TESTIMONY OF

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on

Covering the Uninsured:

Making Health Insurance Markets Work

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INTRODUCTION

Good morning, Mr. Chairman. My name is Kim Holland and I am the Insurance Commissioner for the State of Oklahoma. Thank you for the opportunity to testify today on a topic of great concern to me and the people of Oklahoma – reforming this nation's healthcare system. I applaud the Committee's continued efforts to wrestle with this very difficult task and offer any assistance I can provide to you, Mr. Chairman, and Members.

As Insurance Commissioner, my primary objectives are to protect consumers and ensure that the insurance marketplace remains strong and competitive. For the 3-1/2 years I have served in this position, I have worked diligently with the other stakeholders in the Oklahoma healthcare system to ensure that our citizens have access to affordable health insurance and high quality healthcare. Under our leadership, Oklahomans from all walks of life and all four corners of the state are participating in the creation of a plan for systemic change that will address everything from improving our public's health to greater accountability and transparency within our health delivery system to the development of a lower cost health insurance plan to expanding access to our innovative Insure Oklahoma premium assistance program.

The fact is, however, that the State of Oklahoma does not operate in a vacuum. This is a national issue, a regional issue, and a local issue. Outside forces can, and do, both hinder and help us as we struggle to improve healthcare in our State. True success will only be attained through coordination and cooperation between all stakeholders, both at the state

and federal level. This Committee has always been willing to work with States to resolve issues, and I am confident that spirit of collaboration will continue as work on healthcare reform proceeds.

STATE REFORMS

Over the past 20 years, States have acted aggressively to stabilize and improve the health insurance market for small employers – those that have fewer than 50 employees. States have required insurers to pool all of their small group risk by imposing rating bands or rating limitations, facilitating the fundamental premise of insurance – spreading individual risk across a large population. The National Association of Insurance Commissioners (NAIC) has developed two rating models that have been used, in one form or another, by most states to promote pooling and limit exposure to extraordinary rates due to high claims.

The first model places a cap on the extent to which health status can be used when pricing a new policy. Under this model, a business with a particularly unhealthy population cannot be charged a premium higher than 25% of the base or index rate and a small business that enjoys a healthy population cannot be charged a premium lower than 25% of that index rate. This "rating band" artificially caps the rates for unhealthy policyholders and raises them for healthy policyholders. This methodology has the important effect of spreading the risk to the entire pool. Upon the annual policy renewal, insurers may not increase premiums to a small group policyholder because of high claims or health status by more than 15%. Most States have enacted this model.

A second model has been established that provides for an adjusted community rate. Rates may vary based on age (limited to a ratio of 2:1), geography and family composition only. This is a much tighter rating scheme that makes coverage far more affordable to older and sicker small businesses, but much higher for others.

It is important to note that any artificial cap on rating will create "winners" and "losers"- rates will be artificially higher for some and lower for others. This not only impacts the small businesses involved, but also can significantly impact the risk makeup of the pool – impacting all rates. For instance, a pool with rate caps that make coverage more affordable at older ages would attract individuals/groups more likely to have chronic or serious health conditions. Rating reforms must be carefully considered and must take into account the risk populations and the overall marketplace. A single rating system will not benefit all markets.

There are a few States that have enacted reforms in the individual health insurance market. Some require guarantee issue of coverage and some apply adjusted or community rate requirements. However, due to the high probability of adverse selection in the voluntary individual market (the reality that those most likely to buy will be those most likely to need medical treatment), most States still allow insurers to deny or price coverage based on health status. High-risk pools have been created in many states to help address the issue of the medically "uninsurable", but they are often under-funded and can lock people into limited, but expensive, coverage choices. In Oklahoma, our high risk pool has facilitated insurers' ability to cherry-pick the very healthiest, shifting risk to the pool. Although funded in part by assessments to insurers, premiums to individuals are

150% of the average individual private health plan costs and unaffordable to most. And, while our individual insurance market is robust with many options and attractive pricing, only the very healthiest are approved for coverage.

States continue to experiment with other reform concepts as well, such as reinsurance, tax credits and subsidies, and programs to promote healthier lifestyles and manage diseases, as they pursue the twin goals of controlling costs and expanding access. These state-based reforms are, of necessity, very distinct – based on both the specific needs in the marketplace and the strengths and weaknesses of the marketplace. For example, the State of New York implemented its very successful "Health NY" program, a reinsurance-based scheme that addresses many of the problems identified in New York's individual and small group markets, and utilizing its strong HMO networks. Likewise, the Commonwealth of Massachusetts has implemented a comprehensive program built upon past reforms and their unique insurer, provider and business environment. However, Oklahoma's culture, demography and geography – our distinct market - causes a mirror of either of these reforms to be impossible and requires our own unique solution.

As always, states are the laboratories for innovative ideas. In collaboration with healthcare providers, insurers and consumers, State policymakers are constructing and implementing unique reforms to improve healthcare quality and make health insurance more affordable for our citizens. But, ill conceived interventions – however well intentioned - will hamper our progress.

