

Testimony of

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1. Introduction

Good morning Mr. Chairman and members of the Committee. I am Jeff Closs, President and Chief Executive Officer of BENU, Inc. I am pleased to be here today to participate in the hearing on “Expanding Consumer Choice and Addressing ‘Adverse Selection’ Concerns in Health Insurance”. This topic is exactly what my company, BENU, addresses for small and mid-size companies today. We have a relationship with CIGNA Healthcare and Kaiser Foundation Health Plan in Oregon, and CIGNA and Group Health Cooperative in the state of Washington, to offer choice of health plan delivery systems for employers to offer to their employees, yet reallocate premium to insurers to correct for the adverse selection that inevitably occurs.

Health insurers compete aggressively for the business of the employer. What they cannot do is compete aggressively for the consumer. Let me give you an example. The marketing executive for Group Health Cooperative told us of the wonderful way they treat diabetics. He spent considerable time describing their prescription system which flags a new insulin prescription, which triggers a nurse to call the diabetic person for education on the best methods of monitoring and controlling their blood sugar, to make an appointment with a dietician to review their nutrition and to schedule follow-up appointments to screen for additional diseases. I marveled at the comprehensiveness and effectiveness of their care. But when I asked “Why not encourage all diabetics to join Group Health”, he said “Of course we would love to care for all the diabetic people, however, our current payment of the average premium will not cover the cost of treating the diabetic person no matter how efficient the care!

Our health insurance system is broken. The problem is that we expect our health insurance carriers to be more than plain old insurance. I define insurance as a financial vehicle that spreads the risk of financial calamity from rare, *unpredictable* events—not *predictable* events—among a large group of people. If I tried to apply for home insurance while my house was on fire, and I was turned down, would you be surprised? Of course not. But when a woman with leukemia can't get health insurance, we find that unacceptable. We expect our health insurers to be part social program. Do we expect insurers to be paid the same rate for bad drivers as they receive for good drivers? Of course not. But to engage an insurer to compete for the diabetic as well as the healthy we need to compensate them appropriately. The truth is we expect our health insurance carriers to be part service plan, taking good care of the healthy and chronically ill alike, and part social program, spreading the cost of health care evenly among all participants. Unsurprisingly they are having a hard time being either.

Why is consumer choice so important? It is so we can create an efficient, competitive consumer market whereby insurers have the incentive to provide the service plan component. If insurers are paid appropriately, they will have the incentive to enroll the chronically ill as well as the healthy since they have the potential to make a profit. If they fail to provide high quality care, consumers can 'vote with his or her feet' and change to another insurer that will care for them appropriately. In this model, aligning insurer payment to enrolled risk creates an incentive for insurers to provide efficient, high quality health care.

What we need is an ability for consumers to make choices among competing delivery systems, to make value judgments between cost and quality when assessing their choices. If one system provides better care at an appropriate price, they should have the ability to choose

that delivery system. If the diabetic feels Group Health offers superior care for their needs, they should be able to enroll with Group Health, without Group Health fearing they are going to create unsustainable losses.

But what if I told you that there was a way to fix this system, whereby we could keep the social program aspects of our system, give consumers choices they need, while at the same time engage insurers to compete for all consumers and control costs for employers? In fact, BENU does this today by reallocating premium using risk assessment tools available today.

What is wrong with the current system is not how we FUND health care, but how we PAY insurers. We FUND health care by charging everyone the same premium for the same plan, no matter how sick they are, what I call the AVERAGE COST MODEL. That's how we retain the social program part. But instead of paying the INSURER this average cost model premium, we should adjust payments to insurers based on the chronic illness of those who they enrolled, what I call the RISK-ADJUSTED MODEL. In other words, employers can still offer employees a premium-subsidy based on the AVERAGE COST MODEL, but insurers should be paid using a RISK-ADJUSTED MODEL.

