Insurer Workgroup Report

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INTRODUCTION

One of the tasks under the HRSA State Planning Grant is to elicit the insurer/health plan perspective on identifying barriers to coverage for the uninsured. Representatives from three insurers operating in Vermont participated in the Insurer Workgroup on March 8th from 12:00 p.m. to 2:00 p.m. at Action Research, Inc. The purpose of the meeting was to discuss factors affecting health insurance premiums and coverage in the state and means of expanding health insurance coverage in Vermont. The protocol used in leading the discussion is provided in **Appendix A.**

The material presented here is intended to be a summary of the views expressed by the participants. As such, it does not represent the views of the Lewin group or the state of Vermont.

EFFECT OF STATE MANDATED BENEFITS

Participants felt that it was not possible to predict the impact of mandated benefits on coverage other than general research findings that increasing premiums decrease coverage rates. Insurers have found that coverage mandates increase premiums.

- One insurer indicated that he had data showing that mandatory benefits (e.g., chiropractic and mental health, including the requirement that insurers offering mental health coverage must go through mental health agent licensing) have increased insurance premiums in the state by 5 to 10 percent.

- Mental health parity has had a big financial impact and makes up a larger part of health care costs in Vermont than in most other states (outside of New England).

EFFECT OF COMMUNITY RATING

Workgroup participants stressed that community rating has not, on its own, affected average premium levels. However, premiums for younger groups generally increased after implementation of community rating while premiums for older groups decreased.

- Some small groups with relatively healthy (i.e. low cost) workers escape the community rated premium by establishing a self-funded insurance product supplemented with reinsurance to cover high-cost cases. This typically leaves only higher cost cases in the community-rated risk pool, resulting in higher premiums. One participant said that "selection behavior" has "polluted" the community rated risk pool in Vermont.

- Community rating has helped to "level the playing field" for Blue Cross Blue Shield (BCBS) and the HMOs because prior to this legislation, BCBS and HMOs were the only health plans required to community rate. Leveling the playing field caused some carriers to think about leaving the state, because once community rating was established, the most desirable target groups weren't as easily accessible. However, this alone did not cause them to leave the state.

- Participants asserted that the pre-community rating market was in worse shape than the current market. Doing away with community rating would have a destabilizing effect on the market, especially the small group market.

- There was general agreement that community rating is positive for the state.

REASONS FOR SMALL NUMBER OF INSURERS IN VERMONT MARKET

The participants agreed that there is no one reason for the small number of insurers operating in Vermont. Rather, it is a combination of regulatory and market issues.

- The decline in the number of insurers in the state reflects a nationwide trend of consolidations in the insurance industry and a general reduction in the number of insurers who are interested in staying in the business of health insurance.

- One insurer reported the generally held belief among the insurance industry in Vermont that for some carriers, Vermont is such a small market that it is not worth the effort or expense to comply with the full range of state regulations. State regulations mentioned include community rating, mental health parity (including the requirement that insurers offering mental health coverage must go through mental health agent licensing) and loss ratio limits. One insurer stated that if it were not for an existing office in the state, that insurer would not be operating in Vermont.

- Entering a highly regulated market for a relatively small number of covered lives is not attractive to most insurers.

- Those companies who were not skilled at actually managing care left the state when they were no longer able to profit from risk selection (i.e. marketing coverage to only lower cost groups).

- Lack of competition among providers makes it difficult to form effective networks. Insurers that enter the Vermont market must be prepared to compete with existing managed care plans (TVHP and MVP) as well as offer other products, "[it's not possible] to come in and pull off just one market segment".

- One participant said that Vermont's aggressive regulatory environment (including community rating, loss ratio limits, mental health parity) has kept large transnational insurance/managed care companies that do business in Maine from entering Vermont.

- Talk of a single payer system makes insurers uneasy about investing in Vermont.

IMPACT OF SMALL NUMBER OF INSURERS ON VERMONT MARKET

Participants argued that creating competition through more insurers is not the answer to better cost control. This is due to the fact that insurance costs are driven primarily by utilization which

is difficult to control in a market with few competing providers (i.e., cost control through selective contracting, etc.).

- There was general consensus that with the exception of Kaiser Permanente, those insurers that left the state were not the "major players". In fact, the departure of these insurers has made the market more financially stable.

- One insurer stated that it would be risky to attract a large insurer with substantial capital backing and the ability to artificially reduce prices in the short term. Insurers in the state currently are not prepared to compete in this way and could be driven out of business.

- Alternatively, one insurer pointed out that the cost structure of a new entrant to the insurance marketplace would be worse than that of an existing carrier due to their lack of volume. For this reason, new entrants would not necessarily reduce premiums.