MULTI-STATE POOLING

One national reform concept that I know is of interest to this Committee is multi-state pooling. Small businesses in some states face limited choices when it comes to selecting a health insurance carrier. Some of this problem is due to a lack of insurer participation in the small group market (for a variety of reasons) and some is due to the simple fact that there are not enough small businesses in the state to support a multitude of carriers. The expectation of multi-state purchasing pools is that the combined purchasing power of large numbers of small businesses in multiple states will create the same economies of scale and negotiating power as that of large businesses.

While the multi-state pooling approach is to-date untested, the experience of single-state purchasing pools created in the mid- and late-1990s suggests that multi-state pooling initiatives will likely not fully address the challenges of the small group market. While these pooling arrangements did allow employers to provide more plan choices to their employees, they were not able to reduce costs or increase the number of small employers that offered coverage.[1] This was due to several factors, outlined below, which would similarly apply to multi-state pools.

First, grouping many small employers does not create the equivalent of a large employer any more than grouping three twelve-year-olds creates a thirty-six year old. One of the

[1] Long, Stephen H. and Marquis, M. Susan, "Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?" *Health Affairs* 20:1 (January/February 2001), pp. 154-163;
Long, Stephen H. and Marquis, M. Susan, "Pooled Purchasing: Who Are the Players?" *Health Affairs* 18:4 (July/August 1999), pp. 105-111; and
Wicks, Elliot K., "Health Insurance Purchasing Cooperatives" Commonwealth Fund, November 2002.

major advantages that large employers have when purchasing coverage stems not only from their size, but from their cohesiveness. The employees of a large employer are highly unlikely to reject the employer's choice of plan and purchase coverage on their own as the employer's contribution to the cost of coverage significantly reduces the expense to the employee. There is no similar incentive keeping small employers from purchasing outside the pool, and they will go wherever they can get the lowest premium for comparable coverage. So long as there is an outside market to compete against, a purchasing pool will never offer insurers the large, cohesive group that would give them the incentive to negotiate aggressively. As rates rise and healthy groups are able to obtain coverage less expensively outside of the pool they will do so, leaving high risk, high cost groups behind. This adverse selection creates an inevitable death spiral of the pool as costs continue to rise and groups drop coverage for less costly options or go without. It is this inevitability that precipitated the NAIC rate band models which effectively induce pooling across insurers' markets within a state.

Second, the ability of pools to reduce administrative expenses through economies of scale has been less than expected. Early proponents of pooling initiatives expected these arrangements would facilitate enrollment in the pool and eliminate the need for extensive marketing by participating insurers. Actual experience has shown, however, that small businesses continued to rely upon agents and brokers to assist them in selecting health insurance coverage for their employees, and without commissions comparable to those in the outside market, agents were not inclined to participate in marketing the pools.[2] Furthermore, the reduction in administrative expenses that pools expected to realize by

[2] Wicks, p. 4.

facilitating enrollment did not materialize, and pools were unsuccessful in affecting the higher costs of processing claims, billing and underwriting inherent to the small group market.

This is not to suggest that there is no way to reduce administrative costs. Where possible, state regulators must compel insurers to eliminate unnecessary and burdensome red-tape, and without diminishing consumer protections, work together to ensure regulations are not unnecessarily adding to the cost of insurance.

The creation of a national, regional or multi-state pool poses numerous implications to existing markets. Following are specific issues of concern that must be considered:

- **Benefit Mandates** – For a plan to be effectively and efficiently marketed to the entire pool of small businesses, the package of benefits included in the policy cannot differ from state to state. This means state benefit and provider mandates would need to be preempted to a certain extent. Benefit mandates occur when citizens compel their legislatures to enact them. Each state jurisdiction has its own expectations and tolerance for expanding the scope of coverage required of a health plan. By requiring all plans to comply, States guarantee a level playing field within their market. A competing national plan with fewer mandates would disrupt this playing field by creating opportunity for adverse selection and ultimately raising costs within the local market. Conversely, in those states like Oklahoma where there are fewer than average mandated benefits, a national pool

could actually be more costly than local options and not serve the intended purpose of offering lower cost coverage.

- **Rating and Access Rules –** It is absolutely critical that the rating and access rules in force for each state's small group market continue to apply within the multi-state pool. If these rules differ, businesses will choose to purchase where the rules are most advantageous to them, again resulting in adverse selection that will ultimately undermine either the multi-state pool or the state small group market. Applying different rating and access rules to employers from different states will not prove to be a great obstacle to the creation of a multi-state pool, as geographic variations in the cost of health care services will necessitate different premiums for these employers, regardless of other rating and access provisions.