2. Evidence: Lack of Insurer Competition

Very few employers offer a choice of health plan, let alone choice of insurers. In 2004, 84% of all United States employers offered only one health plan to their employees¹. The percentage of employers that offer more than one plan increased with employer size;

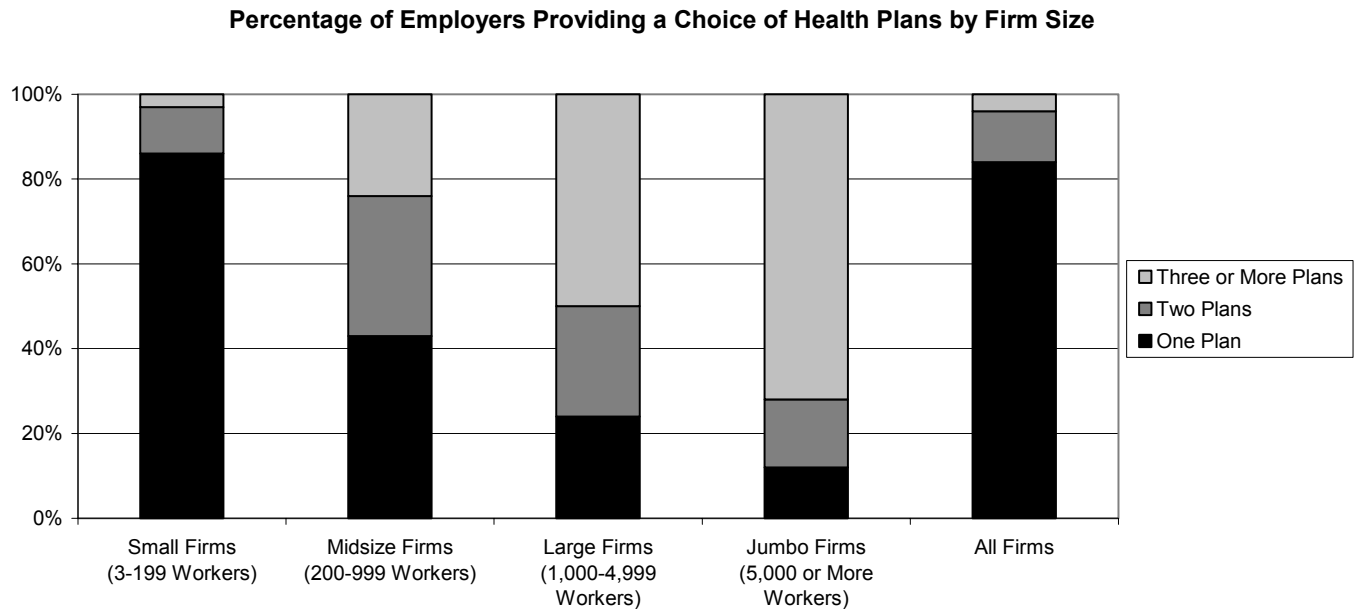


Figure 1

however, in most cases, the additional options were simply different plans offered by the same insurer. For example, an employer might offer an insurer's point-of-service (POS) plan as well as their preferred provider organization (PPO) plan. Typically such plans are served by the same provider networks, so consumers are not offered competition among different delivery systems but rather different financing mechanisms for the same delivery system. Very little data exists regarding how many employers offer more than one *insurer*, but it is certainly less than 16%, which is the percentage of employers that offer more than one *plan*.

¹ The Kaiser Family Foundation–Health Research and Educational Trust, *Employer Health Benefits Annual Survey* (Chicago and San Francisco 2004): 59.

3. Cause: Average Cost Model

Insurers charge a premium that closely matches the *average* member's expected cost to the insurer for the upcoming year. But individual members' expected costs vary dramatically. Someone with chronic heart failure is expected to cost much more than a healthy twenty-year-old. From a financial standpoint, the insurer prefers to enroll the healthy and not the chronically ill. Of course, this runs counter to the commonly assumed mission of insurers: to cover the costs of those who need medical care. Every chronically ill member enrolled costs the plan more than his or her premium. Therefore, there is a disincentive to recruit the chronically ill, and it is this average cost model that creates the misaligned incentive².

4. Etiology: How Did We Get Here?

How did the health insurance industry arrive at an average cost model? Because health insurance is more than just plain old insurance. It is also a service plan and a social program, which make the current average cost payment model inefficient and costly.

First, health insurance is **insurance**: a financial vehicle that spreads the risk of financial calamity from rare, *unpredictable* events among a large pool of members. Health insurance originated in the 1930's primarily as a means of protecting individuals from unexpected hospital costs.⁴ These costs were due primarily to acute conditions, and thus unpredictable. A casualty insurance model for healthcare financing was therefore appropriate at the time.

