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CONGRESSIONAL TESTIMONY

Issues in Health Insurance Market Reform

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My name is Edmund F. Haislmaier. I am Senior Research Fellow in the Center for Health Policy Studies at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

Mr. Chairman, Representative Neal, and members of the committee, thank you for inviting me to testify before you today on some of the key issues involved in health insurance market reform.

There is currently considerable interest in both Congress and a number of states in health insurance market reforms as part of broader designs for health system reform. In that regard, I will focus my testimony today on four key issues:

1) Reforms to create greater choice and portability in the employer-sponsored coverage market.

2) The application of guaranteed issue rules to the individual health insurance market.

3) Risk adjustment mechanisms to accompany these first two reforms.

4) The role of "automatic enrollment" and "personal responsibility" provisions.

1) Creating choice and portability in employer-sponsored coverage.

Whatever advantages the long-standing model of employer group coverage may offer, it still has several major weaknesses. First, because coverage is attached to the employer, and not the worker, it isn't portable and changes in employment often create gaps in coverage. Second, because employers make the coverage decisions, and in most cases offer only a single one-size-fits-all group plan, workers are frequently unable to obtain the coverage that best suits their personal needs and preferences. Third, insurers face distorted incentives because their real customers are the employers, not the individual workers. This skews insurer behavior towards limiting costs in consumer-unfriendly ways, such as by restricting coverage, denying claims, or limiting access to providers -- instead of giving insurers incentives to compete on the basis of providing individual patients with the best value (price, quality, provider access) for their health insurance dollars.

The solution being pursued in Massachusetts, and now in Utah as well -- and under active consideration in a number of additional states -- is for a state to exercise its authority to regulate health insurance to create a new option of "individualized" employer-sponsored coverage. The design works as follows:

Rather than offering a traditional group plan, the employer could elect to provide its workers a menu of different plans, offered by different insurers. Each worker would

be able, at first enrollment and during an annual open season, to choose the plan the best suits him or her and to maintain that coverage if they left their employer. The insurance products would all be subject to state regulation and would also comply with all federal ERISA, HIPAA and COBRA standards for employer-sponsored coverage. Among other things, that means that coverage would be guaranteed issue to enrollees and all employer and employee premium payments would be on a pre-tax basis.

The state would support this arrangement by creating or authorizing some type of administrative mechanism to coordinate the offering of plans, the election by employers to participate, the selection of coverage by participating workers, and the collection and transmittal of premium payments from multiple sources. While "health insurance exchange" is the generic name I have given such administrative mechanisms, the design can take a number of different forms and be given a different name. For example, Massachusetts created its health insurance "Connector" as an independent body to perform these, as well as a number of other tasks.[1] In contrast, the recently enacted Utah legislation envisions the creation of a more decentralized, internet "Portal" to perform the same basic functions.[2]

If this idea sounds somewhat familiar, it is because it is modeled on the very successful Federal Employee Health Benefits Program (FEHBP). While conceptually similar to FEHBP, this basic design is adapted to serve multiple employers on a statewide basis.

2) Applying guaranteed issue rules to the individual health insurance market.

A related issue is the interest at both the state and federal level to applying guaranteed issue to the individual market. While it is possible for lawmakers to institute such a reform, they will need to be careful to do it in a way that does not destabilize insurance markets. The key difference between the employer-sponsored market and the individual market is that it is easier in the employer-sponsored market to prevent the destabilizing behavior of individuals opting to go without coverage until they are sick. I will discuss further in my fourth point some other mechanisms that can be used to control such undesirable "selection" effects.

For now, my main point is that when discussing guaranteed issue it is important to focus on the conditions to be applied to individuals exercising such a right. Properly designed, the rules governing guaranteed issue offer conditional -- not unrestricted -- rights to individual enrollees.

For example, under current federal law if an employer sponsors health insurance coverage, an eligible worker has a right to obtain that coverage on a guaranteed issue basis under the same terms as other, similarly situated, employees of the same firm. However, there are limits to that right. Namely, guaranteed issue applies only when the worker first becomes eligible for coverage, at any subsequent open season, or upon the

[1] The Massachusetts legislation is Chapter 58 of the Acts of 2006.
[2] The Utah legislation is H.B. 188 of the 2009 session.

occurrence of one of the "change of status" events specified in law. In other words, the worker does not have an unrestricted right to obtain and drop coverage any time he or she chooses -- which would be destabilizing to both the employer's plan and the insurance market as a whole.

If guaranteed issue is applied to the individual market it will need to be structured to include the same limitations on individuals exercising that right to avoid damaging the market. Furthermore, I would argue that, given the greater propensity for adverse selection behavior in the individual market, the application of guaranteed issue to individuals should also be on an "earned-right" basis.

