DLC

The New Democratic Leadership Council

Where Ideas Happen

What It Takes

Three Keys to Successful Health Care Reform

By Sarah Bianchi

September 2009

Executive Summary

Washington is consumed by a spirited debate about whether our revamped health care system should include a so-called "public plan," a government-run health plan that will compete with private insurers to deliver health care to some small businesses and individuals. While the fate of the public plan grabs all the headlines, three potent but less controversial reforms merit the most attention:

- **Overhauling insurance rules while requiring all individuals to be part of the system;**
- **Assuring that health care is affordable through sufficient tax credits and robust measures to contain costs;**
- **Putting in place an effective insurance exchange that will create a real health care marketplace.**

If Congress and the administration get these issues wrong, the health reform effort will come up short, no matter what happens to the public plan.

Insurance Reforms Won't Work Without an Individual Requirement

One essential component of a well-functioning health care system is that all Americans have access to quality health care coverage. Today, those who are eligible for Medicaid, Medicare or a large employer plan generally have at least that. But for those in small businesses or individuals without access to employer-sponsored coverage, the market does not even meet that basic test.

Study after study shows that individuals and small businesses seeking health care often get a raw deal. A 2001 study by researchers at Georgetown University's Institute for Health Care Research and Policy had seven different consumer profiles submit 420 applications for coverage in the individual market.[1] Taken together, this group was denied insurance altogether 35 percent of the time. Only 10 percent were given a so-called "clean offer," which basically means that the rest were given some type of extra premium or benefit limitation. The personal stories behind these numbers are heartbreaking – people who pay for insurance that doesn't cover their cancer treatment or heart medication, or that still leaves them awash in debt after a hospital stay, or those who are turned away altogether. There is no question this market needs a serious overhaul.

The leading reform plans offer two main strategies to make sure that everyone has a place to buy quality health insurance. The first is to implement new rules in the insurance market and the second is to implement an effective insurance exchange that will create a real health care marketplace (discussed later in the paper).

[1] Prepared for the Henry J. Kaiser Foundation by Georgetown University Institute for Health Care Research and Policy and K.A. Thomas and Associates, "How Accessible is Individual Health Insurance for Consumers in Less-than-Perfect Health?", (June 2001).

There is general agreement on what type of rules should be put in place: require insurers to accept all applicants (a term known in health policy as "guaranteed issue"); prevent them from excluding pre-existing conditions; limit the amount that insurers can charge due to age, gender, and health status (known as "community rating"); and prohibit insurers from limiting benefit plans and lifetime limits. Taken together, these reforms would assure that individuals can buy quality meaningful coverage in this market and their coverage won't be dropped just when they need it most.

These are critical reforms, but their application in the states demonstrates that, in a vacuum, they won't fix the market. The few states that have put in place guaranteed issue and full community rating ended up with an individual insurance market with very high premiums as people were allowed to buy insurance only when they needed health care.

"Taken together, these reforms would assure that individuals can buy quality meaningful coverage in this market and their coverage won't be dropped just when they need it most."

In some states, people have reportedly bought health insurance in the ambulance on the way to the emergency room or signed up for coverage during pregnancy and dropped it when the baby is born. While these stories are undoubtedly outliers, allowing people to drift in and out of insurance when they need it makes for an expensive marketplace. Insurance works only when the healthy and the sick pay premiums.

The way to fix the "only-the-sick-buy-insurance" problem is by requiring individuals to buy insurance. If everyone has health care, then the healthy and sick populations balance each other out in an affordable pool.

"Opponents may try to abandon comprehensive reform and simply pass the popular new rules for insurers without a sufficient individual requirement. That would raise premiums for most of the 14 million Americans who rely on the private non-group market today."

Some have argued that a public plan – rather than a bunch of subsidies and rules – is essential to keeping coverage affordable. Putting aside whether a public plan is necessary, we should all be able to agree that it won't be sufficient without the right rules in place. Any insurance plan, whether it is for-profit, not-for-profit or public, will have to price premiums based on the health status of the group it insures. As President Obama said in his address to Congress, "The public insurance option would have to be self-sufficient and rely on the premiums it collects."

Even the biggest "public plan" – Medicare – has policies that discourage people from signing up for health insurance only when they are sick. Medicare works because it accepts all comers but also because it has sufficient incentives to assure nearly all beneficiaries join. Even for an insurer like Medicare that is not trying to turn a profit, the notion of insurance simply does not work if people pay only when they need care.