² R.E. Herzlinger, *Consumer-Driven Health Care: Implications for Providers, Payers, and Policymakers* (San Francisco: Jossey-Bass Publishers, 2004): 77-83.

⁴ P. Starr, *The Social Transformation of American Medicine* (New York: Basic Books, Inc. Publishers, 1982): 295-306.

While the casualty model made sense in the 1930's, advances in medicine have created a new group of individuals with chronic illnesses who live much longer, requiring expensive ongoing care. For the insurer, this has meant that loss expectations include not only claims due to unpredictable events, but also some due to predictable events as well. A patient with kidney disease, who did not have a life expectancy of more than a few months in the 30's, now may live many years thanks to costly dialysis treatments. This **service plan** component of modern health insurance, in which one pre-pays for anticipated services in the coming year, does not exist in other lines of insurance. A purchaser of life insurance does not expect to die next year when he buy's term life insurance, nor does a homeowner expect that her house will burn down when she buys homeowner's insurance. (If they did, it would be fraud!) But with health insurance, the insured expects to consume services and file claims in the contract year. A component of costs has become predictable.

Modern health insurance is also unique because of the expectation that the known healthy will subsidize the cost of care for the sick. A recent newspaper article described the case of an uninsured woman who was diagnosed with leukemia. The article lamented that she could not buy insurance to cover the costs of chemotherapy treatments. This sounds reasonable to us. But, by the same token, it would not seem reasonable to us for a person whose house is on fire to buy fire insurance. Why do we think differently about health insurance? Because as a society we view health insurance as part **social program**.

The social program aspect of health insurance has created the average cost model for insurer payment. It is the social program aspect of health insurance that prevents us from charging the person with cystic fibrosis his or her full expected cost in the upcoming year. Instead, the

cost is spread amongst the rest of us who are fortunate enough not to have been born with the illness.

5. Result: Single Insurer, Full-Replacement Health Plans

The average cost model has perpetuated employers' use of a single insurer, full-replacement approach in the health insurance they offer to employees. Insurers market aggressively to employers, competing for a company's entire membership. But if an employer wishes to offer an additional insurer's health plan to their employees (called 'slice business') the original insurer resists, not just because the original insurer wants to retain the business, but because they fear enrolling the costlier portion of the group, a phenomenon called adverse selection.

Adverse selection makes it difficult, if not impossible, for insurers to compete effectively at the consumer level. Historically, insurers have pursued slice business as a means of writing more business. But this extra business is unprofitable if the new members are sicker than the group by which the average cost premium was set. As a result, most insurers will not share enrollment of the same employer group with a competing insurer.

Another way of looking at it is that adverse selection occurs when consumers are offered a choice of insurers and health plans and are exposed to significant cost differences between those plans. A consumer who does not expect to need much health care in the coming year will not see value in choosing the costlier plan. The chronically ill member, who does need a lot of care in the coming year, will likely consider that costlier plan.

When insurers allow slice business, they implement strategies to create an equal sprinkling of the healthy and the chronically ill among all of the insurers offered. They do this to create an enrollment with each insurer with an average cost potential equal to the average cost of the group. One way to achieve this is to standardize benefit designs across insurers to lessen the cost variance between insurers. Another way is to require the employer to subsidize a major portion of the cost difference between insurers.

Unfortunately for employers and employees, the mechanisms insurers use to mitigate adverse selection eliminate the reasons why employers want to offer choice in the first place: a meaningful choice of insurers and plans with meaningful price differences that allow consumers to make value assessments between cost and quality. Add to this the administrative complexity for employers of offering more than one insurer to employees, and one can see why the average cost model leads to a single insurer, full-replacement model of health insurance coverage.

