Testimony
on
Addressing Insurance Market Reform
in National Health Reform

By

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I. Introduction

Senator Bingaman, Senator Enzi, and members of the committee, I am Karen Ignagni, President and 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 solutions for achieving health care reform and how insurance reforms are integral to this effort. We believe that legislation needs to be enacted and signed into law this year, and we are committed to playing a meaningful role in this debate. To that end, we have worked hard to bring tangible strategies to the discussion that will address market issues, make the system more affordable, and facilitate the modernization that needs to occur in the delivery of health care services.

In December 2008, the AHIP Board announced a comprehensive proposal for restructuring the health care system with these cornerstone goals: achieving universal coverage, reducing the future growth rate of health care costs, and improving quality of care.

The AHIP proposal is the culmination of three years of policy work by our Board of Directors, which has focused on developing workable solutions to the health care challenges facing the nation. It also responds to the concerns and incorporates the ideas that were raised by the American people during a nationwide listening tour we conducted last year as part of AHIP's "Campaign for an American Solution." This listening tour included roundtable discussions involving Americans from all walks of life, including people with and without insurance, small business owners and their employees, union leaders and members, elected officials, and community leaders.

Since June 2008, our Board has held eight in-person meetings and 11 conference calls, devoting hundreds of hours to the development of policy proposals for building a stronger health care

system. From the outset, our community has committed to a series of proposals that would transform the health care system. Our Board has made it clear that it does not view the status quo as acceptable, and it is deeply committed to helping this committee, the Congress, and the Administration achieve reforms that work and become the building blocks on which a uniquely American system can be built.

II. Insurance Market Reforms To Provide Affordable, Portable Coverage To All Americans

As this debate moves forward, we believe all participants in the health care system have a responsibility to play a leadership role in identifying strategies in their sectors that will allow the Congress to pass health care reform legislation that will work and that can be sustained.

Rather than build on the existing regulatory structure, we are proposing a fundamental overhaul that would bring all individuals into the system, and allow major changes to be made that would ensure that all Americans can obtain affordable health insurance and do so irrespective of their health care history. We are proposing a series of policy changes which, if implemented together, will ensure that no one falls through the cracks, that coverage will be portable, and that information will be given to consumers that they need and want. To achieve these goals, the following steps are necessary:

- **Helping to Ensure Portability and Continuity of Coverage for Consumers in the Individual Market**

  - **Ensuring that no one falls through the cracks by combining guarantee-issue coverage (with no preexisting condition exclusions) with an enforceable individual mandate:** For guarantee-issue to work, it is necessary for everyone to be brought into the system and participate in obtaining coverage. Achieving this objective will require specific attention to the mechanisms for making the mandate enforceable and will require coordinated action at multiple levels of government.

Indeed, the importance of combining guarantee issue with an enforceable individual mandate is borne out by research and experience from the states. For example, a report by Milliman, Inc. found that states that enacted guarantee-issue laws in the absence of an individual coverage requirement saw a rise in insurance premiums, a reduction of individual insurance enrollment, and no significant decrease in the number of uninsured.

- **Ensuring fairness in the tax code:** Currently, individuals purchasing insurance on their own cannot deduct expenses for health insurance coverage unless total health care expenses exceed 7.5 percent of adjusted gross income. This should be corrected to promote tax equity and help make health care more affordable whether coverage is obtained through an employer or the individual market.

- **Ensuring a stable market for consumers:** A broadly funded mechanism which spreads costs for high-risk individuals across a broader base needs to be put in place to ensure premium stability for those with existing coverage.

- **Ensuring that coverage is affordable for lower-income individuals and working families:** Refundable, advanceable tax credits should be available on a sliding scale basis for those earning less than 400 percent of the Federal Poverty Level (FPL), as discussed below.

