

NEW AMERICA

F O U N D A T I O N

STATEMENT OF LEN M. NICHOLS, PH.D.
DIRECTOR, HEALTH POLICY PROGRAM
NEW AMERICA FOUNDATION

SENATE COMMITTEE ON FINANCE
COVERAGE ROUNDTABLE

MAY 5, 2009

NEW AMERICA FOUNDATION
1899 L STREET, NW SUITE 400
WASHINGTON, DC 20036

Chairman Baucus, Ranking Member Grassley, other distinguished members of the Committee, thank you for inviting me to participate in this roundtable discussion today. My name is Len M. Nichols. I am a health economist and I direct the Health Policy Program at the New America Foundation, a non-profit, non-partisan public policy research institute based in Washington, D.C., with offices in Sacramento, California. Our program seeks to nurture, advance, and protect an evidence-based conversation about comprehensive health care reform. We remain open minded about the means, but not the goals: all Americans should have affordable health insurance and access to high quality health care that is delivered within a politically and economically sustainable system. I continue to believe the best way to accomplish these goals is to work toward bipartisan agreement about specific reforms and pathways. Your committee has long been a beacon of bipartisanship in a city that is too often devoid of it, so I am doubly proud to be before you today. I am happy to share ideas for your consideration today and hereafter with you, other members of the Committee, and staff.

Your letter of invitation indicated your focus today would be on three primary questions:

- How to make the market more affordable and workable for individuals and small businesses?
- What is the role and responsibility of individuals, employers and government in achieving health coverage for all Americans?
- What role should public programs play?

I will address each of these questions in turn in this written testimony, after a prefatory paragraph about coverage in general.

Our goal should be to make sure our insurance markets work for *all* Americans (and for legal immigrants, as well). We fail to live up to our own standards of a Just and strong society, standards which are derived from the roots of our Judeo-Christian heritage, when we accept as inevitable that tens of millions of our fellow citizens will remain without health insurance. There is nothing inevitable about it. We weaken ourselves, our communities, and our very sense of community when we leave so many without a seat at our health care table of plenty. Unlike when we stopped debating health system reform in August of 1994, we now know (from the Institute of Medicine) that roughly 20,000 Americans die every year from lack of access to timely care they would have had if they had garden variety health insurance. We also know now, again thanks to the IOM, that the yearly economic loss from premature death and unnecessarily prolonged illnesses of the uninsured exceeds the likely public cost of covering the uninsured. We simply must find a solution that works for all of us. I know we can, if we but will, and this committee is the right leadership group to show us the way.

MAKING AN INSURANCE MARKET WORK FOR INDIVIDUALS AND SMALL BUSINESSES

The technical goal of health insurance reform is to extend the advantages of large group purchasing – large, balanced risk pools and administrative economies of scale – to all. The fundamental idea is to make our most problematic insurance markets more efficient *and* more fair. The following structural changes are necessary conditions for success:

A new insurance marketplace to pool risk and reduce administrative burden.

Our current individual and small-group markets work far better for insurers than for the people who try to purchase insurance within them. Every small business survey in the past 20 years reports that purchasing health insurance for their workers is one of the greatest headaches of small business owners. Recent polling has shown that health insurance is one of the major impediments to new business formation, a particularly ominous sign for an economy that depends on innovation and small businesses in particular to nurture that innovation. There are few surveys of individual market recipients per se, but we know from representative household survey data that the vast majority of people who have any other insurance option – be it a public program, large group insurance, or even small group insurance – take it rather than purchase in the non-group market. Reform that does not fix these markets is not worthy of the name.

Rather than tweak around the edges, these marketplaces need fundamental reorganization. The cleanest way to do so is make a new market (hereafter insurance “exchange”) that replaces the current individual and small group markets. After a reasonable transition period, total replacement with new rules is strongly preferred to leaving existing markets alongside a new one with different rules. It will be safer and more efficient to have one marketplace with one set of rules rather than risk the inevitable risk-selection activity if old market rules and behaviors are permitted to coexist.

Let there be no doubt: health insurance reform is about changing the business model of insurers, *from* risk segmentation, aggressive underwriting and profiting from dividing us, *to* thriving by helping all of us find value and pathways to better health among the best providers and most effective health-enhancing strategies and behaviors. Many insurers are capable of making this shift. Indeed, the larger, national firms are largely there and many local non-profits have always preferred the search for value within the delivery system to aggressive underwriting. But as long as risk segmentation and underwriting are possible, some traditional insurers will continue to pursue those strategies, for they are highly profitable. As a result, we will be left with many Americans as badly served by these underwritten markets as they are today.

