HEALTH POLICY INSTITUTE

"America's Need for Health Reform"

Statement of

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before the

Subcommittee on Health

Committee on Energy and Commerce

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Good morning Chairman Pallone and Members of the Subcommittee.

Thank you for convening this hearing on the need for national health care reform. My name is Karen Pollitz. I am a Research Professor at Georgetown University's Health Policy Institute, where I have directed research on private health insurance regulation for twelve years. I am pleased to provide testimony on the role that individual health insurance might play in any meaningful health reform program.

I would begin with a few simple statements that, I hope, can garner broad agreement, and perhaps steer a course for the discussion this morning.

We buy health insurance in case we get sick. Therefore, how private health insurance works for us *when* we are sick is of the utmost concern. Health insurance is our ticket to health care. In order for the promised protection of health insurance to be meaningful, it must satisfy four tests.

Availability

First, health insurance must be available. That means we must be eligible to enroll. Today, eligibility for health coverage is largely derived from other factors – our work status, family status, age, income, where we live, and so on. Most non-elderly Americans are covered by job-based group health plans because they are eligible for employment health benefits in their own right or as the spouse or dependent of an employee. The majority of uninsured Americans also work, but they are not offered health benefits or are not eligible to participate in the employer health plan.

Safety net public programs – primarily Medicaid and S-CHIP – offer coverage for millions of low-income persons. Yet, Medicaid coverage is not available to most uninsured low-income adults because they do not meet program categorical and income eligibility rules.

People who are not eligible for job-based coverage or Medicaid – that is, most of the uninsured – can seek coverage in the individual health insurance market. However, medically underwritten coverage in this market conditions eligibility on health status, and so tends not to be available to applicants who are sick or otherwise need health care. Dozens of health conditions – from cancer, to diabetes, to pregnancy – render people "uninsurable" in most states. People also may be unable to buy individual coverage if they have a history of health problems. Even minor health conditions, such as hay fever or acne, can trigger a denial by some insurers.[1]

Only a relatively small proportion of the non-elderly are covered by individual health insurance at any point in time. (See Figure 1) However, over a three-year period, one-in-four adults seek coverage in this market, most without success.[2] That makes individual health insurance the weak link in the health coverage chain today. Two million Americans lose or change health insurance each month. Those who need individual policies when they are sick or after they've been sick may not find coverage available to them.

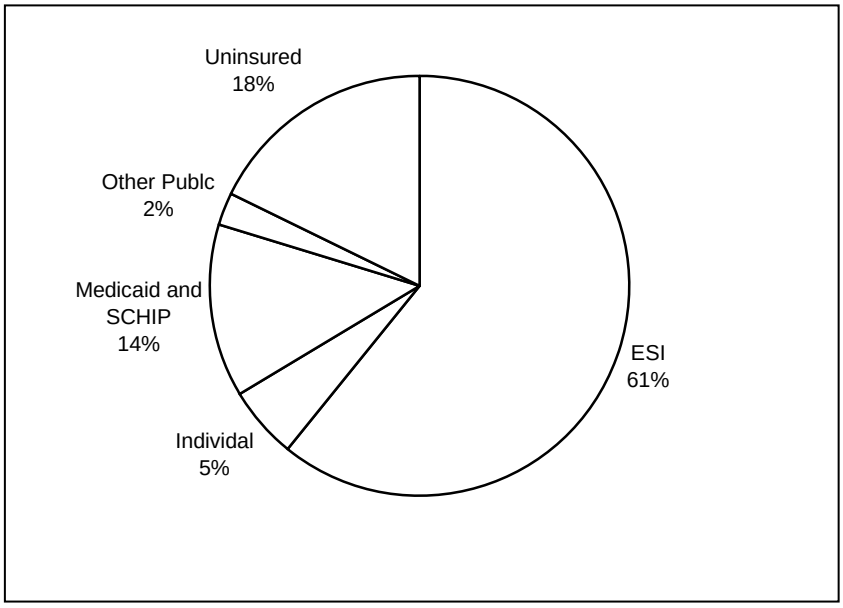
Improving the availability of private health insurance can be and has been addressed through regulation. Some states require individual health insurance to be sold on a "guaranteed issue" basis. That means applicants cannot be turned down because of health status. Federal law

