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U.S. Senate Committee on Finance, Hearing on
"47 Million and Counting: Why the Health Care Marketplace is Broken"

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Chairman Baucus, Ranking Member Grassley, and esteemed Senators, it is a distinct honor to appear before this distinguished committee as it begins the monumental undertaking of reforming our health care system. My name is Mark A. Hall, and I am a Professor of Law and Public Health at Wake Forest University, where I specialize in health care finance and regulation.

My testimony addresses problems in the structure and functioning of private health insurance markets.   I have studied these markets for almost two decades, starting with a Fellowship at the Health Insurance Association of America in 1991, and continuing through fifteen years of empirical studies with insurers, agents, employers, and regulators.

Health policy analysts are fond of invoking medical metaphors, and I too cannot resist. Some might say that the private health insurance market is crippled, severely wounded or on life support. I am not quite that gloomy, but no one can deny that the market is far from a picture of rosy health. Some parts are functional, other parts are in steady decline from chronic ailments, and yet others are fairly stable but show ominous precursors of acute illness. I will describe these critical indicators and diagnose the underlying conditions that afflict different parts of the market organism.

The Numbers

Since 2000, insurance premiums have doubled, increasing four times faster than earnings or general inflation (Figure 2). Today, the average cost of family coverage is over $12,000 a year, which is about one-quarter of median household income.   Single coverage averages about $4500 a year, which is almost half the income of someone at the federal poverty line.

These averages reflect employer-based coverage. For individual insurance, the industry reports average rates that are about half these amounts ($2600 single coverage and $5800 family), but this is for coverage that tends to be much less generous and more difficult to obtain than employer-based insurance.

Premium increases are driving people out of the insurance market. Since 2000, both the percentage of employers offering coverage and the percentage of people covered by employers have dropped more than five points, to around 60 percent (Figure 3 and Exhibit 1). This decline in employer coverage has not been accompanied by any increase in individual coverage. Therefore, the portion of the non-Medicare population covered by private insurance has slipped from about 3/4 to about 2/3 in the past six years.

These disturbing declines have occurred despite strenuous efforts to shore up the market's erosion through legislation. For instance, federal reforms expand tax benefits for purchasing insurance (HSAs) and restrict insurers' from rejecting group applicants (HIPAA). These laws have been vitally important. Without them, conditions would only have worsened much more than they have. But, we must keep in mind that it will take

considerable additional effort simply to keep things from getting worse, let alone to substantially improve or to fix this market.

Things have gotten worse despite corrective efforts because the basic market conditions that cause the problems are still very much in place. Indeed, they are elemental. These market conditions will always plague us to some extent because they derive from a fundamental fact of the human condition – that the need for medical care is highly skewed throughout the population. This point is the main focus of my testimony.

The Highly Concentrated Burden of Medical Costs

<u>The high concentration of most medical costs in a relative few people is the single most important fact for understanding the private insurance market.</u> It is hard to find the right words to describe this foundational statistical phenomenon in terms that are sufficiently compelling, so I will start with a graphic depiction.

Figure 1: Concentration of Health Care Spending in the U.S. Population, 2005
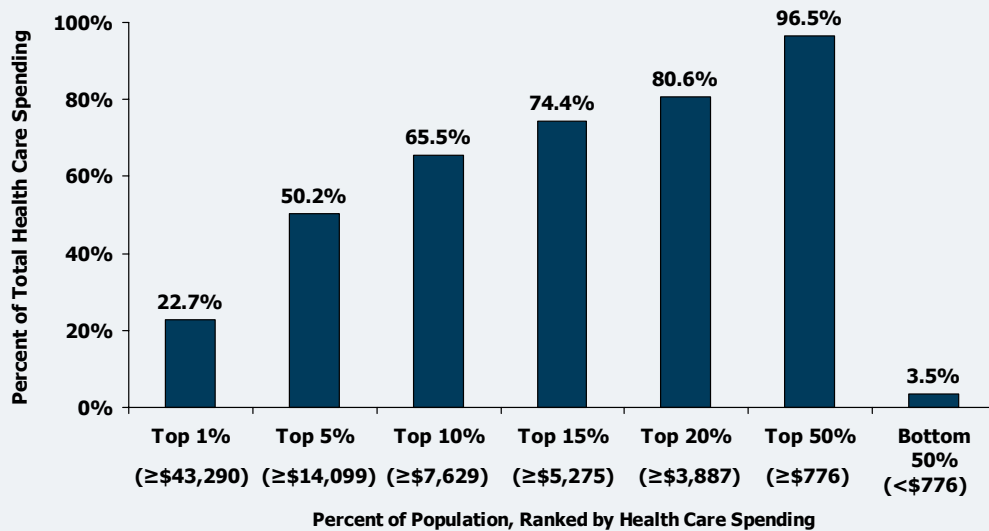
Source: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2005.