Do note, however, these new exchanges could be organized at the state or even sub-state levels. It is not necessary (or wise) to have one national exchange, as explained below.

Within the new exchanges, one immediate question must be answered: how small is “small?”

The answer to this question depends upon your vision of reform. If you want the exchange to work for individuals and *all* small groups, and you expect large groups (i.e., all non-small groups) to be able to self-insure on their own (as the happiest large firms do today), then the dividing line between small and large should be the firm size at which an employer can safely and efficiently self-insure. Actuarial experts tell me this is around 500 or 1000 workers, not the typical 50 that defines the upper bound of the small group market in the vast majority of states (some go as low as 25). Over time, larger self-insured firms might be allowed to enter this marketplace if they so choose.

But if you want to minimize the number of small employers the new arrangements will help (and correspondingly preserve today’s very high profit margins for insurers in this market segment), then you could cutoff eligibility for the exchange near current law levels, at 50 or even 25 workers (or go as low as 10 if you value insurers welfare far, far more than small employers’). This will leave employers of 11, 26 or 51 at the mercy of what the commercial market currently offers up to them today, and in many states, that is highly unsatisfactory. This poor performance is of course why the National Federation of Independent Business (NFIB) and other employer groups have tried so hard for so long to create association health plans and other options for this market segment and why Senators Lincoln and Snowe have worked so hard for so long to fashion their bipartisan compromise legislation that would improve small group markets’ performance for small employers, the customer, not the sellers.

Insurance market rules governing the new marketplaces should be uniform across the country, but the exchanges themselves could be organized on a national, state, or sub-state level. It is important to remember that all health markets (like politics) are local. Competing against Kaiser in San Francisco or Group Health in Seattle is different than competing against Blue Cross of Arkansas in Little Rock. Exchange managers and oversight boards can and should bring local expertise and flexibility to the overall federal superstructure.

New insurance market rules to make quality health coverage accessible to all.

No American should be denied coverage or charged differential premiums because of their health status or family history. The market rules that must govern exchanges include: guaranteed issue and renewal (sell to all); modified community rating (limited age and geographic variation, no health status discrimination); no pre-existing

condition exclusions (after a phase-in period); individual requirement to purchase or obtain health insurance. Age rating, while important to minimize aggregate subsidy cost, must be limited or it could become an effective proxy for health status rating.

Minimum benefit package to ensure that coverage is meaningful. All Americans should have coverage that enables access to effective, high-quality care as well as protects their financial health. Therefore, Congress or another authority should require a minimum level of benefits to guarantee the quality of coverage being offered in the marketplace and protect against adverse selection that could result from wide variations in product design. It is more complicated, but imaginable, that an actuarial value standard be set rather than a specific package of benefits. This would allow insurers with different approaches to quality and efficiency to compete without causing undue risk selection. Risk adjustment (distributing payments to insurers based on differential risk profiles) will be necessary to help reduce the incentive to and consequences of adverse selection. Insurers should also be permitted to sell supplemental products; however, these packages must be priced and described separately to allow consumers to easily compare different choices and create transparency regarding cost and value.

Subsidies to make sure quality coverage is affordable to all. Reform proposals should include sliding scale subsidies for individuals and families who need help affording coverage. Affordability has two dimensions – for households and for governments. Ultimately, the final definition of affordability will reflect political judgments about what households and governments can afford. This definition may evolve over time. Subsidies could be available for both premiums and cost-sharing requirements (depending on the design of the minimum package) and made available directly or through the tax code.

We should keep in mind that the federal government already spends more than \$200 billion per year subsidizing insurance through the tax treatment of employer-provided health coverage. Economists, analysts, and courageous policy makers have argued for years that the income tax exclusion for employer premium payments is both regressive and inefficient relative to other ways to subsidize insurance coverage. The current employer tax exclusion is a poorly targeted subsidy that we could and should use to make our health system both more efficient and more fair. Therefore, as we think about how to finance coverage expansion and necessary subsidies, we should remember that some of the resources we have dedicated already could be targeted far more efficiently.

Requirement to purchase coverage to balance the risk pool and make sure everyone is paying their fair share for health care. When combined with the reforms described above, a requirement to purchase coverage is necessary to make the insurance market function efficiently and fairly. Without a purchase requirement, insurers will legitimately fear that mostly the sick will buy health insurance (adverse

selection). That fear will produce higher premium bids, which will cost people and governments more money. Purchase requirements will guarantee that the population seeking care represents the entire population. As a result, insurers will bid lower in a competitive context. In addition, once insurance is accessible (through the newly reformed marketplace) and affordable (through subsidies), all individuals should be required to purchase coverage to make sure everyone pays their fair share for health care.