- **Helping Small Business Provide Health Care Coverage More Affordably**

Small business owners find themselves in an increasingly difficult marketplace for health insurance because of constantly rising health care costs and the limited ability of most small businesses to bear risks, contribute a substantial share of costs, or support administrative functions. On March 9, AHIP's Board of Directors approved a policy statement outlining solutions to help small business based on the following three core principles:

- **Affordability**

  - **Essential Benefits Plan:** As discussed below, we propose the creation of new health plan options that are affordable for small employers and their employees. These "essential benefits plans" would be available nationwide and provide comprehensive coverage for prevention and wellness as well as chronic and acute care. In addition, these plans would be subject to state regulation, but would not be subject to varying and conflicting state benefit mandates that result in increased costs to small businesses (and that do not apply to the generally larger employers that enter into self-funded health care coverage arrangements).

  - **Tax Credits or Other Incentives to Assist Small Business:** We support the establishment of tax code incentives or other types of assistance that encourage both small business owners to offer coverage to their employees and employees to take up coverage. We recognize the special challenges, both administrative and financial, that small businesses face in offering contributions toward their employees' coverage. Providing assistance can encourage these contributions and help enable employees to take up coverage which improves predictability and stability in the small group market.

  - **Improving Coordination of Private and Public Programs Strengthens Small Group Coverage:** Premium or other assistance offered to low-income individuals and working families can be applied to and work with employer-sponsored coverage. This is important whether the assistance is provided through Medicaid, the Children's Health Insurance Program (CHIP), or other expanded programs designed to help individuals and families obtain coverage. Improved coordination allows workers to take up coverage offered by small businesses by leveraging both public and private sources of assistance, and benefits the firms' employees as a whole by increasing rates of participation in the small group plan.

- **Flexibility**

We are committed to working with the small business community to ensure that small businesses have access to a range of options and tools that better assist them in helping their employees obtain health care coverage. One size does not fit all, as the needs of diverse small firms vary greatly.

- **Micro-firms:** As an example, "micro-firms" (those with fewer than 10 employees) face special challenges in offering coverage. Statistics show that only about one-third of these firms offer coverage. This reflects the administrative, financial, and logistical challenges many micro-firms face in setting up and establishing plans and offering and contributing to their employees' coverage. To help these firms meet these challenges, enhanced tools could be developed that would allow those micro-firms that have found it impractical to offer coverage, to contribute to coverage purchased on a pre-tax basis by individual employees. As part of comprehensive health care reform, employees could then use these contributions to help purchase coverage in a reshaped health care system that combines an individual requirement to obtain coverage with reforms in the individual market.

- **One-stop information source:** All small firms will benefit from collaborative efforts between health plans and the public sector (e.g., insurance commissioners) to ensure that small employers and individuals have one-stop access to clear, organized information that allows them to compare coverage options. This one-stop shop could also allow individuals to confirm eligibility for tax credits or other assistance and even provide a mechanism to aggregate premium contributions from multiple sources. By providing a mechanism to combine even modest contributions from multiple sources (public and private), this new one-stop shop could be especially helpful to employees who may hold multiple jobs.

- **Simplicity**

Small businesses may find the current system difficult to navigate with a lack of simple, streamlined information about multiple coverage and care options and related assistance programs. We propose modifications to introduce greater simplicity to the system through technology and regulatory reform and the creation of a one-stop information source as described above. These proposed efforts will benefit all participants in the health care system, including the small business community.

- **Technological advances:** In our December 2008 Board statement, we emphasized that any health care reform proposal should include recommendations to streamline administrative processes across the health care system. Success will require advances in automating routine administrative procedures, expanding the use of decision support tools in clinical settings, and implementing interoperable electronic health records. Using technology to help streamline administrative processes will improve care delivery, enhance the provider and patient experience, and speed claims submission and payment. Done right, streamlining can also help reduce costs system-wide, leading to improved affordability.