Arraying the population by health care spending in a year, this chart shows that
- the top 1% (those who spent more than $43,000) accounted for almost one-fourth of total spending
- the top 5% (who spent more than $14,000) accounted for half of all spending
- and the top 20% (who spent more than about $4000) accounted for 80% of spending.

The bottom half of the population distribution (who spent less than $800 that year) incurred less than 4% of total costs.

For convenience, I refer to this as "the 80/20 rule." I call it a rule because the pattern is remarkably universal. This pattern has a fractal geometry that appears wherever one looks.   It holds true both for the population at large and for just about any subpopulation of any size one might choose to examine (see Exhibit 3). Medicare spending is essentially just as concentrated as that for people in their 40s, or that in just about any larger employer group. The extreme concentration of health care costs is an economic law of nature that has been observed as early as the 1930s and that will be with us for as long as anyone can foresee – regardless of how we deliver and pay for health care.

There is no easy way to reduce or eliminate the effects of concentrated medical costs because the extremes are so great. Various techniques such as high-risk pools, reinsurance, and risk adjustment have been tried or proposed. These measures can certainly help somewhat, but the amount of money involved is too large to eliminate the basic underlying phenomenon. For instance, if even the top half of expenditures (which are concentrated in 5% of the population) were removed from the market, we would still have a market in which some people's expenses were ten times greater than the *middle* of the distribution. Removing half the costs would cut the total costs in half, but this would not alter the basic dynamics created by the fact that the remaining costs would still be concentrated in a relatively small portion of people.

Market Dynamics: Risk Segmentation, Adverse Selection, and Medical Underwriting

I stress the 80/20 rule because it is the most elemental fact of health insurance. It is as fundamental as gravity, and as pervasive as the weather. It is the endemic First Cause that reaches everywhere and explains just about everything of importance in the market for insurance.

The high concentration of medical costs is why we need and have insurance in the first place. Pooling expenses across a population keeps them affordable for everyone, but the extreme costs at the high end also explain why insurance is so expensive, especially for those who anticipate no real need.

The extreme magnitude of differences in health risks also explains the private insurance market's most perplexing dynamics. I will describe several troubling phenomena, each of which derives from the basic fact that insurers stand to gain a great deal by avoiding or appropriately pricing people with higher risks. They also stand to lose a great deal if they

do not attract a good number of lower risks. Therefore, <u>competitive forces in health insurance markets inevitably focus on risk selection (or risk segmentation).</u> Other points of competitive focus – such as product design, benefit coverage, sales vehicles, and care management – either have much less impact on profitability or are themselves surrogates for risk selection or segmentation.

The most visible form of risk selection is *medical underwriting*. This consists of evaluating the health risks specific to each subscriber in order to assign an actuarially fair price. According to industry figures, about 70% of people who apply for health insurance receive an offer of coverage at standard rates or better. The rest are either declined (12%), offered higher rates (6%), or offered coverage that excludes one or more particular pre-existing conditions (13%). In field studies, market testers found that conditions as common as asthma, ear infections, and high blood pressure can create problems obtaining coverage.