Increased emphasis on insurer transparency to engender fair competition and give consumers the information they need to make informed choices about the insurance products that are right for them. Insurers should be required to report information on quality and patient satisfaction indicators. Also, the marketplace(s) or exchange(s) will want to help the public compare administrative efficiency by making available the ratio of premiums collected versus dollars spent on patient care. The risk profiles of enrollees will need to be reported for exchange-wide risk adjustment as well.

SHARED RESPONSIBILITY: ROLES AND RESPONSIBILITY FOR INDIVIDUALS, EMPLOYERS, AND GOVERNMENTS

Our nation can meet its goals for health reform if everyone shares in the responsibility.

Individuals. As a condition of living in a community that helps individuals afford insurance and care, everyone has a personal responsibility to maintain their own health. Value-based design features in the minimum benefit package that encourage healthy eating, exercise, and lifestyle behaviors will help give Americans some of the tools they need to achieve this goal. In addition, part of taking individual responsibility for one's own health includes a requirement to access appropriate health care services when necessary. This is possible only if a person is insured. Therefore, a requirement to purchase or enroll in coverage represents one part of an individual's personal responsibility to the larger community.

Employers. Employers have played key roles for a long time in our health system, and will likely always be involved in various ways, for the economic case for healthy workers is increasingly clear. Certainly in the short run, we expect large employers who choose to, to continue offering health insurance to their workers on a largely self-insured basis. But when I think about the global nature of the 21st century economy, I must say I am increasingly skeptical that we can continue to rely on employer financing as much as we have in the past. Therefore, I would recommend designing purchasing arrangements that can function without explicit employer contributions over time, and yet offer the distinct advantages of large group purchasing. This is what exchanges do, with the right rules, as we have outlined.

I do not believe that it is necessary or even wise to have an employer requirement to finance a sustainable health system for all. But I also understand that this approach has political resonance because of the simple and profound logic of shared responsibility. Therefore, I would offer the following observations:

The vast majority of large firms offer coverage. Likewise, most small, high-wage firms also offer coverage to attract and retain workers. Therefore, in a pay or play framework, the only firms who will be required to “pay” the tax would be small and low-wage. Workers or owners in these firms do not have much ability to pay by definition. Too high a tax rate on small, low-wage firms risks forcing layoffs or even closings. Therefore, the tax rate on these firms would have to be relatively low. In my view, there is just not enough potential revenue in this scenario to justify the very high political cost of forcing employers to contribute to health costs against their will. One possible compromise approach could be to make the “pay” requirement a function of firm size and average wage or revenue per worker and exempt the smallest and lowest wage businesses.

However, let me be clear: employers should be allowed to continue to offer coverage and/or continue to contribute toward the coverage their workers choose in the exchange(s) if they would like.

This does raise a key point about choice of plan within the exchange. I am a strong proponent of individual choice. The exchange managers’ job is to determine which insurers and which plans of those insurers meet the conditions of participation. Small employers (and large ones eventually) should be allowed to contribute toward their worker’s choice, with a fixed payment or voucher, but individual workers, just like individuals with no employer offer (and individuals who work for governments or large firms in their own contexts) should determine which plan they want to enroll in. Individual choice will force insurers to satisfy individual customers, not benefits managers or heads of companies alone.

Governments. There are two main roles for government, rule maker and enforcer, and steward of the system as a whole. Good policy sets rules and enforcement mechanisms to channel self-interest to serve the public interest. This is what the insurance reform rules and new exchanges are all about.

But the government must also be a steward of our collective health care resources. Stewardship requires government to evaluate the performance of our system as a whole, and to use all available resources, including the Medicare program, to re-align incentives to improve the quality and efficiency of our health delivery system. Part of stewardship is also accountability to taxpayers, so that subsidy costs – absolutely necessary to make the purchase of insurance and access to care affordable for many – are nevertheless kept to the minimum necessary to accomplish our collective goals.

ROLE FOR PUBLIC PROGRAMS

As we create a sustainable system of coverage for all, public programs will play indispensable roles.