6. Implication: Increased Health Care Costs

In a single insurer, full-replacement model, the employer is the one choosing the insurer, not the employee. But employers are not as effective as employees in making value assessments because individual needs and preferences differ. In the late 1980's and early 1990's many employers controlled double-digit health care inflation by forcibly moving their employees into managed care. With restricted networks and tight utilization controls, managed care slowed health care inflation dramatically. While many employees did not mind this style of care, others disliked the restriction of services that used to be abundantly available. The

managed care backlash led employers to negotiate with their insurers to lessen the utilization controls and to be more inclusive in their networks. Employee satisfaction increased, but costs again skyrocketed.⁵

The single insurer, full-replacement model of health insurance coverage does not control costs. It leads instead to a demand for all-inclusive networks, forcing the insurer to include the efficient and the inefficient, and the good and the poor quality provider. These wide networks are not the cohesive provider organizations needed to efficiently take care of the chronically ill.⁶

7. Solution: Consumer Choice of Competing Insurers and Paying Insurers For Risk Enrolled

The best way for employees to become engaged in value assessments is to have employers offer them a meaningful choice of health plans from competing insurers. Competition among insurers creates incentives to provide value to consumers and maximizes consumer satisfaction. If consumers are exposed to the true cost differences between insurers, they will have a reason to choose less expensive delivery systems or costlier options if they see value in doing so. This is called a defined-contribution approach because employers offer all employees a fixed dollar subsidy to their health plan choice. This approach is necessary for consumers to make value assessments. It yields savings for the employer by allowing them to fund only the lowest cost plan, employees then buy-up to the options they desire.

⁵ A.C. Enthoven and S.J. Singer, "The Managed Care Backlash and the Task Force in California," *Health Affairs* 17, no. 4 (1998): 95-110.

⁶ A.C. Enthoven, "Employment-Based Health Insurance Is Failing: Now What?" *Health Affairs* (Web Exclusive May 2003): 237-249.

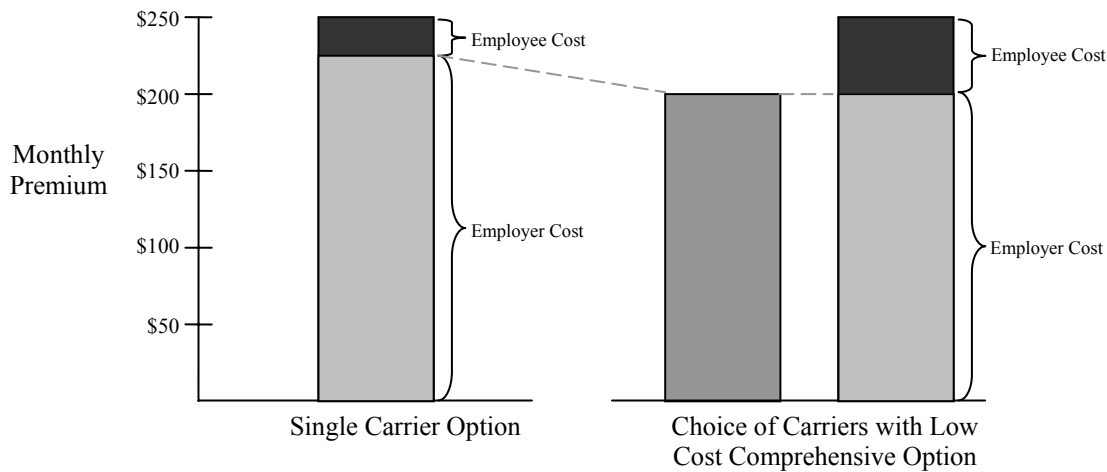


Figure 2

Figure 2 demonstrates how an employer who currently offers only one moderately priced, one-size-fits-all PPO can save significantly by introducing a lower cost, comprehensive HMO plan from a competing insurer. In the single insurer situation, the PPO plan premiums are \$250 and the employer pays 90% of that, or \$225. In the package with choice, the HMO costs \$200 per month and the PPO is still \$250. If the employer subsidizes \$200, then it yields a \$25 savings per covered employee. The employees now have a no-cost option, but they can keep the PPO if they are willing to spend \$50 per month, the cost differential between the plans.

Insurers, however, need to be kept whole in this process. **While average cost payments from employers can be maintained (social program), an intermediary, such as BENU, must reallocate payments to insurers proportional to chronic illness burden, or ‘risk’, that enrolls (service plan).** In the example in Figure 2, healthier employees will be attracted to the low cost HMO option, raising the average per-employee-cost of those remaining in the

PPO. Risk assessment tools that predict future costs based on clinical diagnoses can reallocate the average cost rates funded by employers into risk-based rates paid to insurers.