Medical underwriting is necessary because of *adverse selection* – the tendency of people to avoid the purchase of insurance unless they expect to need it, and for those with more need to buy more insurance. A health insurance market could never survive or even form if people could buy their insurance on the way to the hospital. Therefore, medical underwriting rewards people who purchase while they are still young and healthy, and imposes pre-existing condition exclusions or charges higher rates, for those who are not.

An especially aggressive form of risk screening is called "post-claims underwriting" – namely, waiting to assess pre-existing conditions until a paying subscriber submits large claims. If, after more scrutiny, insurers find that applicants were not completely forthcoming, they have been known to *rescind coverage retroactively*, even after people have paid premiums and received authorized treatment. State insurance regulators monitor such practices and determine when they are excessive or inappropriate, but it is a constant tension between public-minded regulators and competing insurers to determine the boundary of proper underwriting and claims adjudication.

The mirror image of adverse *selection* is adverse *retention*. A newly underwritten insurance pool will tend to deteriorate over time, meaning that the pool's health costs will increase fairly steeply relative to marketwide averages. This *durational effect* is pronounced because people are free to shop around for cheaper or better insurance – but only if they are still healthy. To remain competitive, insurers target these shoppers by offering them their most attractive rates. To compensate, they must increase the rates of renewing subscribers – which is one reason people experience rate hikes that are much steeper than their increases in wages.

Existing subscribers who no longer can pass medical underwriting, or who would be subjected to new pre-existing condition exclusion periods, are stuck with the insurance they have. Although they are guaranteed to be able to keep this coverage forever, at some point mounting medical costs in the pool make it no longer economical for the insurer to sell that particular policy. And, once no new healthier subscribers are entering the pool, the costs skyrocket into what is called a "death spiral." Some insurers exploit

this dynamic by *churning* risk pools. They frequently close off existing policies to any new subscribers and instead market new policies that are very similar but that are available only to freshly underwritten subscribers. This practice results in more hermetically separating lower versus higher risk subscribers into differently-priced policies.

Medical underwriting, plus constantly searching for a better price, adds additional costs to the system. These transaction costs account for a sizeable portion of the premiums people pay – on the order of roughly 20-25% for individual insurance and 10-15% for small groups. Constant turnover in coverage also undercuts the inherent efficiency of insurance markets. Insurers have little incentive to invest in life-long health prevention measures because the typical policyholder remains with a plan for an average of only about three years.

The natural dynamics of risk segmentation are so strong that risk selection occurs even without overt medical underwriting. Subscribers naturally sort themselves by risk to some extent, according to the covered benefits and plan features they find most attractive. Insurers and employers have learned that features such as deductibles, managed care, and particular benefits that are covered or excluded appeal differently to people with lesser versus greater health care needs. This is one reason many health policy analysts favor uniform benefits and why most employers limit their workers' choice of health plans.

Necessary Reforms

Various insurance market reforms have worked well to mitigate the worst excesses of these market-driven competitive practices, but these counteractive measures are not capable of eliminating these effects. Risk selection practices flow directly from the very nature of how competitive markets should and must respond to highly concentrated health risks. Therefore, these effects will never be eliminated unless the market is fundamentally restructured.