- Insurers do not have leverage to force competition among providers, hospitals and clinicians. This makes it difficult to compete on the basis of controlling costs through effective provider networks.

COMPETITION IN THE DELIVERY SYSTEM

Participants agreed that hospitals are not as "neat and clean" as they should be or have been made to be in other parts of the country. While not all participants agreed that there are too many hospitals in the state, there was agreement that existing hospitals could operate more efficiently. Also, there was consensus that hospital inefficiency is due to a lack of competition among providers. Competition is minimal because each hospital is the only hospital within many miles. Thus, insurers believe that they do not have the leverage to effect competition among providers.

- The centers of excellence model whereby hospitals develop expertise due to large volume of patients is not taking hold in Vermont. System formation has been affected by the promise that local hospitals will not be eclipsed by larger tertiary hospitals, so that hospital services will be available within most communities. Vermont providers are very committed to community-based care.

- The two systems which have formed in the state (Fletcher Allen and Dartmouth Hitchcock) did not form through "true consolidations and mergers...what's happened is they have affiliated, integrated and haven't changed a whole lot. They're protecting themselves...it's a contracting strategy". Another participant concurred that the alliances and affiliations in Vermont are "protective rather than accelerating [the] consolidation of services".

- Insurers would like to realize some of the gains that they "would hope would be attributed to an integrated community tertiary base system of care" and would be willing to work with these hospital systems to realize cost savings.

- One participant stated that the Dartmouth-Hitchcock and Fletcher Allen systems, along with 2-3 other hospitals, could cover the inpatient service needs in the state alongside a system of urgent and emergency care facilities.

- Another participant suggested that having two medical schools in Northern New England may be too many. However, there also seems to be support for the proposed expansion at Fletcher Allen.

- Insurers would like to have the ability to vary premiums by geographic area. They argued that this would encourage cost control by providing purchasers with information on the cost of providing care in their area.

- The insurers reported that it is not the hospital *systems* in Vermont which are the high cost entities but rather the small, rural hospitals.

TRI-STATE REGULATORY MODEL

The idea of creating a tri-state (Vermont, New Hampshire, Maine) regional insurance authority was brought up with Workgroup participants. The authority would take care of insurance rate approvals, guaranteed issue rules and rule standardization, effectively standardizing regulatory compliance across the tri-state area.

- The participants indicated that this might increase the number of carriers operating in Vermont but said that they do not believe that this increase in competition would decrease premiums because there would still be little competition among providers.

- The tri-state regulatory model would affect only those fully-insured firms that are subject to the community rating regulations (i.e., firms with 50 or fewer members).

IMPACT OF COST-SHIFTING

There was a general consensus that in response to underpayment in Medicaid and Medicare, hospitals have generally shifted costs to private payers in the form of higher charges. This was cited as a major reason for higher private insurance premiums in Vermont rather than in other parts of New England including various urban centers.

- Premiums are reported to be higher in Vermont than in some major cities, primarily due to the cost shift. One participant indicated that the premium for a given health plan in Bennington, Vermont is about 22 percent greater than it is in Glens Falls, New York (located about one hour from the Vermont border).

- Cost-shifting is a major reason for premium increases.

- When payments are averaged across all payers in the state, per capita health care costs in Vermont are generally lower than in other states. What this average masks, however, is a sharp difference in payment levels for public programs and commercial insurers. Public

program payments for health services in Vermont are substantially lower than in other states, which causes Vermont providers to shift a greater proportion of costs to commercial insurers than in other states. Consequently, per capita costs for commercially insured persons in Vermont are substantially higher than in many other states where there is less cost shifting, even though overall average costs in the state comparatively low.

- There was general consensus that increased Medicaid/Medicare payment rates would result in decreased commercial rates. One participant remarked however, that, "it does take a leap of faith that the hospitals just won't pocket the money". The participant suggested that a "structure" is needed (such as the state's hospital budgeting system) to prevent this from happening.

CONTROLLING UTILIZATION AND COSTS

Participants generally agreed that changing provider behavior and utilization is the key to cost control.

- Disease management has been found to be an effective means of controlling beneficiary utilization. The focus for reducing costs in the long term is to influence utilization decisions by providers using: financial incentives (such as "risk sharing"), providing comparison and best practice information, sharing data, disease management strategies, small process interventions, and developing good working relationships with providers.

- One participant mentioned that the number of hospitals in the state should not be the main focus of health planning efforts. Instead, the state should focus on a health planning model for the whole delivery system.

BARRIERS TO ACCESS FOR THE UNINSURED

Participants cited several reasons why some people do not buy health insurance coverage: (1) cost, (2) lack of "need", it may be wiser to pay out-of-pocket when a healthcare need does arise, and (3) it does not cover alternative therapies.