New requirements for individuals and employers, if done right, can go a long way to getting more people insured. In Massachusetts, much of the new coverage came from these requirements. Some employers that didn't offer insurance before have started, and many individuals who hadn't taken coverage before have done so. In fact, 35 percent of the newly insured in Massachusetts have gotten coverage from their employer.[2]

All of the leading Congressional reform plans include individual and employment requirements. So what is the problem? Some reform opponents simply oppose the notion of requiring people to buy health insurance and others, worried about the impact on families, may try to water down the penalties to the point where they are meaningless. Also, as passing health reform becomes more complicated, opponents may try to abandon comprehensive reform and simply pass the popular new rules (guaranteed issue and community rating) for insurers without a sufficient individual requirement. That would raise premiums for most of the 14 million Americans who rely on the private non-group market today.

Insurance companies should be prohibited from denying or limiting coverage to individuals and small businesses. However, these reforms won't do us much good without a meaningful requirement that individuals buy health care.

Affordability and Cost Savings Are Crucial to Expanding Coverage

In the same way that insurance reforms won't work without an individual requirement, an individual requirement won't succeed without making sure that health care is affordable. While the median family income is around $50,000, the average cost of an individual health care plan is $4,824 and a family plan is $13,375.[3] Thus, without some kind of meaningful employer or government subsidy and efforts to contain costs, a requirement to buy health care would mean that many Americans would have to spend an outsized portion of their income to do so.

"Health care costs have been rising three times as fast as wages, placing burdens on families and businesses, and on government programs like Medicare and Medicaid."

To address these concerns, health reform must include robust proposals to contain costs or the subsidies won't be meaningful enough over time and reform will cost too much. Health care costs have been rising three times as fast as wages, placing burdens on families and businesses, and on government programs like Medicare and Medicaid. As President Obama stated in his speech to Congress, "Our health care problem is our deficit problem. Nothing else even comes close."

There are proposals to take some of the political pressures out of Medicare rates by empowering an independent board. For years, the Medicare Payment Advisory Committee has been saying that Medicare HMOs are overpaid, and this is the first year that it looks like Congress is finally going to seriously reform the system. With the Medicare Trust Fund set to go broke by 2017, we simply don't

[2]The Health Connector, www.mahealthconnector.org/portal/site/connector/
[3]Employer Health Benefits 2009 Annual Survey.

have time to wait.

There are other proposals to reduce hospital readmission rates and compare health care treatments to determine what is effective. While there will be far more work to be done to contain rising health care costs, Congress should pass as many of these reforms as possible to keep reform affordable for consumers and for the system as a whole.

> *"A meaningful subsidy will be essential to making coverage affordable. This is true regardless of what cost containment measures are enacted. This is true with or without a public plan."*

Everybody agrees, however, that those reforms will – at best – only slow the rise in the cost of health care, not stop it. Thus, a meaningful subsidy will be essential to making coverage affordable. This is true regardless of what cost containment measures are enacted. And this is true with or without a public plan.

There have been, however, efforts to whittle down the subsidy. Because of the enormous deficits it inherited, the administration has wisely committed to pay for the full cost of health reform. Cutting even the most excessive government waste or closing tax loopholes can be controversial and negotiators will be under pressure to slim down the offsets. Congress may find it tempting to keep down the cost of health reform, with smaller tax credits to middle class families that are phased out at lower income thresholds.

> *"The long-term success of health reform depends on making sure that size and scale of the subsidies match the scope of individual requirement."*

At a certain point, however, these proposals would either require the middle class to buy something they simply can't afford or alternatively require the government to exempt more people from buying coverage, which, of course, would reduce the number of people with insurance. Congress should work to maintain every offset with sound policy justification. At the same time, it should understand that the long-term success of health reform depends on making sure that the size and scale of the subsidies match the scope of the individual requirement.

One oddity of even the most liberal plans is their exemption of the very poor (those whose incomes fall below the threshold for even filing a tax return) from the individual requirement. At first glance, this seems to make sense, as people with the lowest incomes have the least to spend on health care. That population, however, is typically eligible for Medicaid, which charges hardly any premiums.

In fact, approximately 10 million uninsured Americans are eligible for Medicaid or the Chil-

dren's Health Insurance Program but are not signed up.[4] That problem will only compound if they are exempt from the individual requirement. The Congressional Budget Office estimated that under the House tri-committee plan, several million eligible for Medicaid would remain remained uninsured, significantly undermining the goal of universal coverage.[5] Making an individual requirement work for these families is critical to assuring that millions of the most vulnerable Americans are not left out.

"Approximately 10 million uninsured Americans are eligible for Medicaid or the Children's Health Insurance Program, but are not signed up. That problem will only compound if they are exempt from the individual requirement."

Congress should work to make sure reform insures as many people as possible. It is the right thing to do both for our families and for the health care system. We all know that the uninsured are inefficient consumers of health care, delaying preventive care, and then seeking more expensive help in emergency rooms. Just because they don't have health insurance doesn't mean they don't use health care – and it costs the system dearly.