- **Regulatory reform:** Regulatory structures should be rethought so that they work better and provide for a more consistent approach in areas such as external review, benefit plan filings, and market conduct exams. In a reformed market, policymakers should be driven by striking a balance between the traditional roles of the federal government and the states, and the objectives of achieving clearer and "smarter" regulation that promotes competition and avoids duplication of existing functions. Greater consistency in regulation and focusing on what works best will enhance consumer protections across states and help improve quality, increase transparency, and increase efficiency leading to reduced administrative costs.

- **Strengthening the Large Group Market**

We support building upon the existing employer-based system, which currently covers 177 million Americans according to the U.S. Census Bureau. It is a key part of our economic fabric. Although the employer-based system faces challenges, more than 90 percent of employers report that offering high-quality coverage is important to their ability to recruit and retain valuable workers and enhance employee morale. Thus, as a first priority, the nation's reform agenda should be committed to a policy that "first does no harm" to that system and limits strategies that would reduce employer coverage. Focus should be placed on retaining a national structure for the large group market that continues to promote uniformity and ensures the smooth functioning of the employer-based system.

At the same time, the nation's economic uncertainties and job losses underscore the need for new strategies to assist individuals who become unemployed or are transitioning from job to job. While a Congressional Budget Office (CBO) study found that nearly 50 percent of the uninsured go without coverage for four months or less, additional protections are still needed. We propose ensuring that tax credits are available to individuals on an advanceable basis to help them through job transitions along with access during these times to more affordable coverage options consistent with our proposal for a basic benefits plan.

- **Establishing an Essential Benefits Plan**

Individuals and small businesses should have access to an affordable "essential benefits plan" available in all states that provides coverage for prevention and wellness as well as acute and chronic care. To maintain affordability, the essential benefits plan should not be subject to varying and conflicting state benefit mandates.

An essential benefits plan should include coverage for primary care, preventive care, chronic care, acute episodic care, and emergency room and hospital services. Alternatively, it should include coverage that is at least actuarially equivalent to the minimum federal standards for a high-deductible health plan sold in connection with a health savings account, along with the

opportunity to include enhancements such as wellness programs, preventive care, and disease management.

Allowing benefit packages to vary based on actuarial equivalence is crucial to ensure that any package can evolve based upon new innovations in benefit design and the latest clinical evidence.

- **Confronting the 'cost-shifting surtax' currently imposed on employers and consumers purchasing health care coverage**

As part of any national health care reform initiative, Congress must address the fact that reducing outlays in one area inevitably means shifting costs elsewhere. Underpayment of physicians and hospitals by public programs shifts tens of billions in annual costs to those with private insurance. A December 2008 study by Milliman, Inc. projects that this cost shifting essentially imposes a surtax of $88.8 billion annually on privately insured patients, increasing their hospital and physician costs by 15 percent. This study concluded that annual health care spending for an average family of four is $1,788 higher than it would be if all payers paid equivalent rates to hospitals and physicians. The transfer of these costs to those with private coverage cannot be sustained and is critical to addressing concerns over affordability.

The impact of cost-shifting is dramatically illustrated by the tables below, which use real data showing that hospitals in California recorded significant losses in 2007 by serving Medicare and Medicaid beneficiaries. These losses are offset, however, by higher costs charged to commercial payers. This cost shifting translates into higher premiums for working families and employers.

Hospital Net Income Figures in California (millions)						
Year	***Medicare and Medicaid***		***Commercial***		***Total***	
	DSH	Non-DSH	DSH	Non-DSH	DSH	Non-DSH
2001	256	(1051)	137	1621	(825)	853
2007	(914)	(4292)	790	6230	(1450)	1852

Hospital Payments to Non-DSH Hospitals Relative to Costs in California (percentages)			
Year	*Commercial*	*Medicare*	*Medicaid*
2001	117	98	67
2007	142	85	56

Non-DSH Hospital Margins in California (billions)			
Year	*Commercial*	*Medicare*	*Medicaid*
2001	2.0	(0.2)	(0.9)
2007	6.2	(2.4)	(1.9)

In addition, the U.S. currently spends approximately $50 billion each year to provide health services to those without coverage, leading to high levels of uncompensated care. This too results in cost-shifting to those with coverage in the form of higher premiums and other related costs. According to a 2005 Families USA study, the cost-shift due to uncompensated care adds $922 annually to family premiums. When these costs associated with uncompensated care are combined with the cost shifting that results from the underfunding of Medicare and Medicaid, the impact for families with private coverage is an overall surtax of $2,710 annually due to cost-shifting.

