U.S. Senate Finance Committee
Hearing on Health Insurance Market Reform

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Good morning, Chairman Baucus, Ranking Member Grassley, and members of the Finance Committee. I am Pam MacEwan, Executive Vice President for Public Affairs at Group Health Cooperative, an integrated health care coverage and delivery system based in Seattle, Washington.

Thank you for inviting me to be here this morning to discuss Group Health, the Washington state insurance market, and our ideas for improving the current system so that all people in this country have access to patient-centered, high-quality care. I particularly appreciate the leadership you have shown in convening the committee for hearings like this, and in looking ahead to bipartisan collaboration and progress in the coming year.

Group Health Cooperative is a nonprofit health system that provides both coverage and care. Directly and through our subsidiaries, we cover more than 580,000 residents of Washington State and Northern Idaho, about 70% of whom receive care in Group Health owned-and-operated medical facilities. About 900 physicians are part of the Group Health group practice, and we contract with more than 9,000 providers throughout the state. We offer health coverage through public programs and in the commercial market– in Medicare, Medicaid, the state Basic Health Plan, on the individual market, and to small, medium and large employer groups. We also support employers who have elected to self-fund their employee health coverage.

We are fairly unique in the health care market given that we also provide healthcare directly to the majority of our members. We are a regional plan, serving Washington State. This means several things. First, for most of our beneficiaries we operate under the rules governing Washington state insurance market, which are different from many other states. Secondly, we know that while rating rules and insurance market regulations are necessary for an efficient and affordable marketplace, rules are not enough to solve the problems of access to affordable health insurance, and the uninsured.

Our system at Group Health is built on a mission of providing health care. The best regulations are those that will allow us to provide high-quality, patient-centered care to our patients. **We know that insurance market reform – likely through a combination**

of state and federal activity – is needed to ensure that everyone can get access to health care coverage. And we know that *both* insurance market and delivery system reform will be necessary to ensure that everyone's coverage provides them access to high quality patient-centered care.

Let me begin by describing the Washington state insurance market. On the whole, Washington's insurance market provides affordable, high-quality insurance products to the consumer, through the use of premium rating protections and the availability of a high-risk pool. In Washington, insurance cannot be denied to any applicants for coverage if they are part of a small group (defined as between 2 and 50 employees**)** or other kind of group coverage – this is called guaranteed issue. However, exclusions and waiting periods are allowable for pre-existing conditions, to prevent people from waiting until they get sick to enroll in coverage.

Washington has struck an interesting balance for the individual market. Everyone has access to coverage, either through the individual market, or through the state's high risk pool. Washington employs a state-mandated health status questionnaire. Those without previous continuous coverage who score higher may be denied coverage on the individual market but will be automatically offered enrollment in the state high-risk pool. Generally, people who have complex medical conditions such as AIDS or Lou Gehrig's disease, or a combination of conditions such as diabetes and hepatitis A, would score high enough on the questionnaire to be screened out into the high risk pool. The high-risk pool currently covers about 3,300 individuals, who have access to a variety of different benefit designs through that pool. It is funded principally by an assessment on the insurance carriers. The proportion of individual market applicants that can be denied by each carrier and offered coverage in the high-risk pool is capped at 8% of applicants, significantly less than the typical underwriting practices in other states.

For both the small group and individual markets in Washington, monthly premiums are guided by what is called adjusted community rating, which means that carriers can only adjust premiums by demographic factors such as age, geography, family size, or by enrollees' participation in certain wellness activities. This system of rating constrains the amount of variability between the premiums different individuals or small groups can pay, thereby spreading the risk of the population's health status among more people.

For a brief time, our market was even more regulated than is it today. In the 1990s, I was a member of the Washington State Health Services Commission, working to implement a sweeping health reform bill. The comprehensive reforms were passed in 1993, with most taking effect in 1995. Under those reforms, everyone would have been required to have coverage through an employer or individual mandate. Unfortunately, things did not play out as the original reform bill intended.

First, the law allowed the insurance commissioner to proceed in implementing prescribed insurance regulation changes before the full reforms (including the individual mandate) took effect. This meant that while the pre-existing condition exclusion was reduced to three months, there was a three month open enrollment period where people were

allowed to sign up with no waiting periods or limitations whatsoever, and guaranteed issue was put into effect, these changes were made without any of the other underpinnings designed to help make the system sustainable. There was no requirement that people enroll before they got sick – no individual mandate to purchase coverage – and no risk adjustment mechanism in place.

