

Statement of Janet Trautwein

**Executive Vice President and CEO
National Association of Health Underwriters**

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**National Association of Health Underwriters
2000 North 14th Street
Suite 450
Arlington, VA 22201
(703) 276-0220
(703) 841-7797 FAX
jtrautwein@nahu.org
www.nahu.org**

Good morning. My name is Janet Trautwein, and I am pleased to be here today on behalf of The National Association of Health Underwriters (NAHU). NAHU is a professional trade association representing more than 20,000 health insurance agents, brokers and employee benefit specialists all across America. Our members work on a daily basis to help individuals and employers of all sizes purchase health insurance coverage. They also help their clients use their coverage effectively and make sure they get the right coverage at the most affordable price. Furthermore, most NAHU members are small business owners themselves.

All of this experience gives our membership a unique perspective on the health insurance market place. Our members are intimately familiar with the needs and challenges of health insurance consumers, and they also have a clear understanding of the economic realities of the health insurance business, including both consumer and employer behavioral responses to public policy changes. They have had the chance to observe the health insurance market reform experiments that have been tried by the states and private enterprise, and are in a unique position to report on which of these efforts have worked the best. I am honored to be here today to share these unique observations with Congress.

The members of NAHU believe all Americans deserve a health care system that delivers both world-class medical care and financial security. Americans deserve a system that is responsible, accessible and affordable. This system should boost the health of our people and our country's economy. That being said, the system must also be realistic.

We believe the time is right for a solution that controls medical spending and guarantees access to affordable coverage for all Americans. We believe this can be accomplished without limiting individuals' ability to choose the health plan that best fits their needs and ensures them continued access to the services of independent state-licensed counselors and advocates. We also believe that the federal government could adopt several key reform measures that would go a long way toward making health insurance coverage more affordable and more accessible to millions of Americans.

By far, the greatest access barrier to health insurance coverage in America today is cost. NAHU believes that any successful comprehensive health reform plan will need to address the true underlying problem with our existing system—the cost of medical care. Constraining skyrocketing medical costs is the most critical—and vexing—aspect of health care reform. The cost of health care delivery is the key driver in rising health insurance premiums and it is putting the cost of health insurance coverage beyond the reach of many Americans.

There is no one magic answer to health care cost containment and there are many reasons health care costs are skyrocketing. Addressing this massive societal problem requires a multitude of comprehensive actions by individual citizens and elected officials. Many of the topics that need to be addressed to truly lower health care costs in the country, like physical education for children or wiser nutritional choices, are not ones in which NAHU members as a whole have any particular expertise. However, as health insurance

producers and employee benefit specialists, we do have extensive knowledge of health insurance markets and the factors that are directly driving up health insurance claims costs and, consequently, health insurance premium rates. We feel that the following recommendations would make important improvements to the U.S. health care system to lower costs, improve quality and create greater efficiency:

- Encourage federal and state governments to incorporate wellness and disease-management programs into medical programs for employees and government-subsidized health coverage.
- Provide employers with legal protections and tax and premium incentives for wellness programs.
- Provide incentives for doctors and medical facilities to improve system efficiencies and eliminate errors with pay for performance, best-practice guidelines and support for evidence-based medicine.
- Create federal standards for interoperable electronic medical record technology to help unify the health care system, reduce errors and improve patient satisfaction.
- Enact comprehensive medical liability reform that limits non-economic damage awards, allocates damages in proportion to responsibility for adverse events, places reasonable limits on punitive damages and attorney fees, and imposes reasonable statutes of limitations on claims. Encourage state authorities to increase the effectiveness of discipline imposed on substandard providers. Alternative dispute resolution mechanisms, like health courts, might also be considered to ensure more timely and less costly avenues for both patients and providers.
- Reimburse providers participating in all federal health care coverage programs, including Medicaid, Medicare and SCHIP, at the same level paid to providers serving federal employees through the Federal Employees Health Benefit Plan.
- Encourage states to streamline the application processes for public health insurance programs like Medicaid and SCHIP, and allow for presumptive eligibility so that all eligible participants are enrolled and their providers are paid properly to mitigate uncompensated care expenses.
- Encourage expansion of consumer-directed health insurance products.
- Make consumers more aware of the cost of the health care that they are purchasing by enabling and encouraging health plans and providers to overcome policy concerns (e.g., prohibiting gag provisions in provider contractors) and bring greater price transparency to the public as soon as possible.