- **Improving Public Programs**

For health care reform to succeed, we also need to improve the public safety net. We strongly supported the funding that is committed to this priority by H.R. 2, the "Children's Health Insurance Program Reauthorization Act of 2009" (CHIPRA). We also support extending Medicaid eligibility to all individuals with incomes at or below 100 percent of the FPL. In addition, adequate support should be provided to community health centers, recognizing the critical role they play in providing access to services for vulnerable populations and to ensure they can continue this role in the future.

- **Protecting Americans from Bankruptcy**

  To guard against medical bankruptcy, a system of tax credits should be designed for lower-income individuals and working families that would cap their total health care expenses (to include spending on premiums and cost-sharing) as a proportion of income. Achieving the goal of universal coverage is also critical to preventing medical bankruptcies, as research shows medical expense related bankruptcy is most prevalent among those without health insurance coverage.

III. Containing Health Care Costs

A broad consensus is emerging that reform of the system – that covers all Americans and provides safer and more effective care – is possible *if* we can contain the future growth in health care costs. At present, U.S. health expenditures are rising at an unsustainable rate, placing unaffordable burdens on families and small businesses, and hampering our competitiveness as a nation. In order to confront these issues, all stakeholders need to be challenged to innovate, perform better, and come to the table with solutions.

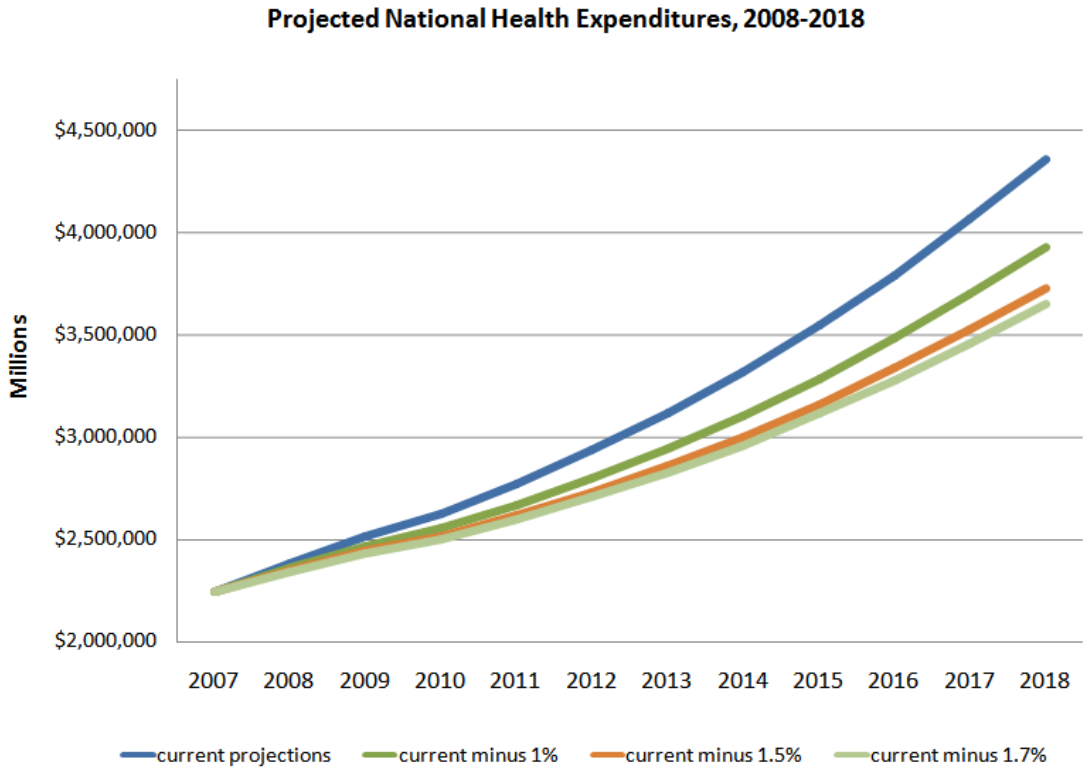
Health plans are leading the way by pioneering disease management and care coordination programs, promoting prevention, wellness and early intervention, and implementing innovative payment strategies that reward performance and outcomes. We are committed to working with the Administration, Congress and other stakeholders to advance strategies that promote effective, efficient, and high value health care.