[1] See, for example, K. Pollitz, R. Sorian and K. Thomas, "How accessible is Individual Health Insurance for Consumers in Less than Perfect Health?" Henry J. Kaiser Family Foundation, June 2001. See also D. Grady, "After Caesareans Some See Higher Insurance Cost," *New York Times*, June 1, 2008.

[2] L. Duchon, et. al., "Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk," The Commonwealth Fund, December 2001. See also J. Hadley and J. Reschovsky, "Health and the Cost of Nongroup Insurance," *Inquiry*, Volume 40, Number 3. Fall 2003.

(HIPAA) requires individual health insurance to be sold on a guaranteed issue basis to certain eligible individuals when they leave job-based group coverage. That same federal law requires that all policies sold to small employers must be offered on a guaranteed issue basis.

Figure 1. Sources of Health Coverage, Non-Elderly



Source: Urban Institute estimates of March 2007 Current Population Survey, U.S. Census Bureau

If the individual market is to play a role in any coverage expansion strategy, policies must be available to all individuals without regard to their health or risk status.

Adequacy

Health insurance coverage must also be adequate. Adequacy must be measured against the health needs of people who are sick, pregnant, or in need of other expensive care or treatment. Adequate health insurance must ensure that people can obtain needed care without owing more than a manageable level of costs out-of-pocket. One recent study suggested that people may be underinsured if out-of-pocket medical expenses reach ten percent of income or higher (five percent for persons with incomes below 200 percent of the poverty level), or if deductibles

constitute five percent of income or more.[3] Evidence suggests the problem of underinsurance is serious; medical debt and medical bankruptcy are primarily problems of the insured.[4] Coverage adequacy problems tend to be worse in the individual market, where policies are less comprehensive compared to job-based health plans.[5] A recent survey of Midwestern farm and ranch operators (who rely disproportionately on individual health insurance) found that people covered by individual policies were more than twice as likely to be burdened by high out-of-pocket costs and medical debt compared to those covered under employer-sponsored group health plans.[6]

Numerous health plan features can affect adequacy of coverage:

- Pre-ex exclusions and riders – Most private health insurance policies will temporarily exclude coverage for a new enrollee's pre-existing condition. In the individual market, insurers in most states can also amend policies with riders that permanently exclude coverage for an applicant's health condition, or for the body part or system it affects.
- Covered and excluded benefits – Insurers in most states have broad flexibility to design policies to cover or exclude specific benefits. Especially in the individual market, it is possible to find many policies that do not cover, or that strictly limit coverage for, key health services such as medical office visits, chemotherapy, mental health care, maternity care, and prescription drugs.

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[3] C. Schoen et. al., "How Many Are Underinsured? Trends Among US Adults, 2003-2007," *Health Affairs*, Web Exclusive, June 10, 2008.

[4] D. Himmelstein, E. Warren, et. al., "Illness and Injury as Contributors to Bankruptcy," *Health Affairs*, Web Exclusive, February 2, 2005. See also J. May and P. Cunningham, "Tough Trade-offs: Medical Bills, Family Finances and Access to Care," Center for Studying Health System Change, June 2004. See also, H. Tu, "Rising Health Costs, Medical Debt, and Chronic Conditions," Issue Brief No. 88, Center for Studying Health System Change, September 2004.

[5] J. Gabel, et. al., "Individual Health Insurance: How Much Protection Does it Provide?" *Health Affairs*, Web Exclusive, April 17, 2002.