Medicare. Medicare has served some of our nation's most vulnerable citizens for generations. Yet, rising health care costs threaten the long-term sustainability of the program. Medicare can and must lead the way to broader health system transformation through reforms that add value and reduce cost growth over time. By changing Medicare's payment structure to align the incentives of providers across silos of care (hospitals, physicians, post-acute facilities, drugs, devices, labs, etc.), we can create powerful incentives for providers to adopt high-value care processes. In turn, this will make the delivery of care to the under-65 population more efficient (as did the move to diagnosis-related group payments to hospitals in the 1980s) and inspire private insurers to adopt similar, if not identical, incentive-based contracts. In many ways, Medicare reform is integral to health system reform and will have the triple benefit of making Medicare sustainable while delivering higher quality care to beneficiaries along with savings that can help finance coverage expansion subsidies in the intermediate and long runs.

Medicaid. The strengths and weaknesses of the Medicaid program are well known, and you have true Medicaid experts on this panel so I will be brief. Today, Medicaid provides essential services to some of our most vulnerable citizens. We must be mindful of its essential role today when thinking about system reform.

I am, however, haunted by this question: what other country with a commitment to coverage for all has a different health insurance program specifically for the poor? Provider payment rate and other variations across the nation lead me to believe that it would be preferable in the long run to transition non-elderly Medicaid enrollees into the insurance available in the exchanges, as long as they qualified for appropriate subsidies, perhaps some wrap around benefits for cost effective social support services that are not provided by traditional insurance, and special low-income cost sharing benefits. In the short run, however, I would recommend strengthening Medicaid payment rates to allay access problems and continuing current Medicaid programs at least for all those with incomes below poverty.

New Public Health Insurance Plan. No issue has been more contentious than this one so far, much to my surprise. Granting individuals the choice between public and private health plans serves two primary purposes. First, many Americans distrust private health insurers. A public health insurance plan would assure these individuals that their insurance company is accountable to them and not profits or boards of directors. Second, a public health insurance plan could serve as a valuable "benchmark" and provide a way for consumers to compare premiums, benefit

design, and the administrative efficiencies of different health plans. This benchmark role could be especially valuable in year one of a new exchange that some insurers (at least) will oppose and would like to erase. This benchmark role can be provided without inevitably leading to a government takeover of the health system, as some seem to fear.

Let me be crystal clear: if the playing field is level, it is possible for public and private health insurance plans to compete and deliver value for consumers without distorting the insurance market. This policy question should not create an impasse or stall reform efforts.¹

Three conditions are absolutely necessary for public and private health plans to compete fairly:

- All insurance market rules must apply to all plans equally.
- The authority governing the insurance marketplace cannot also manage the public health insurance plan.
- The public health insurance plan cannot leverage Medicare or other public insurance products to administer prices or claim an unfair advantage.

Real-world experience is instructive. More than 30 states offer their employees a choice between privately insured products and a self-insured product for which the state bears the insurance risk. Under this scenario, the state picks the managers of the self-insured product, which then competes with traditional private insurers. In her recent testimony before the this committee, Secretary of Health and Human Services, Kathleen Sebelius, pointed to state employee benefit plans as examples wherein “public and private plans compete on the basis of benefits, innovation, and cost,” without destroying the marketplace.

Yet, this type of public plan alone will not be sufficient to control costs. Therefore, cost growth control must be addressed through a systemic approach that includes a health information infrastructure, realigned provider and patient incentives, and best practice information. Medicare can and must lead the way for the private sector. But simply using Medicare’s pricing power to control costs without addressing the underlying reasons health care costs are growing so rapidly will not fix our problem.

CONCLUSION

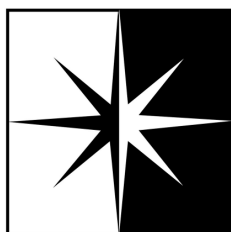
Coverage for all is an essential part of re-making our health system. Comprehensive health reform must also include efforts to improve quality and reduce cost growth.

¹ For further information on my thoughts about a competing public plan, see: Len M. Nichols and John M. Bertko, “A Modest Proposal for a Competing Public Insurance Plan,” *New America Foundation*, March 2009.

But the foundation of a *health* system must be coverage. Without coverage, tens of millions of Americans will never have access to appropriate, life-saving care.

There is a compelling collective interest in making sure coverage is a reality for all Americans: the economic loss we suffer as a result of the uninsured exceeds the cost of covering everyone.² Also, everyone must be in the system for it to work at its highest possible level. I hope this testimony is useful and I remain, as always, eager to answer any questions.

² Health Policy Program, “The Case for Health Reform,” *New America Foundation*, 2009.



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ROLE FOR PUBLIC PROGRAMS

As we create a sustainable system of coverage for all, public programs will play indispensable roles.