Paying insurers risk-adjusted rates allows employers to offer a choice of insurers while pursuing a defined contribution strategy that was not sustainable when the employer paid the insurer the average cost. Employers protect themselves, but employees are empowered to make the value assessments critical for efficient competitive markets.

8. Additional Benefit: More Attention to the Chronically Ill

When employers offer choice to employees *without risk adjusting payments to insurers*, powerful incentives are created for insurers to figure out how to enroll low cost, healthy members and not to enroll high cost, chronically ill members. One cannot blame insurers for this strategy. When employer's offer a choice of insurers in an average cost model, it creates financial calamity for insurers that actively recruit the chronically ill. Consider an HMO that may have an excellent diabetes care pathway, including an early detection system that identifies new enrollees with insulin prescriptions, an education program taught by nurses, a nutrition program in which a dietician contacts patients with nutritional advice, and a follow-up care program with specialists who help with co-morbid disease prevention. The HMO then markets this excellent program to an employer that will offer it to employees. But when it comes time to enroll members, there is no incentive for the insurer to enroll the diabetics. Why? Because the average premium is not sufficient to cover the costs of the diabetic, no matter how good the care is.

If employers pay insurers premiums commensurate with the chronic illness burden of enrollees, it will actively encourage these plans to compete for all members, effectively removing the underwriting profit incentive. Insurers will have the incentive to provide high quality care to the chronically ill because they represent greater revenue. If they fail to do so, the chronically ill member can vote with his or her feet and change to another insurer that will care for them appropriately. In this model, aligning insurer payment with enrolled risk creates efficient, high quality, cost effective health care.

9. Solution for Employers: BENU's Risk-Adjusted Premium Payments

BENU is currently the only independent 3rd party market-maker that allows employers to maintain average cost premiums for their employees, yet pays risk-based premiums to insurers. The key to BENU's method is to present rates to employers that the insurer would quote if each plan were to receive the entire enrollment, what BENU calls the group neutral risk level. After enrollment, BENU calculates the insurer-enrolled risk level and adjusts the premium paid to each insurer proportionately. Essentially, the rates that BENU pays the insurers are what the insurers would have quoted had they known in advance the enrollment they eventually received.

The rates BENU charges and collects from the employer for insurers differ from the rates that BENU pays the insurer, but the total premium the employer pays BENU equals the total premium paid to insurers.

Figure 3 shows how the average enrolled risk for insurers can differ from the group neutral risk.

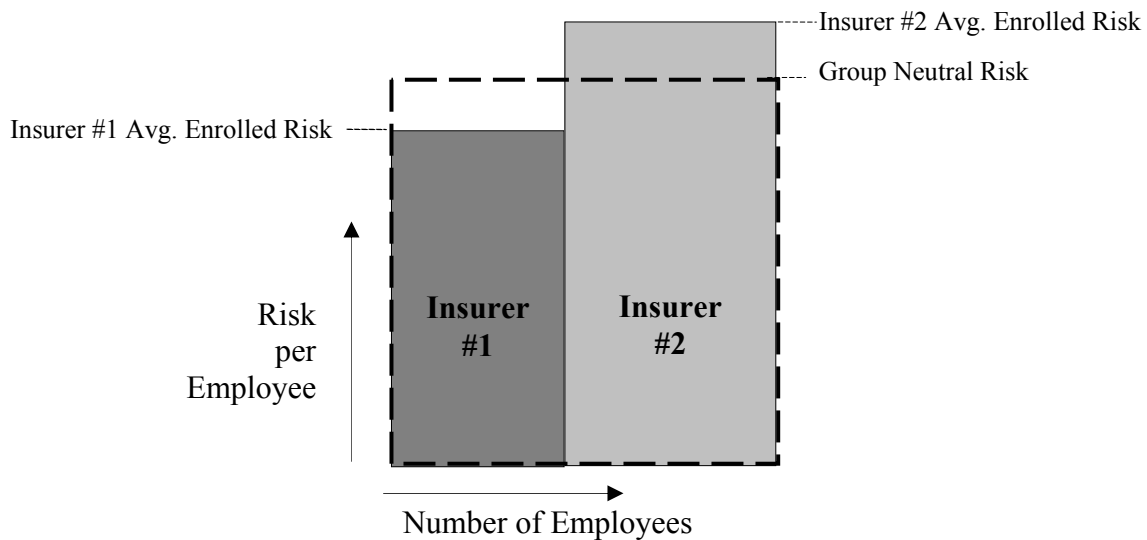


Figure 3

10. Results: Experience at BENU

BENU currently operates in two states, Oregon and Washington. In Washington we currently offer Group Health Cooperative and CIGNA Healthcare, while in Oregon we offer Kaiser Foundation Health Plan of the Northwest and CIGNA Healthcare.