It is estimated that anywhere from 25-33% of our nation's \$2 trillion annual health care expenditures might be considered inefficiencies. Improvements including the ones highlighted above can go a long way toward reducing our growing health care costs.

This panel's focus is health insurance market reforms, and I would like to urge you to consider cost with every single health insurance market reform proposal you entertain. Not just whether or not the market reform idea includes cost containment elements, but also whether or not the market reform idea itself would cause health insurance premiums to increase. Great care needs to be taken when implementing market reforms on a

national level to not inadvertently induce cost increases in the existing private market system. No matter how “fair” a market reform idea might seem on its surface, it’s not at all “fair” if it also prices people out of the marketplace.

State Reforms

Our states are excellent laboratories for democracy, and some state health insurance markets have greater stability and competition, and lower costs and fewer uninsured than others. State governments have tried all kinds of health insurance market reform measures—both large-scale and small. I encourage you, as you think about national market reform changes, to look at things like how implementing guarantee issue coupled with community rating and a high number of mandated benefit requirements have priced thousands out of the individual market in New Jersey. Whereas allowing for the assessment of insurable risk in the individual and small-group health insurance markets for effective risk-management have yielded substantially lower premium and higher coverage rates in the adjoining state of Pennsylvania.

Look at how creating a public coverage option to compete with the private market in Maine has been a costly experiment that hasn’t yielded a significant dent in the uninsured population. Think about the soaring costs associated with the Massachusetts Connector experiment, and how the program has resulted in a huge number of people who are eligible for subsidized coverage to enroll (which is a positive, albeit expensive result). But also consider how the Connector has attracted very few private paying customers, which was not at all what the Commonwealth thought would happen. Then look at states like Oregon and Oklahoma, which have both addressed the issue of subsidizing employer-provided health insurance premiums for lower-income individuals and small business in very different, but equally market-friendly, ways. Or look at the legislation Georgia just passed to provide an innovative state tax incentive for the purchasers of private consumer-directed coverage.

Some states have also been highly successful in crafting measures to fill gaps in federal coverage protections. For example, the issue of preexisting conditions and individual market coverage portability has been repeatedly identified as a problem with our nation’s individual market coverage system. People who have obtained individual coverage when healthy and then acquired a medical condition can be limited in their options for switching coverage plans, due to preexisting condition and medical underwriting requirements. However, these very requirements are what helps prevent individual market adverse selection and keeps individual market prices down for the entire insured population. Texas addressed this issue a number of years ago in a way that ensures people access to coverage while still preserving affordability in the private market. The state offers individuals who have been responsible and maintained individual market health insurance coverage over time credit for their prior coverage with just a one-month waiting period.

Utah and Idaho have both managed to provide guaranteed access to private individual market coverage, using a unique twist on a high-risk pool in Utah and a reinsurance mechanism in Idaho. States such as Florida have implemented innovative price

transparency requirements helping those without health insurance and those with consumer-directed health insurance coverage to be much more aware of both the true cost and the quality of the medical care they are purchasing at the point of purchase.

NAHU believes that Congress would be wise to look at our existing system for holes, and see what the states have done to fill those coverage gaps successfully. A few simple reform measures enacted at the federal level of government would go a long way toward extending health insurance coverage to millions of Americans.

Guaranteed Access Initiatives

State-level high risk pools are a good example of a state reform that in most cases are successful and fill a coverage need, but could benefit from some additional federal assistance. A few states like Georgia and Arizona have residents who do not have access to employer based coverage, who are sick, and cannot buy health insurance coverage—at any price. Federal access protections in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) ensure that small-group health insurance customers and individuals leaving group health insurance coverage must always have at least one guaranteed purchasing option, but these do not apply to everyone. People purchasing coverage in the traditional private individual health insurance market who are not transitioning from an employer’s plan do not have federal guaranteed-issue rights. Most states (but not all) have independently established at least one mandatory guaranteed purchasing option. While the mechanism for access to health care coverage may vary, no American should be denied. To solve this problem quickly and efficiently, the federal government should require that all states have at least one private guaranteed purchasing option for all individual health insurance market consumers.