A Well-Functioning Exchange Is Essential to Creating a Healthy Marketplace

Finally, a well-designed exchange, where individuals and small businesses band together so health plans compete for their business, is necessary to create a real marketplace for its members. But it must be structured correctly to keep competition up and costs down.

Working examples today include the Federal Employees Health Benefits (FEHB) Program, which covers nine million federal workers, retirees, and dependents, and the Massachusetts connector, which enrolls 171,000 residents. Both highlight the advantages of a transparent marketplace where consumers can choose from among competing plans.

My husband is a federal employee, and for us the federal plan offers 26 plan options, ranging from HMOs to PPOs to high deductible plans. With the click of a mouse, I can see what benefits each offers and how much each plan would cost. I entered our family data for the Massachusetts connector as well. There, we were offered 21 options, with a range of premiums and benefit designs and which doctors participate.

The reasons insurance exchanges work are not surprising. First, because insurers are attracted by a large group of customers they are willing to compete for their business. Second, buying health care is no different from buying anything else: the more you buy, the more you save. As such, consumers are given more affordable choices.

Third, administrative expenses for individuals and small businesses are more than four times higher (30 percent vs. 7 percent)[6] than they are for larger employer plans. Broker fees are one big

---

[4]Dubay, Holahan and Cook, "The Uninsured And The Affordability Of Health Insurance Coverage" Health Affairs (November 2006).
[5]Congressional Budget Office, Letter to Honorable Charles B. Rangel (July 14, 2009).
[6]Congressional Budget Office, "Effects of Changes to the Health Insurance System on Labor Markets"

reason for the higher administrative costs of the former. Those fees, which are incurred because a broker is often necessary to navigate what is currently a confusing, nontransparent marketplace, often account for 15 percent to 20 percent of a first year's premium.[7]

Those fees are dramatically reduced by an exchange, in which plan options are laid out simply and clearly on website so that buyers can compare and choose among options. After implementing its exchange, Massachusetts found that only 1.3 to 3.3 percent of premiums went to commissions.[8] With fewer dollars going to administrative costs, more can go to paying for health care itself.

> *"Congress must resist the claim of some conservatives that large businesses should be excused from covering their workers and the claim of some liberals that anyone who is unhappy with their health insurance should be able to join the exchange. If either claim prevails, the exchange will likely fail."*

Not all health care exchanges, however, function effectively, and it is hard to imagine the exchanges being debated today working well unless they contain three key elements.

First, there must be strong rules to prevent the 99 percent of large employers that are offering coverage today from telling their employees – particularly their sickest – to get subsidized insurance courtesy of Uncle Sam. In the absence of those rules, more people will become eligible for government subsidies, driving up the cost of health reform.

Second, there must be rules to prevent just anyone from joining the exchange. FEHB works because it is a diversified yet finite pool. Massachusetts also has strict eligibility limits. In the absence of such rules, the exchange pool will likely attract higher users of health care than it otherwise would, pushing up the cost for all participants.

Congress, therefore, must resist – equally – the claims of some conservatives that large businesses should be excused from covering their workers and the claims of some liberals that anyone who is unhappy with their health insurance should be able to join the exchange. If either claim prevailed, the exchange will likely fail for the predictable reason that insurance works only if it covers the healthy and the sick.

Finally, there must be strong rules to prevent insurers from gaming the system. Back in the 1990s, a flaw in Medicare's rules rewarded insurance companies that cherry-picked healthier and wealthier seniors. Not surprisingly, insurers targeted this group by offering gym memberships and providing information about their plans on the fourth floor of buildings with no elevators.

If there are loopholes and misaligned incentives, we should expect they will be exploited. So Congress should pass strong rules and penalties to make sure they can't be. These rules are key to holding insurers accountable and making sure consumers get a fair deal.

(July 2009).
[7]Blumberg and Pollitz, "Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals." April, 2009.
[8]Blumberg and Pollitz.

Conclusion

In the childhood fairy tale, Goldilocks, after wandering in the woods aimlessly and lost, found a home and, once inside, spent a lot of time trying out porridges of different temperatures, chairs of different sizes, and mattresses of different softness – all things, by the way, that mattered a lot to a tired, little girl. It's time we emerge from our policy wilderness and spend what time remains thinking about and testing the core issues – access to quality coverage, making health care affordable, and more choices and responsibilities for individuals and employers and insurers alike – that will determine whether health care reform succeeds.

Sarah Bianchi has advised President Bill Clinton, Vice President Al Gore, and Senator Edward M. Kennedy on health care policy. She also served as the National Policy Director for the Kerry-Edwards Presidential Campaign. She currently works for Eton Park Capital Management, a global alternative investment fund.