At the same time, efforts to make our health care system more affordable for the long run will succeed only if the nation as a whole makes a strong commitment to reducing the future rate of increase in health costs and we all work together to achieve it. The critical link between reducing costs and increasing quality should help guide this effort. Spending more on health care does not necessarily equate to better quality; rather, the opposite has been shown. In

particular, many regions of the nation with higher spending actually have poorer quality of care and exhibit wide variations in practice and treatment patterns.

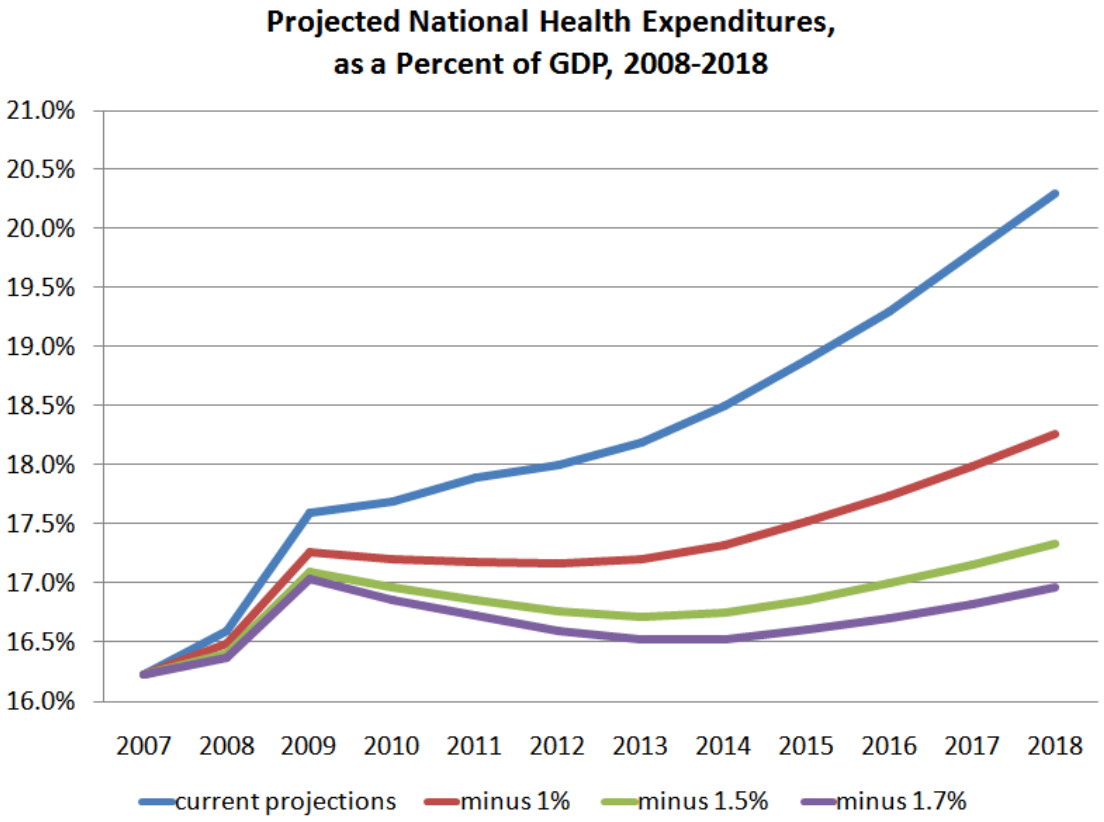
Recognizing the need for bold action, we are encouraging Congress to consider setting a goal for reducing future health care costs over a ten-year period and designate a public-private advisory group to develop a roadmap to reduce projected growth by 1.5 – 1.7 percentage points. The importance of such an effort cannot be overstated, nor can the responsibility that each stakeholder group must assume. Leaders in each sector know best about how to reduce future cost trends, and we are proposing a strategy where each of the key groups would be expected to take the lead in outlining a blueprint to reduce future cost growth in their sector.