In 34 states that have already acted to fill this important coverage need, the state has elected to create a high-risk health insurance pool. These public/private institutions are currently providing thousands of consumers who do not qualify for need-based public assistance like Medicaid with a private safety-net of coverage. Risk pool consumers in most states are beneficiaries of well-run comprehensive coverage plans with excellent disease and claims management programs. Furthermore, traditional individual market and small-group health insurance consumers in these states benefit from the existence of the pool because the highest and least predictable health risks are removed from these insurance markets.

However, in some states, high-risk pools do not work particularly well, and most of the problems stem from high costs. High-risk pools must be subsidized, because with their inherent high-needs populations, capped pool premiums are never enough to cover participant claims. And because risk pool premiums are age-rated and normally are priced between 125-150% of the average individual market rate, premiums can be too high for lower-income individuals and early retirees, even in a state with a well-functioning pool. A relatively small and stable federal investment to provide state risk pools with additional funding assistance could help make risk pool coverage affordable and accessible for millions of Americans. Congress should also consider increasing the

function of risk pools to be a more transparent backdrop to guarantee access to coverage for those in poor health.

Reinsurance Issues

Another area where Congress should consider effecting change is the subsidization of reinsurance. Numerous studies of health insurance claims indicate that a small number of insured individuals with serious and/or chronic conditions are responsible for the vast majority of health care expenses that health insurance companies pay. Spreading the potential risk of these individuals is difficult in every insurance market, which is why private reinsurance coverage is already broadly used and why there are insurers that specialize in this type of product. It is often surprising for people when they learn that even insurance companies buy reinsurance. Doing so provides additional stability for their clients by protecting them against large rate fluctuations that can occur when losses are greater than anticipated. It is those unexpected losses that are the problem, much more than those that are expected, and this is why insurers may buy additional reinsurance. This is also the reason that self-funded employers purchase reinsurance coverage, which is often called “stop-loss”.

Although there are many different types of reinsurance, there are two main categories or types of coverage for health insurance purposes. First, reinsurance can be purchased either to protect against excessive claims by an individual, or second, against losses from an aggregate pool of insured people or businesses, such as an employer group or an insurer's pool of small employer health insurance policies, or both. It is very important to those who purchase reinsurance that they purchase the right amount of coverage. Too much reinsurance is a waste of dollars, and results in higher rates. Too little reinsurance can cause huge rate fluctuations when a number of large claims occur in a given year.

The amount of coverage purchased is related to claims expected by the pooled group, even when buying coverage for individuals. For example, an insurer who sells policies to small employers can anticipate the amount of expected claims in a given year from its pool of small employer policies. The insurer may decide to buy reinsurance coverage for individuals within those groups who have claims above a certain level, which is likely to be a percentage of expected claims for the whole pool of individuals they have. Larger employer groups who self-insure use a similar calculation when they are deciding how much reinsurance to buy against losses by individuals in their group. It is very important to note that for a very large employer or an insurer with a large block of a particular type of business, the calculation for an individual reinsurance level may be so high that they decide not to purchase coverage and self-insure against individual losses. This is one reason why reinsurance should not be for an arbitrary amount, but rather directly related to the ability to spread risk and absorb losses.

Reinsuring coverage for a group's losses is aggregate: in other words, heavy utilization by many members of the group is a similar calculation. Again, the “group” for an insurer is likely to be the block of a particular kind of business, for example, the insurer's block of small employer policies. Again, expected claims are calculated and reinsurance coverage for losses in the event there are many claims within this block of business in a

given year may be purchased. Again, large insurers or large employers will not need the same level of protection as that of smaller insurers or smaller self-funded employers because of their greater ability to spread risk and absorb losses.