[6] "Who Experiences Financial Hardship Because of Healthcare Costs?" The Access Project, Issue Brief No. 3, September 2008, available at www.accessproject.org

- Cost sharing – Typically patients must pay at least a portion of the cost of covered services through deductibles, co-pays and coinsurance. High deductible health plans have become more common, particularly in the individual market. While some urge that high deductibles will promote more cost conscious use of health care by patients, in fact, research shows high deductibles deter use of necessary care, as well.[7] Further, high-deductible plans are unlikely to curb health spending overall because most health care spending arises from conditions whose treatment costs far exceed the level of health plan deductibles.[8]

  High deductibles and other cost sharing will, however, shift cost burdens onto seriously ill patients. Further, those with chronic conditions (who account for 75 percent of health care spending) [9] will feel this burden year after year. Even modest co-pays can mount relentlessly. For example, over 18 months of active treatment, a breast cancer patient might have as many as 165 doctor visits and outpatient treatments and require up to 40 prescriptions and refills.[10] If a co-pay of $25 applied for each, her expenses due to co-pays alone would exceed $5,000. Most policies provide for an annual out-of-pocket maximum, but this cap may be porous; in particular, co-pays may not count toward the limit.

- Other coverage restrictions – Additional features that may be less obvious and less easy for patients to investigate can also limit what is covered. Tiered provider networks mean patients may pay more, or all, of expenses for covered services depending on where care

[7] R. H. Brook, et.al., "The Health Insurance Experiment: A Classic RAND Study Speks to the Current Health Care Reform Debate," RAND Research Brief RB-9174-HHS, 2006.
[8] See, for example, L. Blumberg and L. Burman, "Most Households' Medical Expenses Exceed HSA Deductibles," *Tax Notes*, August 16, 2004.
[9] For example, most nine-month pregnancies will span two years. A recent study of out-of-pocket spending for maternity care under consumer driven health plans found patients might be liable for as much as 80 percent of the cost of their care when pregnancy is covered under two different plan years. See K. Pollitz, M. Kofman, A. Salganicoff, and U. Ranji, "Maternity Care and Consumer-Driven Health Plans," Henry J. Kaiser Family Foundation, June 2007.
[10] Georgetown University Health Policy Institute, estimated costs of care for various serious and chronic health conditions, unpublished.

is rendered, with higher cost sharing applied to more specialized services. Tiered formularies vary cost sharing depending on the cost of drugs. These policy features exist for cost containment purposes, but also can have the effect of shifting cost burdens to the sickest patients. Further, their impact may not be obvious to consumers until they get sick and experience firsthand how their coverage works.

Adequacy of health insurance can also be addressed through regulation. Most states have addressed adequacy only incrementally, through mandated benefit laws. Some states have gone beyond discreet benefit mandates to define more broadly the covered benefits and cost sharing limits that licensed insurers must provide.[11] By contrast, federal law provides very little guidance on coverage adequacy, defining health insurance as "benefits consisting of medical care…under any hospital or medical service policy or certificate…offered by a health insurance issuer."[12] A more comprehensive definition of health insurance is needed. Coverage that is inadequate should not be called health insurance.

Affordability

Health insurance premiums must also be affordable. Premiums for private coverage vary widely today, driven largely by differences in the availability and adequacy of policies. Policies that exclude sick people or coverage for key health benefits will have lower premiums relative to policies that are available and adequate; but we must not be distracted by this comparison of unlike products. Rather, we must accept the fact that health insurance, which covers people and their needed health care, will be expensive. Per capita health care spending in the U.S. is

[11] Massachusetts, New York, New Jersey, Maine, and Vermont are examples of states that have adopted such standards.
[12] Section 2791 (b), Public Health Service Act.

roughly $7,000.[13] By contrast, median household income is just over $50,000.[14] Therefore, significant subsidies will be needed in order for coverage to be simultaneously affordable, adequate and available.

In addition to subsidies, insurance market regulation is needed to prevent insurers from varying premiums based on health status, age, gender, and other factors. The experience of the Health Coverage Tax Credit (HCTC) is instructive. Congress provided for a variety of possible qualified coverage arrangements but no rating standards. In a number of states, HCTC-qualified coverage includes individual market policies that are not subject to rating limits. For example, in North Carolina, individual policy premiums for a 55-year-old with serious health conditions were found to be as high as $3,926 per month.[15] Even with a 65 percent tax credit, this policy was unaffordable.