Soon afterwards, a change in political climate resulted in the repeal of the individual mandate. But the changes in insurance regulation described above were allowed to stand. As a result, many individuals with serious health care needs signed up for coverage. This rapidly led to a classic adverse risk spiral in the marketplace. In short order, claims costs for many health insurers were exceeding their premium collections. Community rating in this context meant that everyone's premiums went up significantly. More individuals decided not to take coverage. The individual market collapsed when the two major carriers, Blue Cross and Blue Shield, closed enrollment in that individual market. Group Health followed suit because of adverse selection.

We learned four things from this experience. First, that rules governing the insurance market must protect the consumer, but must also make such allowances that massive adverse selection does not drive insurers out of the market. Second, that guaranteed issue, community rating, and limits on pre-existing condition exclusions and waiting periods will only be successful if there is an individual mandate to balance the risk in the insured population. Third, that as long as you have an individual mandate, some people will need financial subsidies – to be provided by the government – in order to purchase insurance. Finally, we have learned that in reforming the insurance marketplace, both individuals and small business prefer some degree of flexibility and choice when purchasing health insurance, and that successful insurance reform will allow for value-based benefit design, support high-quality patient-centered care, and therefore be coordinated with delivery system reform.

Regulation that mandates that insurance products have the same benefits and cost sharing – a "one size fits all" approach – will not succeed. We at Group Health provide a number of integrated delivery products that provide flexibility for consumers in how they access their health care, from the physician's office to the telephone, to home visits and web-based secure messaging with the care team. Many of our products focus on primary and preventive care, provide incentives for engaging in healthy behaviors, and offer care management tools to engage patients in their health care in a way that works best for them. Successful health reform will support such innovation in value-based benefit design and foster patient-centered care.

One of the challenges this country faces in achieving successful reform nationally, and ensuring that all people have access to health care coverage, is that states today are playing by different sets of rules. In Washington, for example, I mentioned that only 8% of applicants for coverage in the individual market can be denied coverage, while some states screen out a significantly higher fraction. Moreover, some states do not even have high-risk pools to provide them with a safety net. In Washington, our adjusted community rating system keeps variation between premiums fairly low; while in some

states, a person with a severe medical profile will pay many times more than a healthy individual for the same coverage, contributing to an already high health care cost burden for that person or family.

I am not saying that Washington is perfect – in fact, we are working hard to achieve further reforms so that everyone in Washington can get access to affordable care and coverage. But I do believe that one important role the federal government can play is to look at the different results achieved by various states' insurance regulations, and to determine which rating rules strike the right balance. Another important role will be to support the unique nature of regional insurance and healthcare markets, which are today so very different. This will be critical if the federal government considers implementing a nationally-managed marketplace mechanism – like the Massachusetts' "Connector" – on a national stage. Absent sensitivity to regional markets, such an entity risks squashing regional innovation.

As the federal government approaches insurance market reform, it will be important to protect states like Washington that have developed markets that are more generous to the consumer, and that work. Proposals allowing insurance to be sold across state lines, based on the regulatory framework of the state of domicile of the carrier, would severely destabilize our markets. As a general rule, our goal should be to lift all boats, and this will require some careful policy development.

Before I close and welcome your questions, I want to tell a story that illustrates Group Health's unique perspective as a provider of health care as well as coverage.

Back in March, a man named Fred Watley, from Spokane, Washington, needed a liver transplant. But when the time came for him to get his new liver, he found out that since his employer – a small group – had transferred over to Group Health at the beginning of that year, he had entered into the standard 6-month waiting period for a transplant. Even through Mr. Watley had been continuously covered with health insurance for years; he would be required to serve a new waiting period. Group Health doctors wanted him to receive the transplant. But legally, that would mean he was on the hook for the cost, and we knew that was unfair; in fact, it would have been a death sentence. So we decided to change our policies – breaking ranks with the rest of the Washington insurers – and approve Mr. Watley's transplant. Our doctors got right back on the case, Mr. Watley got his new liver, and over the following days we proactively worked with our insurance commissioner and with the other health carriers in the state and agreed to work on changing the rules going forward. This next legislative session, we will be working to assure that others in Mr. Watley's situation will be able to get the care they need.

A solution in Mr. Watley's case was relatively simple when we were willing to think differently, and thankfully it was also possible without waiting for statutory change. But as I hope I've illustrated, most problems in the insurance system are not so quickly solved by the private sector, and regulatory strategies will require delicate balancing between state and federal government. We urgently need coordinated action to improve both the insurance market and our nation's system of care.

Your topic today is a broad one, and I have touched on a number of points. First, the need for insurance reform to assure that more people in all states can get access to coverage and have the right incentives to get coverage before they are sick. Second, the need to pay attention to states like Washington where some form of community rating is in place and working, and where the rules are more generous toward the consumer. And finally, the need to do insurance reform and delivery system reform in concert so that we can ensure not only access to coverage for all people, but access to high-quality, patient-centered care.

Thank you for your attention, and I will welcome your questions.