Reinsurance does not offer full protection against rising costs due to excessive claims expenses. The reason is there is a cost to provide reinsurance (a premium) and if there are claims on the reinsurance, this cost will increase at a higher rate than it normally would. Regardless of whether or not there are claims, the cost of reinsurance is a cost of doing business and is factored back into the premium policyholders pay for their coverage.

Insurance carriers who operate in the small employer health insurance market currently pool similar small employers together in each of the states where they do business. Although they may be allowed some limited initial pricing flexibility based on underwriting of each small employer, and even though they are pooling many small employers together, it is often difficult to adequately spread the risk for individuals with significant health problems. The result is higher claims for the whole “pool” of small employers, which in turn results in higher premiums for all small employers.

It should be noted for comparison purposes that in the *individual* health insurance market in the majority of states insurance carriers can underwrite based on health status, and can decline to issue coverage on the sickest of individuals. This keeps rates affordable in the individual market, absent other regulations that impact premiums. Those who are turned down for coverage can obtain coverage in a state high-risk pool in 34 states, and most other states have some other mechanism to guarantee coverage to those with significant health conditions. A key element of these mechanisms is that the sickest individuals are pooled separately from those who are healthy.¹

HIPAA does not allow this type of high-risk pool arrangement in the small employer market, although the small employer market shares many of the characteristics of the individual market. HIPAA does not allow individuals to be excluded from a group, or rated separately based on their individual health status. For this reason, each small employer’s claims—including the claims from high-risk individuals—are included when calculating the total claims expense incurred for the whole “pool” of small employer business. This claims cost is the largest component of small employer health insurance premiums. Some states have tried to assist with the cost of reinsurance especially for smaller insurance carriers by forming state reinsurance pools for insurers in the small employer health insurance market. These pools are not purchasing pools, but rather financial pools set up at the state level strictly to handle the financial side of insuring high-risk individuals. Small employers purchase coverage through carriers as they normally do, but when a carrier initially underwrites a case, they purchase extra reinsurance coverage on the unhealthiest risks from a state reinsurance pool. This is transparent to the covered individual, who continues to receive benefits exactly the same as all other members of the employer group. If claims on the individual exceed a certain level, the reinsurance pool reimburses the carrier for their losses above that level. The

¹ States that guarantee issue all individual health insurance policies do not pool sick individuals apart from those who are healthy, but prices are significantly higher for all individuals in those states.

carriers continue to retain a small part of the risk at that point, to ensure that incentives to control claims cost are retained.

Today there are nineteen active reinsurance pools, and another eleven pools that are either inactive or in the proposal stage. Reinsurance pools are currently funded by premiums paid by participating carriers. Up until this time, reinsurance pools' success has been marginal in terms of their ability to produce cost savings in a given state market, primarily due to the size of current pools. The main reason for this is that the pools are largely voluntary and small with only a few participants to share in the cost of the reinsurance. Many large carriers have decided not to participate in the pools, because they felt they were large enough to absorb more risk, or because they had already developed their own source of internal or external reinsurance. Their feeling was that they had no need to pay premiums to a reinsurance pool. Thus, some—but not all—carriers in a market participate in the current state reinsurance pools. As a result, savings have been less than they would have been in a larger pool, and the cost of reinsurance passed back to consumers has been greater than it would have been with more participation by more and larger carriers with more risks to reinsure.

Part of the reason why the current structure of the state reinsurance pools is unattractive to carriers is the arbitrary nature of the pools. They follow an older NAIC model that uses a very low stop-loss level considered ridiculous by many larger carriers. They have no need to incur the cost of reinsurance at the level, and they have wisely chosen not to do so. Thus, for these pools to ever be truly successful, some significant changes are needed.

One idea that has been circulated is for the federal government to subsidize reinsurance in some way. If done correctly, this could reduce the cost of coverage currently paid by employers and their employees today by taking away part of the dollars paid in claims that are normally factored into calculation of the health insurance premium. The amount of savings would depend on the amount of subsidy provided, but any reduction is more than they now are receiving. Although this reduction could be structured many ways, it is simple math that if you take away part of the total number used to calculate a premium, the total premium will be less. That means a lower cost to small employers, a reduction in the employee's share of the cost of coverage, and hopefully more employers who could offer coverage to their employees.