The value of launching such an effort is illustrated by the chart below, which shows the dramatic impact of reducing annual increases in the projected growth of national health expenditures by 1 percentage point, 1.5 percentage points, or 1.7 percentage points. The aggregate cost savings under any of these scenarios would be very large, with the third scenario – achieving a reduction of 1.7 percentage points – yielding savings of $3.5 trillion over ten years, or more than $700 billion in 2018 alone.



Reducing cost trend in this manner would strengthen the nation's economic position relative to the global economy, provide significant relief to individuals and employers, and improve the solvency of the Medicare trust fund. Moreover, cost savings of this magnitude could go a long way toward ensuring that every American has access to affordable, quality coverage and care. These savings could help finance part of the costs of providing coverage to the uninsured, as well as reduce costs for those who are currently covered.

The impact on the U.S. economy is particularly important, as the chart below shows. Modest reductions in cost trends would have a dramatic effect in holding down future projections of national health care spending as a percentage of our nation's gross domestic product (GDP).



A financially sustainable and affordable health care system can only be achieved by bringing underlying medical costs under control. If health care costs are allowed to continue rising at rates far exceeding economic growth, they will stall all efforts to expand coverage and improve care. Meeting specific affordability goals will require leadership from all stakeholders. Health

plans are prepared to step up and meet that challenge and participate in a fast-track process with other stakeholder groups.

IV. Creating A High-Value Health Care System

The goal of containing costs can only be realized if it is coupled with parallel efforts to improve the ability of our health care system to deliver high-quality care that is in line with best practices and addresses the disparities in care experienced by cultural and ethnic minorities.

The fragmented U.S. health care delivery system is wasteful and unsustainable. Patients across the nation fail to receive high quality care on a consistent basis, while the system overpays and encourages the overuse of costly specialty care, yet underpays primary care which fosters care coordination and chronic care management. About 18 percent of Medicare hospital admissions result in readmissions within 30 days of discharge, accounting for $15 billion in spending and $12 billion in potentially preventable readmissions.

The total costs of preventable medical errors that result in injury are estimated to be between $17 billion and $29 billion – of which over half represent health care costs. Additional research demonstrates that there is an alarming gap between what is recommended by scientific evidence and what is actually practiced, including a 2003 RAND study which found that only 55 percent of patients receive treatments based on best practices.

To address these challenges, we need to focus on several critical areas to create a high-value health care system.

- **Updating and recalibrating the Medicare physician fee schedule.** The current process for determining physician payment across different specialties under the Medicare program should be overhauled, and a transparent, public process should be created. Payment levels

should be adjusted for cognitive and procedural services as well as account for gains in efficiency and provider productivity. Recalibrating the value of professional services will create renewed interest in important areas such as primary care.

- **Setting standards and expectations for the safety and quality of diagnostics.** The 2001 Institute of Medicine's landmark report, *Crossing the Quality Chasm,* recommended setting and enforcing explicit professional and facility standards through regulatory and other oversight mechanisms, such as licensure, certification and accreditation, that define minimum threshold performance levels for health care organizations and professionals. Standards will hold providers accountable for ensuring a safe environment in which patients receive care.