How does BENU assess risk? BENU uses predictive modeling tools developed over the last decade. Specifically, BENU uses DxCG software, the same company that the Medicare program currently uses in determining payment to insurers in the Medicare+Choice program. The software was developed by using claims data from a large data set of over two million members over a period of two years. By tracking diagnoses that are recorded for members in the first year with costs those members generate in the second year, a statistical model was created where future year costs can be predicted based on prior year diagnoses. To use the

software, one simply enters the diagnoses for each member and the software will generate relative cost factors for each member. We call this a prospective risk factor.

For example, a member diagnosed with diabetes in the first year may have a prospective risk factor of 3.2. This means that next year, we can expect, on average, that this member will incur 3.2 times the cost of the average cost per member of the two million members in the original reference data set.

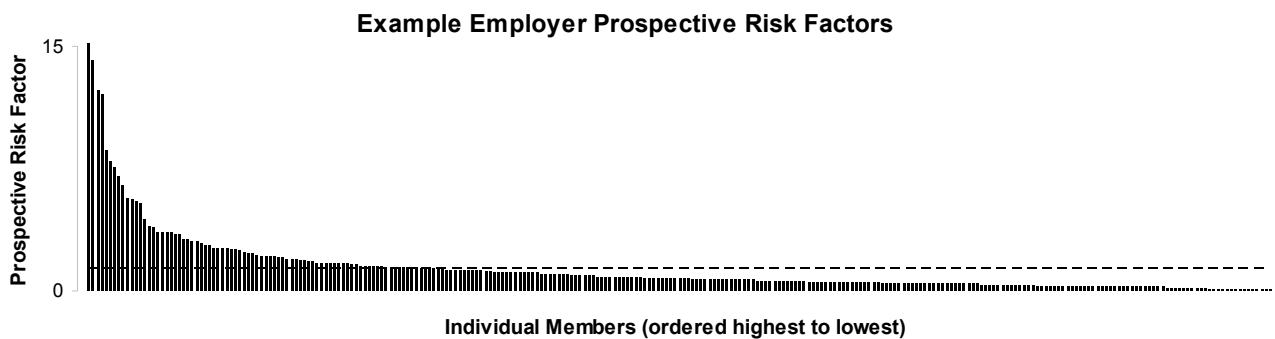


Figure 4

Figure 4 demonstrates the amount by which prospective risk factors can vary for a typical BENU employer. The graph shows prospective risk factors for each member in a 275 member group, ordered from highest to lowest. The prospective risk factor at the extreme left is 15.33, representing a member diagnosed with cancer. The factor at the extreme right is about 0.08, representing a completely healthy individual that never needed to see a physician. The most costly member in this group is expected to cost 192 times the cost the least costly member in this group. This example demonstrates a 192-fold difference between what the costliest and least costly member is expected to cost. Yet the insurer is paid the average premium whether the member with the prospective risk factor of 15.33 or the one with 0.08 enrolls.

How much has BENU reallocated premium among insurers? Figure 5 answers this showing the results for the first thirteen employers to purchase health insurance through BENU.