It is important to note that if reinsurance were subsidized in the health insurance market, some important principles should be followed. Because there is a vibrant reinsurance market already in existence, it is not necessary for federal or state governments to become reinsurers. In fact, it is very important that in trying to provide assistance, federal and state governments do not harm the market that already exists or impose demands on plans that would ultimately increase rather than decrease costs. The simplest approach would be a simple federal grant program similar to the current program for subsidies to state high risk pools. The purpose of such a plan would be to remove cost for high cost cases from the system through reimbursing some of the employer or insurer's reinsurance premiums if they incur losses significantly higher than those they would already expect to incur. Some important principles to ensure such a grant program would work effectively within the current insurance market structure would be:

- Reinsurance subsidies would need to be available across a market and must not segment markets. For example, if it were decided to provide reinsurance subsidies for the small employer market, those subsidies would need to be available for every insurer in that market, not simply to insurers that offer coverage in a particular purchasing pool.
- Reinsurance subsidies should not be arbitrary. One of the reasons for the lack of success in small employer reinsurance pools that exist in states today is that the level of coverage is at an arbitrary level that is too low to be attractive to the large insurers that could make the pools more effective.²
- Reinsurance subsidies should be based on losses significantly in excess of those already expected.

If done correctly, providing some help with the cost of reinsurance would seem an appropriate role for the federal government, and one that is consistent with its other roles. It would mean that the federal government would be subsidizing the cost of coverage for those who are sick. It would not create a new government-run bureaucracy, but merely provide financial assistance on behalf of those who need help most. The government would subsidize reinsurance premiums, but not become the reinsurer itself. It would bolster the private system, and make coverage more affordable for all small employers.

Pooling Options

Another market reform idea that has received a great deal of attention at the federal level and has been tried in numerous different ways with varying degrees of success in states is pooling individuals and or small businesses together to purchase coverage. Whether called a “purchasing pool,” “connector” or “exchange,” the fundamental idea is similar: If a significant amount of small businesses and/or individuals can be grouped together, enough risk can be spread around and the same savings and economies of scale can be achieved as coverage through a single large employer.

Pools are not new. They have been tried in numerous states and with varying degrees of success in lowering costs (California’s HIPC experience achieved some initial positive results, but recently disbanded). They have all had to deal with the very real and very negative consequences of adverse selection, or the tendency for people with greater needs to be more likely to sign up for insurance, or to enroll in one plan instead of another. We all know disproportionate enrollment in a health plan by less healthy people leads to higher premiums for all, which tends to drive healthier people out of that plan, further increasing costs. The same holds true for health plans that are grouped together in a pool.

Cost containment can be achieved in group purchasing under the right setting. Two of the unique characteristics that make large-group employer coverage work so well are controlled entry into and exit from the plan (mitigating adverse selection), and employer

² A large employer or large insurer does not buy reinsurance today at the same level as does a smaller insurer or employer, and subsidies should reflect that dynamic. For example, if a self-funded employer were purchasing reinsurance against individual losses, a \$50,000 level would probably be selected only if expected claims were \$500,000 for that year. This would represent a fairly small employer and would be a ridiculously low level for a large insurer or employer.

premium contributions to all eligible employees regardless of their need for coverage. These mechanisms help ensure a good mix of insurable risks.

Success of any pooling arrangement also depends on who is being insured. From a risk-management, or administrative perspective, a pool with 1,000 five-employee groups is very different—more risk, higher cost—from one employer with 5,000 employees. And although political temptations are strong to combine individuals seeking insurance with small employers in hopes of creating a large purchasing pool, careful consideration must be given to preserve health insurers' ability to assess risk and price products accurately, and to avoid the creation of an unbalanced playing field in the health insurance marketplace.