My recommendation is to stipulate that individuals can obtain coverage on a guaranteed issue basis only during an annual open season, and that they are charged standard rates for their coverage only if they can give evidence of 18 months or more or prior creditable coverage. In cases where the individual has less than 18 months of prior creditable coverage, they could still obtain coverage on a guaranteed issue basis, but insurers would be permitted to impose pre-existing condition exclusions and rating surcharges to the maximum extent and duration allowed by HIPAA -- namely, pre-existing condition exclusions for up to 12 months, reduced by the number of months of prior creditable coverage, and rating surcharges of up to 150 percent of standard rates for up to two years.

Thus, while the coverage would be guaranteed issue to all, the right to obtain that coverage at standard rates and without the imposition of any pre-existing condition exclusions must be "earned" by the individual obtaining and maintaining continuous coverage. Such a policy rewards those who do the right thing -- getting and keeping coverage -- while appropriately discouraging any who are tempted to decline available coverage so long as they are in good health.

3) Risk adjustment mechanisms.

Guaranteed issue and the creation of the option to offer portable, "individualized" employer-sponsored coverage are necessary preconditions for realigning insurer incentives away from avoiding risks and toward maximizing value for patients. However, those steps alone are not sufficient. What is also required are risk adjustment mechanisms to ensure that the market works smoothly and fairly for all insurers and policyholders.

This involves both a "front-end" and a "back-end" component. On the "front-end," lawmakers will need to reach agreement with insurers on the specifics of the parameters that insures will use to price their products so that consumers can effectively comparison shop. For example, to account for some of the variation in health risks and health status, will the premiums vary by age, and if so by how much? On the "back-end," lawmakers will need to authorize market-wide health risk pooling mechanisms that enable insures to fairly share the costs of expensive cases so that no insurer is

disadvantaged relative to its competitors and all insures have incentives to compete, on a level playing field, in offering the best value to subscribers.

For a further discussion of these concepts, I would refer you to two papers I have published on the topic.[3] However, for purposes of today's discussion I would simply note that the absence of such a mechanism in the Massachusetts reform design has in some degree limited the Connector's options and contributed to the delays that they have experienced in implementing their private market reforms. In contrast, the Utah legislation sets up tackling both the "front-end" and a "back-end" components of risk adjustment as one of the first orders of business in implementing their private market reforms.

4) The role of "automatic enrollment" and "personal responsibility" provisions.

Finally, there is the consideration of other, accompanying changes that lawmakers can make to ensure the success of reform efforts. The issue is identifying other provisions to further prevent the market destabilization that would occur if individuals with the ability to pay for coverage chose to decline coverage until they need it.

My first suggestion is to include an "automatic enrollment" feature to accompany employer participation in a health insurance exchange. In other words, rather than leaving with individual workers the initiative to accept the offered coverage, the employer would instead pick one of the plans on the menu and the exchange would automatically enroll the employer's workers in that plan, but then give each of them the option to choose different coverage, or to decline coverage if they can show that they have coverage from another source, such as a spouse's plan or a public program.

Second, if the conditional guaranteed issue provisions I described above are to be extended to the non-group market, lawmakers will want to consider also adding "personal responsibility" provisions to the reforms. In Massachusetts, that took the form of the legislature requiring all residents to obtain health insurance coverage, and unless otherwise exempted from that requirement, pay a fine if they fail to do so. While such an individual mandate to buy coverage has raised philosophical objections, as well as some practical difficulties in defining and enforcing it, I would note that it is not the only option available to lawmakers. Indeed, then Governor Romney's original proposal would have allowed individuals to fulfill their "personal responsibility" requirement in other ways, such as by setting aside money to pay for their own medical care.

Regardless of the mechanism the basic principle is the same, and it is a sound one. Namely, if lawmakers are going to reform health insurance markets to make coverage

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[3] See: Edmund F. Haislmaier, "State Health Care Reform: The Benefits and Limits of "Reinsurance," Heritage Foundation *WebMemo* No. 1568, July 26, 2007, at www.heritage.org/Research/HealthCare/wm1568.cfm, and; Edmund F. Haislmaier, "State Health Care Reform: A Brief Guide to Risk Adjustment in Consumer-Driven Health Insurance Markets," Heritage Foundation *Backgrounder* No. 2166, July 28, 2008, at www.heritage.org/Research/HealthCare/bg2166.cfm

portable and accessible for all, further provide all individuals with a wide choice of coverage options, and finally, ensure that those with lower incomes have sufficient financial help to buy coverage, than citizens have no excuses left for not obtaining coverage, or otherwise paying for the medical treatments that they and their dependents receive.

Mr. Chairman, this concludes my prepared remarks. I will be glad to answer any questions you or the other committee members may have. Thank you.

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