- **Eligibility –** Eligibility rules can greatly impact the outcomes of the pool. Including individuals and sole proprietors in the pool can provide additional options for these difficult-to-cover purchasers, but can also have implications for adverse selection, the stability of the pool, and the average cost of coverage. Requiring all small businesses' coverage to be purchased through the pool can help reduce some adverse selection problems and create a more cohesive group to more effectively reduce rates, but also reduces the choice of plans available to employers and could dramatically impact local markets depending on carrier participation.

- **Carrier Participation** – Like eligibility rules, the rules governing carrier participation can also have a profound impact on the success or failure of the pool. If all carriers are eligible to sell through the pool, participant choices will be maximized, but the pool's negotiating leverage will be greatly reduced. Conversely, limiting the number of carriers that sell through the pool can provide greater leverage to reduce premiums, but also reduces participant choice and creates disruption in local markets if non-participating plans are forced to compete unfavorably.

There are many other issues to consider such as how many states would constitute a pool, who would administer the pool, would there be risk adjustment among the participating carriers, and how would network adequacy be assured. However, the challenges outlined above must be overcome before these other matters are addressed.

KEYS TO REFORM

As Congress deliberates health care reform, I urge you to consider the following as means to the most successful outcome:

Address Healthcare Spending. Any effort to increase access to insurance will not be successful over time unless the overriding issue of rapidly rising healthcare costs is also addressed. While the health care challenge in this country is generally expressed in terms of the number of Americans without health insurance coverage, the root of the problem lies in the high cost of meeting our citizens' health care demands. According to the most recent National Health Expenditures data, health care spending reached $2.1 trillion in

2006, 16 percent of GDP and $7,026 for every man, woman and child in the United States.[3] This level is twice the average for other industrialized nations.

This level of healthcare spending has badly stressed our health care financing system. Health insurance is primarily a method of financing health care costs not the cause of health care costs. Roughly 85 cents out of every health insurance premium dollar is spent to pay for care to policyholders. The best estimates for gains produced by pooling and reducing administrative expenses would generate barely a ripple of savings in the sea of ever-increasing health care expenditures. Nevertheless, insurers do have a vital role to play in controlling costs by promoting and facilitating disease management, enhanced use of information technology, improved quality of care, wellness programs and prevention, and evidence-based medicine—all of which have shown promise in limiting the growth of health care spending and improving the quality of care provided. Effective insurance reform is merely one component of the healthcare and health system reforms necessary for a better society, but a vital tool in creating access, providing choice, controlling costs, and ensuring accountability.

Protect the Rights of Consumers. States already have the rigorous patient and policyholder protections, solvency standards, fraud prevention programs, and oversight mechanisms in place to protect consumers; these should not be preempted by the federal government. As the members of this committee know all too well, the preemption of state oversight of private Medicare plans has led to unethical and fraudulent marketing practices and considerable harm to thousands of seniors. In similar fashion, the

[3] Centers for Medicare and Medicaid Services, National Health Expenditures

Employee Retirement Income Security Act of 1974 (ERISA) severely restricts the rights of employees covered by a self-insured plan. I urge federal policymakers to assist state regulators in safeguarding our consumers by avoiding any further preemption of state oversight of health insurers and insurance, and to enact NAIC recommendations for the necessary overhaul of existing preemptions that impede our efforts.

Avoid Adverse Selection. Any program that grants consumer the choice between two pools with different rating, benefit, or access requirements will result in adverse selection for one of the pools. For example, if a national pool does not allow rating based on age or health status, while the state pool does allow rating based on those factors, then the national pool will attract an older, sicker population. Such a situation would be unworkable. While subsidies or incentives could ameliorate some of the selection issues, as costs continue to rise and premiums increase the effectiveness of such inducements could erode. If a national pool cannot create attractive savings through economies of scale alone, the potential for market disruption in the midst of states' robust reform efforts could have disastrous consequences.

Promote State Innovation. The NAIC urges Congress to review current federal laws and regulations that hinder State efforts to reform the healthcare system. As mentioned earlier, laws such as ERISA curtail consumer protections and supersede State laws, limiting the reform options available to states. In addition, inadequate and inequitable reimbursement payments in federal health programs have led to shifting of costs to the private sector. This has resulted in higher overall costs and decreased access for many consumers, and limits the ability of states to implement reforms. Cost shift has had

staggering consequences in my state, adding $954M annually to the cost of care and coverage and resulting in a growing population of uninsured.

To promote innovations and eliminate these barriers, the NAIC supports legislation like S. 325, the Health Partnership Act, that provides funding for state initiatives and establishes procedures for waiving federal requirements, such as certain ERISA provisions, that impede state innovation.

Just as important, Congress must carefully consider the impact of any new federal reforms on the states' ability to be effective partners in solving our health care crisis.

CONCLUSION

Years have been spent talking about broad healthcare reforms that will ensure that all Americans have access to affordable health insurance coverage and the peace of mind that goes with it. Action is long overdue.

I encourage Congress and the Members of this Committee to support – with resources and funding – State healthcare and health insurance reform efforts. Working together, we can attain our rightful place as the world leader in providing for the health and wellbeing of all our citizens.