Medicare. Medicare has served some of our nation's most vulnerable citizens for generations. Yet, rising health care costs threaten the long-term sustainability of the program. Medicare can and must lead the way to broader health system transformation through reforms that add value and reduce cost growth over time. By changing Medicare's payment structure to align the incentives of providers across silos of care (hospitals, physicians, post-acute facilities, drugs, devices, labs, etc.), we can create powerful incentives for providers to adopt high-value care processes. In turn, this will make the delivery of care to the under-65 population more efficient (as did the move to diagnosis-related group payments to hospitals in the 1980s) and inspire private insurers to adopt similar, if not identical, incentive-based contracts. In many ways, Medicare reform is integral to health system reform and will have the triple benefit of making Medicare sustainable while delivering higher quality care to beneficiaries along with savings that can help finance coverage expansion subsidies in the intermediate and long runs.

Medicaid. The strengths and weaknesses of the Medicaid program are well known, and you have true Medicaid experts on this panel so I will be brief. Today, Medicaid provides essential services to some of our most vulnerable citizens. We must be mindful of its essential role today when thinking about system reform.

I am, however, haunted by this question: what other country with a commitment to coverage for all has a different health insurance program specifically for the poor? Provider payment rate and other variations across the nation lead me to believe that it would be preferable in the long run to transition non-elderly Medicaid enrollees into the insurance available in the exchanges, as long as they qualified for appropriate subsidies, perhaps some wrap around benefits for cost effective social support services that are not provided by traditional insurance, and special low-income cost sharing benefits. In the short run, however, I would recommend strengthening Medicaid payment rates to allay access problems and continuing current Medicaid programs at least for all those with incomes below poverty.

New Public Health Insurance Plan. No issue has been more contentious than this one so far, much to my surprise. Granting individuals the choice between public and private health plans serves two primary purposes. First, many Americans distrust private health insurers. A public health insurance plan would assure these individuals that their insurance company is accountable to them and not profits or boards of directors. Second, a public health insurance plan could serve as a valuable "benchmark" and provide a way for consumers to compare premiums, benefit

design, and the administrative efficiencies of different health plans. This benchmark role could be especially valuable in year one of a new exchange that some insurers (at least) will oppose and would like to erase. This benchmark role can be provided without inevitably leading to a government takeover of the health system, as some seem to fear.

Let me be crystal clear: if the playing field is level, it is possible for public and private health insurance plans to compete and deliver value for consumers without distorting the insurance market. This policy question should not create an impasse or stall reform efforts.¹

Three conditions are absolutely necessary for public and private health plans to compete fairly:

- All insurance market rules must apply to all plans equally.
- The authority governing the insurance marketplace cannot also manage the public health insurance plan.
- The public health insurance plan cannot leverage Medicare or other public insurance products to administer prices or claim an unfair advantage.

Real-world experience is instructive. More than 30 states offer their employees a choice between privately insured products and a self-insured product for which the state bears the insurance risk. Under this scenario, the state picks the managers of the self-insured product, which then competes with traditional private insurers. In her recent testimony before the this committee, Secretary of Health and Human Services, Kathleen Sebelius, pointed to state employee benefit plans as examples wherein “public and private plans compete on the basis of benefits, innovation, and cost,” without destroying the marketplace.

Yet, this type of public plan alone will not be sufficient to control costs. Therefore, cost growth control must be addressed through a systemic approach that includes a health information infrastructure, realigned provider and patient incentives, and best practice information. Medicare can and must lead the way for the private sector. But simply using Medicare’s pricing power to control costs without addressing the underlying reasons health care costs are growing so rapidly will not fix our problem.

CONCLUSION

Coverage for all is an essential part of re-making our health system. Comprehensive health reform must also include efforts to improve quality and reduce cost growth.

¹ For further information on my thoughts about a competing public plan, see: Len M. Nichols and John M. Bertko, “A Modest Proposal for a Competing Public Insurance Plan,” *New America Foundation*, March 2009.

But the foundation of a *health* system must be coverage. Without coverage, tens of millions of Americans will never have access to appropriate, life-saving care.

There is a compelling collective interest in making sure coverage is a reality for all Americans: the economic loss we suffer as a result of the uninsured exceeds the cost of covering everyone.² Also, everyone must be in the system for it to work at its highest possible level. I hope this testimony is useful and I remain, as always, eager to answer any questions.

² Health Policy Program, “The Case for Health Reform,” *New America Foundation*, 2009.