- Their experience has been that high deductible packages are not necessarily popular with employers. Employers are interested in plans that provide reasonable deductibles, reasonable co-pays, comprehensive network access, and comprehensive coverage in general.

- One insurer stated that a combination of strategies is required to extend insurance to the last 10 percent of uninsured in Vermont. The same participant believes that a new insurance product with a "25 percent discount" (refers to a combination of lower rates and reduced coverage), for example, could encourage some Vermonters to buy their own coverage: "[the percent uninsured] might only [go down] a percent or two in the state but that to me is part of the solution...I don't see any silver bullet".

- Encouraging people to sign up for Medicaid could cause some privately insured persons to substitute public for private coverage (i.e. crowd-out) which would disenfranchise other people and possibly result in the loss of coverage for some persons.

- There is a perception that "if you are hurt, you're going to be taken care of and if you can't work anymore, you'll be on Medicare/Medicaid".

- One insurer indicated that unless required to do so, the last 10 percent of the uninsured may not opt for insurance coverage, even at discounted prices.

INSURERS' RECOMMENDATIONS TO THE STATE

Throughout the Workgroup discussion, the following suggestions were made:

- Allow for regional ratings differentials such that insurers can pass on savings in certain communities to employers (and therefore employees), thereby encouraging changes in provider practice. An insurer reported that there can be as much as a 25 to 30 percent cost differential (for provision of healthcare services) between certain zip codes in the state. Instead of instituting regional ratings at the zip code level, it was suggested that five regions be developed for this purpose.

- Collect and distribute utilization and outcomes information for individual hospital services areas throughout the state to foster quality improvements, reduce practice patterns variation, and encourage more competition among providers.

- Maintain hospital oversight, however, restructure the process. Regulate hospital budgets on an annual basis is not productive and the framework the state is using is outdated. Instead, the state should be proactive about planning for the future of the healthcare system as a whole five years from now, including both inpatient and outpatient services.

- The State should focus on the planning of health systems (including major sources of outpatient revenue) rather than just hospitals. One participant however, questioned the usefulness of expanding the "less than perfect process [that is currently] in place for hospitals." All agreed that a wider mix of measures is necessary to "reflect the diversity in the systems that are regulated."

- Develop better tools (data) to effectively negotiate spending levels with providers. They asserted that the current State program for hospital budget review does not have the resources to match what the hospitals are capable of devoting to the regulatory process.

- Capitalize on affiliations/hospital integration already in place through the Fletcher Allen and Dartmouth Hithcock systems and try to bring about true consolidations and mergers for realization of economies of scale.

- Involve stakeholders (other than hospitals) in hospital/system strategy, planning and regulation.

APPENDIX A: INSURER WORKGROUP PROTOCOL

- What has been the effect of state mandated benefits on premiums and the number of persons with coverage (chiropractic, mental health, maternity etc.)?

- How has community rating affected your business? Has it raised premiums? Has it increased or decreased coverage?

- Has community rating caused insurers to leave the state? Why have you stayed?

- Would you advise any revisions of the existing guaranteed issue and community rating laws? What would be the effect on high premiums by age and health status? Would this reduce or increase the number of persons with health insurance?

- Is community rating in the small group market (50 or fewer lives) being undermined by groups who escape the community rated pool by self-insuring? Is community rating being undermined by the use of association health plans?

- What is the minimum number of lives for your plan to be viable? Do you define service areas in terms of state boundaries or regional markets?

- How can managed care work in a predominantly rural state such as Vermont? Is there enough competition among providers to make selective contracting viable? Are there effective financial incentive models that can be used with provider networks (i.e., risk sharing, capitation etc.)?

- What can be done to expand coverage? Would a high risk pool lead to increased coverage? Would it attract more insurers to the state? If it were funded with an assessment on all insurance?

- Could a low cost package be developed for Vermont that would lead more employers to offer coverage? Have employers been asking for such an option?

- Would it be to an advantage to introduce a program that permits small firms who are not currently providing coverage to purchase a basic benefits package that is free of state mandated benefits? In your experience, would employers buy such a package?

- What would be the effect of subsidizing the basic benefits package for employers who are not now offering coverage? (New York has established a similar program using a reinsurance program funded with Tobacco settlement funds).

- What proportion of premiums is attributed to the cost-shift and how has this affected costs and the number of persons with coverage?

- If public program payment levels were increased would providers lower their private payer rates or would they retain the increase as a windfall? Could the state hospital budgeting process be used to preclude providers from retaining such a windfall? Would this be necessary?

- Would a program that standardizes insurance regulation across the three-state region of Vermont, New Hampshire and Maine make it more attractive for insurers to operate throughout this region?

- Do you have any other ideas on how coverage could be expanded in Vermont?