One of the most important lessons we have learned from state-level pooling experiments is that care must be taken to ensure that the same market reform measures apply to coverage purchased both inside and outside the pool. Otherwise, an unlevel playing field can destroy both the pool and also the conventional private market. If, by government dictate, the true value or cost of insurance is markedly different than the value/cost that people inside a special pool are being promised, conventional markets will likely erode over time. We have seen this happen in a number of states, and the end result typically has been less choice and increased costs.

The real world experiences from pooling arrangements illustrate that the most stable and competitive marketplaces have been those that maintain as level a playing field as possible for all players in the health care equation—consumers, insurers, employers and providers.

It is possible that purchasing pools could evolve into a better cost-saving vehicle than they have proven to be in the past if the right regulatory environment and financial incentives are in place. However, care must be taken to ensure that competitive prices both inside the pool and in the outside market can be maintained over time in order for any savings to be meaningful.

Tax Treatment of Health Insurance

A final access issue that the federal government should address is tax equity for health insurance purchasers. The vast majority of privately insured Americans receive their health insurance coverage through their employer or their spouse's or parent's employer. To help encourage the provision and acceptance of employer-sponsored health insurance, there is a current federal tax exclusion in which the amount of an individual's group health insurance coverage premium paid by an employer is excluded from the employee's gross income for income and payroll tax purposes. NAHU strongly supports employer-based coverage, and ways to encourage more employers to contribute toward the cost of their employees' health insurance coverage. We believe that any successful market reform effort must include employer-based coverage as its pillar, and that the preservation of the federal employer deduction and employee exclusion is critical.

However, the employer-sponsored health insurance system does not work for everyone. The availability of employer-based coverage has declined in recent years as costs have increased. Employer-based coverage is also not always an option for early retirees or the self-employed. As such, NAHU supports equity in the tax treatment for individuals and families who purchase health insurance coverage on their own and equal tax treatment for the self-employed. NAHU believes federal tax laws should be updated to provide the same federal tax deductions to individuals and the self-employed that corporations have for providing health insurance coverage for their employees.

Specifically, Congress should take action to:

- Remove the 7.5% of adjusted gross limit of medical expenses on tax filers' itemized deduction Schedule A form.
- Allow the deduction of individual insurance premiums as a medical expense in itemized deductions.
- Equalize the self-employed health insurance deduction to the level corporations deduct by changing it from a deduction to adjusted gross income to a full deductible business expense on Schedule C.
- Clarify that individual health insurance policies purchased by employees with no premium paid by the employer are not the same as group health insurance policies and are not subject to the group insurance requirements specified in HIPAA. Employees own these policies and they stay in force when workers leave their jobs. In particular, the federal requirements regarding individual policies sold on a list-bill basis—whereby the employer agrees to withhold individual health insurance premiums on behalf of its employees and send the premium payments to the insurance carrier but does not contribute to the cost of the premiums—need to be clarified. Furthermore, insurers should recognize the individual insurance plan as a valid coverage option for the accounting of participation guidelines of the insurer.
- Clarify that employers implementing list-billing arrangements for their employees may also establish Section 125 premium-only plans for their workers. This would enable employees to pay for their individual policies on a tax-favored basis. If an individual participated in a Section 125 plan for a list-billed policy, those premiums would not be eligible for deduction as a medical expense under Schedule A.
- Establish that all individual health insurance policies sold under a list-billed arrangement are subject to all state insurance regulations governing the issuance of traditional individual insurance policies in the state in which the policy was sold, including rating requirements, issuing requirements and the requirement that such products only be sold by licensed health insurance producers.

With the benefit of years of experience observing health insurance markets nationally, NAHU has found time and again that states that create perverse incentives for individuals to forgo health insurance coverage while driving up the cost of insurance for those who maintain it have only exacerbated the growing problem of the uninsured. Conversely, states that have implemented market-friendly measures have higher degrees

of health plan competition, more consumer plan choices, lower health insurance rates and a lower number of uninsured. NAHU urges Congress to carefully consider the cost and market impact of all potential reforms to America's health insurance marketplace. Our private health insurance plans are innovative, flexible and efficient, and our marketplace is up to the task of responding to well-structured reforms. We look forward to working with you to both fill the gaps in our nation's coverage system and also to make private health insurance more affordable and accessible for all Americans.