- **Promoting care coordination and patient-centered care by designating a medical home as well as supporting other primary care delivery models.** The patient-centered medical home is a promising concept that would replace fragmented care with a coordinated approach to care. By providing physicians with a periodic payment for a set of defined services, such as care coordination that integrates all treatment received by a patient throughout an illness or an acute event, this model promotes ongoing comprehensive care management, optimizes patients' health status, and assists patients in navigating the health care system. Other models which utilize nurses and other professionals to coordinate and manage patients' care also should be explored.

- **Linking payment to quality.** Payment incentives which reward physicians that practice both efficiently and consistently with clinical practice guidelines should continue to be promoted. The next generation of pay-for-performance models will move beyond the current focus of ensuring that processes of care are followed and performance metrics are reported, and instead, reward providers for achieving results including better clinical outcomes, improved patient experience, and lower total cost of care. Similar incentives which apply to hospitals also may have potential benefits.

- **Bundling payments for better management of chronic conditions across practitioners and facilities.** Bundled payments could allow for better management of chronic conditions by providing a single prospective payment for all providers involved in the management of a patient's condition. Under this model, providers would have shared accountability and responsibility, and thus be motivated to individually provide quality care in more efficient ways as well as work with other professionals to improve collective performance.

- **Redesigning acute care episodes.** Global case rate models – which typically provide an all-inclusive payment for a defined set of services, regardless of how much care is actually provided – may be a beneficial payment approach for procedures and conditions which have a relatively clear beginning and end.

- **Refocusing our health care system on keeping people healthy, intervening early, and providing coordinated care for chronic conditions.** Additional proactive steps need to be taken to identify individuals at risk for chronic conditions, help them access care, and encourage them to maintain healthy lifestyles. A proactive approach that keeps people healthy and productive needs to: (1) address the growing shortage of physicians and nurses in selected disciplines, including primary care and general surgery; and (2) reward providers for spending time with patients and coordinating their care.

- **Improving care nationwide by adopting uniform standards for quality, reporting, and information technology.** AHIP strongly supports the investments in health information technology that were enacted as part of H.R. 1, the "The American Recovery and Reinvestment Act of 2009." This legislation lays the groundwork for steps that must be taken to ensure that health care providers, consumers, payers, and policymakers have access to consistent and useful data on the quality of care delivered.

- **Investing more in research to better understand which treatments and therapies work best.** We need to close gaps in research, organize information on practices yielding the best outcomes for patients, and diffuse this information among practitioners and patients. H.R. 1, the "American Recovery and Reinvestment Act of 2009," provided $1.1 billion in federal funding – which we strongly supported – to support research that will advance these important priorities.

- **Creating accountability for consistently delivered, high-quality care based on the best evidence.** All stakeholders should promote the delivery of the best clinical outcomes and patient experience while ensuring the most effective and appropriate utilization of health care services. To accomplish this objective, investment in the development of new and improved measures that assess episodes of care and efficiency must be fast-tracked as part of health care reform.

- **Making targeted investments in our public health infrastructure.** Our public health infrastructure needs to be better positioned to implement strategies that prevent or ameliorate health care concerns and promote well being and healthy lifestyles as part of health care reform. We advocate a new, targeted national initiative to increase public awareness of the links between preventable conditions and chronic illness and to support new and existing prevention programs in our schools, worksites, and communities. Health plans are committed to working directly with communities to promote safe and healthy living and provide models for targeted investments in public health across the nation.

The visual on the following page shows that many of the initiatives that have been implemented in the private sector today are paving the way for future innovations under a reformed health care system. Existing programs listed in the left column provide a valuable foundation for the tools and strategies of tomorrow's health care system.

V. Conclusion

AHIP appreciates this opportunity to outline our suggestions for enacting meaningful health care reforms. We are doing our part to advance new strategies, and we are strongly committed to working with committee members and other stakeholders to develop solutions for ensuring that all Americans have access to high quality, affordable health care coverage.