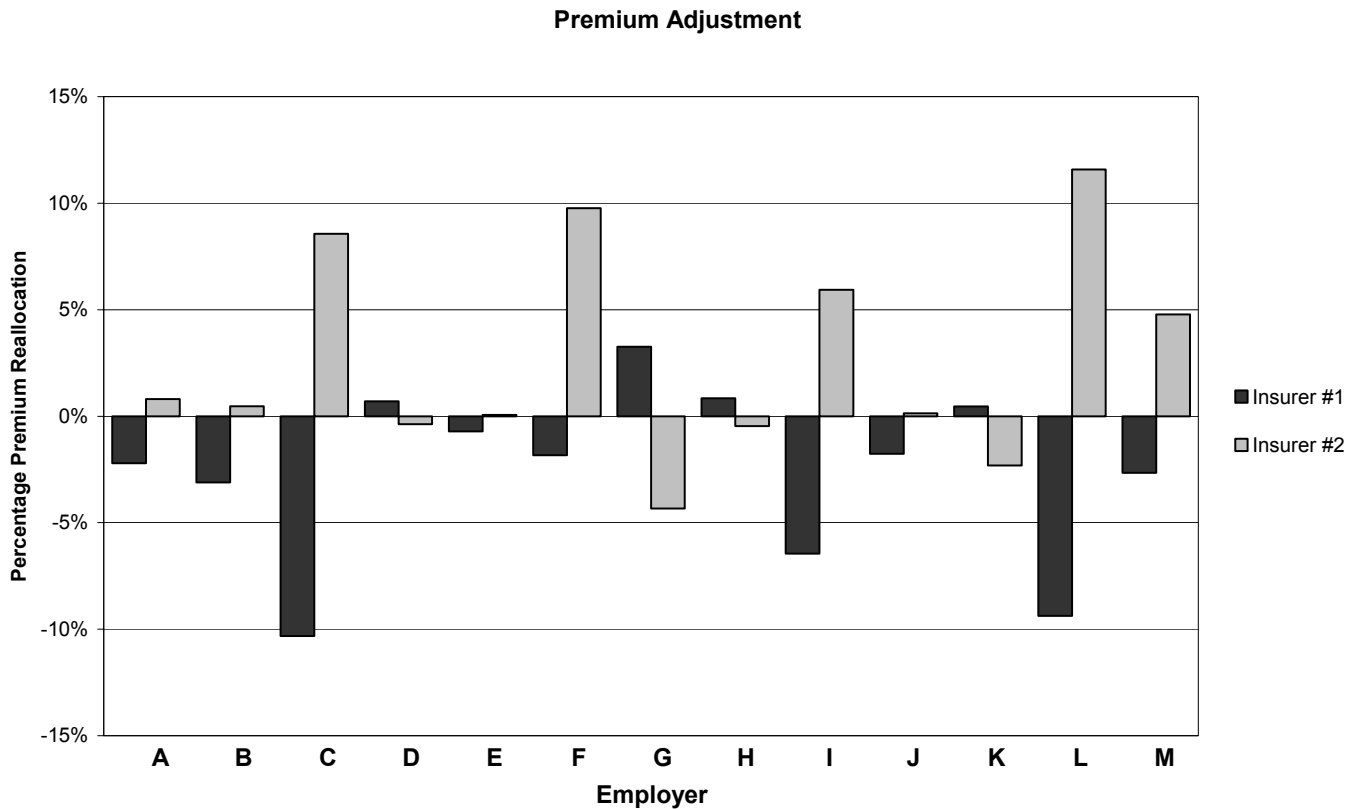


Figure 5

Notice how in several groups the adjustment altered premium more than 5%, which is significant because insurers operate on less than 5% profit margin. Adverse selection can easily turn slice business into an unprofitable venture. Without risk adjustment, the insurer that received the higher proportion of chronically ill would be forced to raise premium, making the cost share to the employee higher, further exacerbating the adverse selection, eventually making the affected insurer leave the offering—a situation called the death-spiral. Risk adjusted premiums to insurers prevent the death-spiral.

11. Risk Adjustment in Other Government Programs

As mentioned above, BENU uses the same predictive modeling software as currently used by the Medicare program in determining payments to insurers in the Medicare+Choice program. Several Medicaid programs across the country are using similar predictive modeling tools in their programs as well. If participants in these programs have a choice of insurers, it bodes well for creating efficient healthcare since insurers will actively compete for all participants, the chronically ill as well as the healthy, and yet create economic pressures (i.e., loss of patients) on the most costly alternatives to innovate to contain and reduce cost. The most efficient plans gain market share and are rewarded for being economical.

12. Conclusion

Our current system of paying insurers perpetuates a single-insurer full-replacement model of health insurance coverage that leads to higher costs. While the current system may be an appropriate way to *fund* health care, it is not an appropriate way to *pay* insurers. BENU's risk adjustment method sensibly reallocates the funding of health care to pay insurers in a manner that creates a competitive consumer market that lowers costs for employers, satisfies employees and motivates insurers to provide value for the chronically ill.

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