurable residents whom private insurers refuse to cover. In 2000, Minnesota's attorney general found private health insurers were shifting to taxpayers the cost of mental health care it contracted to provide its beneficiaries by forcing policyholders, through claims delays and denials, to turn to public programs for mental health care.[17] Offering a public health insurance plan option also ensures that the sickest patients will always have a source of affordable, adequate health coverage in the event that some private insurance companies do not immediately cease cost avoidance activities.

<u>Transparency and accountability</u>

Finally, transparency of information is critical in a competitive market where consumers have choices. Lack of transparency promotes inefficiency and bias in consumer choices.[18] Health insurance policies are complex and confusing for consumers, who often do not understand what type of coverage they have or how it works.[19] One industry survey found than less than one-fourth of consumers understand the terminology in their health insurance contracts; and rather than try to read their policy, most would prefer to prepare their income taxes or go to the gym.[20]

Greater transparency in market behaviors will also be needed to ensure accountability. Compliance with market rules must be closely monitored and enforced if we want insurers to cease competition on the basis of risk selection.

How reform can help - In an organized marketplace, there can be rules to ensure that insurance products are understandable. One important task of an Exchange must be to provide more and better information about health insurance than most consumers have today. The Commonwealth

Connector, for example, designates types of health insurance plans as gold, silver, and bronze to make it easier for consumers to compare across option. In addition, the Connector makes available plan comparison tools that highlight differences in key plan features such as deductibles, co-pays, and benefit limits.[21] Members of Congress and other participants in the Federal Employees Health Benefits Program (FEHBP) have on-line access to full health insurance policy language for each available plan option. Under health reform, the Exchange should require all health insurance policies to be available for public inspection at all times in order to promote transparency.

If a goal of reform is to encourage health insurers to compete on the basis of efficiency, this information must also be readily available. In Washington state, for example, the Office of the Insurance Commissioner (OIC) makes available a Health Carrier Information Comparison tool with information about carrier loss ratios, profit margins and other characteristics to help consumers see how much of their premium dollars are spent on medical claims vs. administrative costs.[22] Health insurers should be required to disclose plan loss ratios including detailed information about administrative costs by type and amount. In addition, price transparency will help consumers and providers see and compare variation in prices (charged and allowed) for different health care services.

The Exchange should also collect data to hold health plans accountable for compliance with nondiscrimination rules. Insurer marketing, rating, and plan administration practices that might be used to evade such rules must be monitored. Disclosure must include data on applications, enrollment and disenrollment by plan, including demographic and health status characteristics. Rating of policies at issue and renewal must also be monitored. In addition, it will be important to track claims handling practices, including payment denials and delays, with detail disclosed on type of service and patient diagnosis. Data on grievance and appeals procedures and outcomes will also be needed.

In recent months, accountability and transparency have become watchwords in our effort to strengthen financial markets and the economy generally. These themes must also apply to health insurance and guide your efforts on health care reform.

Notes

[1] See Committee hearing transcript at http://oversight.house.gov/story.asp?ID=2089. See also Girion, L., "Health insurer tied bonuses to dropping sick policyholders," *Los Angeles Times,* November 9, 2007.
[2] "Individual Health Insurance: An Update" Henry J. Kaiser Family Foundation, August 2004. http://www.kff.org/insurance/7133.cfm
[3] "On their own," *Consumer Reports*, January 2008. Available at http://www.consumerreports.org/health/insurance/health-care-on-your-own-1-08/overview/health-care-on-your-own-ov.htm.
[4] "2007 Health Insurance Survey of Farm and Ranch Operators" Issue Brief No. 3, The Access Project, September 2008. Available at http://accessproject.org/adobe/issue_brief_no_3.pdf
[5] Cunningham, P., "Tradeoffs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families, 2003-2007" Center for Studying Health System Change, Tracking Report No. 21, September 2008.
[6] Schoen, C., et al., "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs*, Web exclusive (June 10, 2008).
[7] Goldman, D, et al, "Pharmacy Benefits and Use of Drugs by the Chronically Ill," *Journal of the American Medical Association*, Volume 291, No. 19, May 19, 2004.
[8] See for example, "Hospital Strategies for Addressing Out of Pocket Expense," Healthcare Financial Management Association Roundtable, October 1, 2008. Available at http://www.allbusiness.com/company-activities-management/operations/11664702-1.html See also Cash, Cheryl, "Adding up the cost of high-deductible health care plans: Quality care, billing and collection challenges face many pediatricians as more families switch to consumer-driven health insurance," *AAP News,* Vol. 28, No. 1, January 1, 2007.
[9] Cunningham, P. et al, "Living on the Edge: Health Care Expenses Strain Family Budgets" Center for Studying Health System Change, Research Brief No. 10, December 2008.
[10] "Employer Health Benefits 2008 Annual Survey," Henry J. Kaiser Family Foundation and Health Research and Educational Trust, available at http://ehbs.kff.org/pdf/7790.pdf
[11] Blumberg, L., et al, "Setting a Standard of Affordability for Health Insurance Coverage" *Health Affairs* Web Exclusive, June 4, 2007.
[12] Kaiser Family Foundation - http://ehbs.kff.org/pdf/7790.pdf
[13] http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage
[14] http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf
[15] Robinson, J., "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs,* Vol 23, No. 6, November/December 2004.
[16] Holahan, J. and Blumberg, L., "Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?" The Urban Institute, 2008. http://www.urban.org/UploadedPDF/411762_public_insurance.pdf
[17] Hausman, K., "Insurer Admits Errors, Agrees to Implement Parity," *Psychiatric News* Vol. 36, No. 14, July 20, 2001
[18] Gabix, Xavier and Daibson, David, "Shrouded Attributes, Consumer Myopia, and Information Suppression in Competitive Markets," *The Quarterly Journal of Economics,* Vol. 121, No. 2, pp 505-540, May 2006. http://www.mitpressjournals.org/doi/abs/10.1162/qjec.2006.121.2.505
[19] Reschovsky, J., and Hargraves, J.L., "Health Care Perceptions and Experiences: It's Not Whether You are in an HMO, It's Whether You Think You Are," Center for Studying Health System Change, Issue Brief No. 30, September 2000.
[20] ehealth, Inc., "New Survey Shows Americans Lack Understanding of Their Health Coverage and Basic Health Insurance Terminology," January 3, 2008, available at http://www.marketwire.com/press-release/Ehealth-Inc-NASDAQ-EHTH-806855.htm
[21] See http://www.mahealthconnector.org
[22] See https://fortress.wa.gov/oic/hcis/public/comparisonhome.aspx