The basic requirement is to place people into large groups whose membership is not tied to health risk, and to limit the choice of plans within the group. This is currently how large employer groups work, which is why they remain the best-functioning part of the market. These conditions also fit subsidized insurance pools such as the Massachusetts Connector. To meet these essential conditions, everyone (or almost everyone) who is eligible must agree to purchase insurance from their assigned group, and the insurers must not have a great deal to lose or gain according to how healthy or sick each subscriber is. This is easy enough to state in the abstract, but exceedingly difficult to achieve in practice.
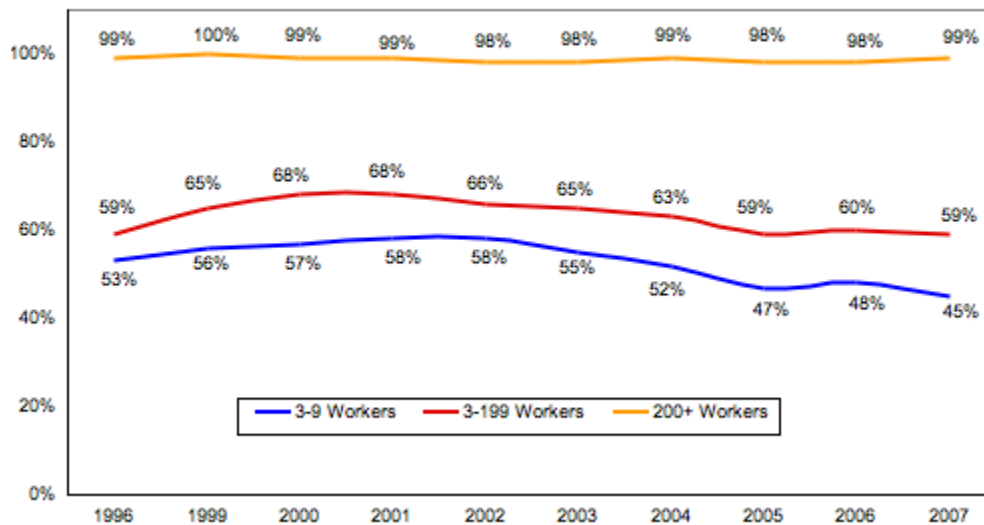
I wish this Committee and the Senate Godspeed and wisdom in pursing this formidable challenge.

Figure 2: Annual Growth Rates for Health Insurance Premiums, Workers Earnings, and Overall Inflation, 1988-2007
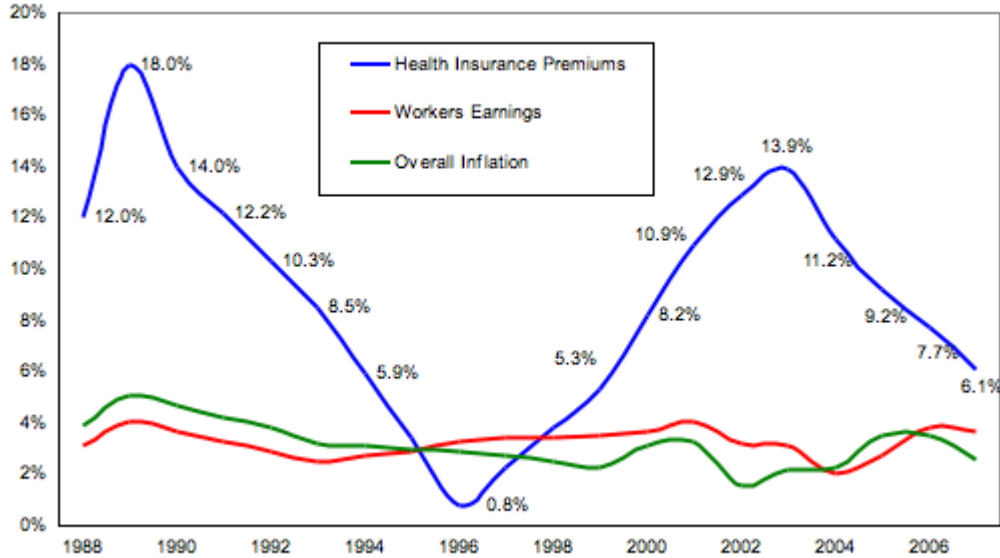
Source: Kaiser Family Foundation/Health Research and Educational Trust.

Figure 3: Percentage of Employers Offering Health Benefits by Firm Size, 1996-2007

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits.