Always

Finally, health insurance must be available, affordable, and adequate all of the time. Nearly 40 percent of non-elderly Americans experience a spell of uninsurance at some point over a three-year period.[16] If we are to continue with our current, pluralistic coverage system, we will have to provide mechanisms to make continuous coverage possible even as people move from plan to plan.

Regulation must also address insurance industry practices that make it difficult for people to remain enrolled in coverage once they get sick. These practices have been described as "lemon

[13] Center for Medicare and Medicaid Services, National Health Expenditure Accounts, 2006.
[14] U. S. Bureau of the Census.
[15] S. Dorn, T. Alteras, and J. Meyer, "Early Implementation of the Health Coverage Tax Credit in Maryland, Michigan, and North Carolina: A Case Study Summary," The Commonwealth Fund, April 1, 2005.

[16] P. Short, D. Graefe, and C. Schoen, "Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem," The Commonwealth Fund, November 2003.

dropping" (in contrast to "cherry picking," which refers to practices that deter initial enrollment.) Several renewal rating practices fall into this category. "Experience rating" increases premiums at renewal for policyholders who have made claims. More common in the individual market, "durational rating" increases premiums for all policyholders over time and prompts those who remain healthy to resubmit to medical underwriting in order to escape renewal rate increases. Many insurers also engage in a practice known as "closing a block" of business. This means the insurer ceases to actively market a policy to new enrollees. Without an influx of newly underwritten healthy enrollees, the average cost experience of in-force policyholders increases dramatically until premiums reach prohibitive levels. Current federal law requirements of guaranteed renewability laws dictate that policyholders must be allowed to remain eligible for coverage, but not that coverage remain affordable over time.[17]

"Post-claims underwriting" triggers another category of practices that can threaten the availability, affordability, and adequacy of coverage over time. Policyholders who make claims for expensive health conditions after they enroll may be investigated to determine when the condition first appeared and whether it was disclosed. Insurers may exclude coverage for conditions determined to be pre-existing, in some cases even if they were disclosed during the underwriting process. Post-claims underwriting may also result in the retroactive imposition of exclusion riders or premium surcharges; or coverage may be cancelled or rescinded. Post-claims investigations are defended as necessary to deter consumer fraud, but abusive insurer practices have also been documented, including recent reports that one carrier paid staff bonuses based in part on how many individual policyholders were dropped and how much money was saved.[18]

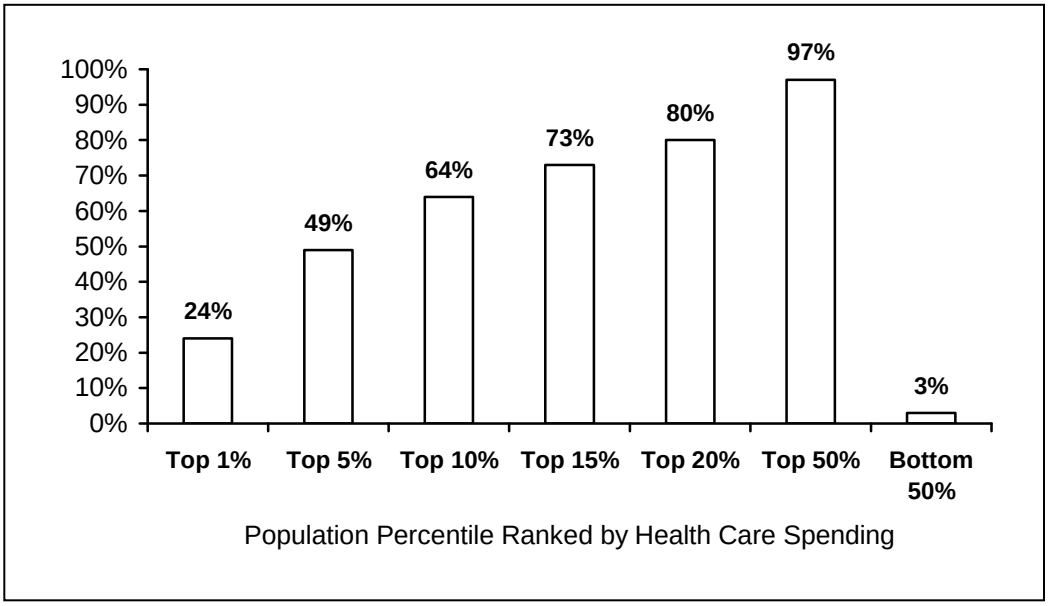
[17] "On their Own: Far from a remedy, individual health insurance is a world of pain," *Consumer Reports*¸ January 2008