EXHIBIT 1
Health Insurance Coverage Among Nonelderly Americans, By Age And Source Of Coverage, 2000–2004 And 2004–2006

	All nonelderly			Adults			Children		
	Coverage distribution		Change (millions of people)	Coverage distribution		Change (millions of people)	Coverage distribution		Change (millions of people)
2000–2004	2000	2004	2000–04	2000	2004	2000–04	2000	2004	2000–04
All incomes (millions of people)	245.1	255.1	10.0[c]	168.8	177.3	8.5[c]	76.3	77.8	1.5[c]
Employer	67.8%	63.3%[a]	–4.9[c]	68.9%	64.4%[a]	–2.2[c]	65.4%	60.7%[a]	–2.6[c]
Medicaid/state	8.8	11.2[a]	6.9[c]	5.3	6.5[a]	2.6[c]	16.7	21.9[a]	4.3[c]
TRICARE/Medicare	2.1	2.3[a]	0.7[c]	2.3	2.7[a]	1.0[c]	1.7	1.3[a]	–0.3[c]
Private nongroup	5.1	5.4[a]	1.3[c]	5.6	5.8[b]	0.9[c]	3.9	4.4[a]	0.4[c]
Uninsured	16.1	17.8[a]	6.0[c]	17.9	20.6[a]	6.3[c]	12.3	11.6[a]	–0.4
2004–2006	**2004**	**2006**	**2004–06**	**2004**	**2006**	**2004–06**	**2004**	**2006**	**2004–06**
All incomes (millions of people)	255.1	260.0	4.9[c]	177.3	181.8	4.5[c]	77.8	78.2	0.4
Employer	64.0%	63.0%[a]	0.5	65.2%	64.4%[a]	1.5[c]	61.4%	59.7%[a]	–1.0[c]
Medicaid/state	11.2	11.3	0.7[c]	6.6	6.6	0.3	21.9	22.4	0.5[d]
TRICARE/Medicare	2.3	2.3	0.3	2.7	2.8	0.3[d]	1.4	1.4	0.0
Private nongroup	5.6	5.5	0.0	6.0	5.9	0.1	4.5	4.5	0.0
Uninsured	16.9	17.9[a]	3.4[c]	19.5	20.4[a]	2.4[c]	10.9	12.1[a]	1.0[c]

SOURCE: Urban Institute, 2007, based on data from the 2001, 2005, and 2007 March Supplements of the Current Population Survey.
**NOTE:** Excludes those age sixty-five and older and those in the Armed Forces.
[a] Change in percentage of people is statistically significant (at the 95% confidence level).
[b] Change in percentage of people is statistically significant (at the 90% confidence level).
[c] Change in numbers of people is statistically significant (at the 95% confidence level).
[d] Change in numbers of people is statistically significant (at the 90% confidence level).

EXHIBIT 4
Percentage Of Medicare Spending Attributable To The Most Expensive 5 Percent And 1 Percent Of Beneficiaries, Aggregated Over Four-Year Periods, 1975–2004
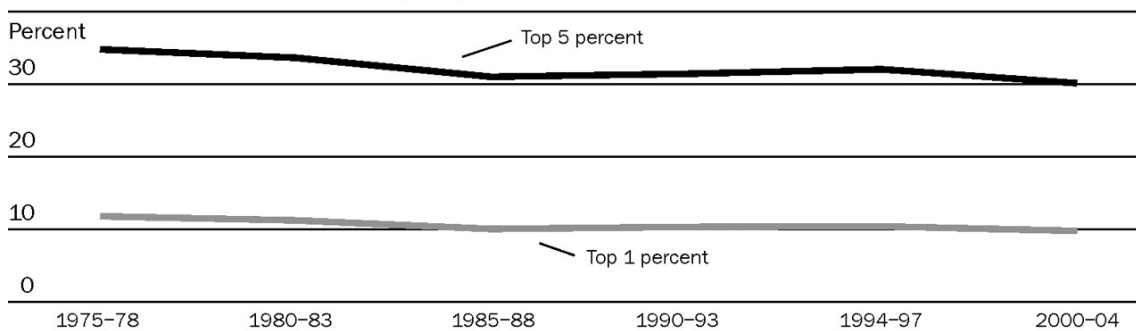
SOURCE: Claims and enrollment data from the Continuous Medicare History Sample, various years.
NOTES: Data are for beneficiaries entitled to Part A and Part B and in fee-for-service in each year they were alive. Data have been inflation adjusted to the last year in the period using the Consumer Price Index–All Urban Consumers.