[18] L. Girion, "Health insurer tied bonuses to dropping sick policyholders," *Los Angeles Times*, November 9, 2007.

Oversight and Transparency

Even under health reform that provides for mandatory universal coverage and generous subsidies, the incentive to "cherry pick" and "lemon drop" will persist. The distribution of health expenses across the population makes this inevitable. It will always be more profitable for insurers in a competitive market to avoid that small proportion of the population who account for the lion's share of health care spending. (See Figure 2) Therefore, strong rules must be created and enforced to create a level playing field.

Figure 2. Concentration of Health Spending in the U.S. Population



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2003.

Federal standards for health insurance will be critical to ensure that all Americans enjoy health insurance protections, no matter where they live. In light of states' more extensive regulatory experience and infrastructure, the federal government will likely need to work cooperatively with state insurance departments to implement national standards. However, the federal government

also needs its own independent capacity to exercise oversight of the health insurance industry, monitor state enforcement, and provide for direct enforcement when or if states do not.

Improved transparency of health insurance is also necessary to make markets function well. Health coverage must become more readily obvious and understandable to consumers and patients. A blizzard of varying policies offered today leaves consumers confused as to the type of health insurance they have.[19] Two seemingly similar policies may offer vastly different levels of coverage because the definition of covered benefits, the application of cost sharing rules, and other policy features vary. Fine print and jargon further obscure how coverage works. While unlimited variation in health plan features may seem, at first blush, to expand choices for consumers, it also permits insurers to obscure limitations in coverage in ways consumers might never think to investigate until it is too late. Standardization can take much of the guesswork out of coverage and reduce opportunities for abuse. Standardizing coverage will also reduce adverse selection. And if all policies offer comprehensive protection, nobody will be under-insured.

The creation of "health insurance exchanges" or "connectors" can help ensure that policies comply with standardized rules and offer consumers objective comparative information about plan choices. Exchanges or connectors can also play a critical role in administering coverage subsidies.

Conclusion

Mr. Chairman, it is time for this nation to move ahead on a program of health care reform to ensure that all people enjoy health coverage that will take care of them when they are sick – and that is available, adequate, and affordable all of the time. We won't reach this goal by

[19] D. Nelson et.al., "What People Really Know About Their Health Insurance: A Comparison of Information Obtained from Individuals and Their Insurers," *American Journal of Public Health*, Vol. 90, No. 6, June 2000.

happenstance. Rather, these goals must guide our public policy decisions and design. As you contemplate the next round of health reform, one key question is whether it makes sense to continue a role for a competitive, private health insurance market and, in particular, an individual market. If we agree health coverage must always be available, affordable, and adequate for everyone, then we must ask whether the health insurance industry is up to this task. Over the years it has been argued that carriers must engage in the practices just described if they are to remain viable and offer coverage for affordable premiums. Yet too often, these business practices collide with public health needs. When health insurance fails people who are sick, they cannot get the care they need.

Coverage expansion might be achieved through individual health insurance, though not the

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markets we have today. Continued reliance on individual health insurance will require

substantial change if we want such coverage to provide meaningful protection that guarantees all Americans access to care when we need it.