The Continued Need for Reform: Building a Sustainable Health Care System

Sustainable reform must address cost and quality, while expanding coverage through a vibrant and functional marketplace

As the largest health benefits company in the U.S. — covering one in nine Americans\(^1\) and processing over $100 billion in medical claims per year\(^1\) — WellPoint has the opportunity to drive changes in the delivery system that improve health care for everyone. Through our implementation of health care reform, we are working to implement delivery system and market reforms that improve quality and expand coverage for consumers through a vibrant and competitive marketplace — a marketplace that provides consumer choice and optimal value.

Our national scale and local market presence uniquely position us to work with policymakers at the state and federal levels to implement reforms that create a sustainable health care system. We are focused on fixing what’s broken in our health care system while preserving what works, and we are leading efforts to implement an affordable and quality delivery system for all Americans for the 21st century. In sum, WellPoint believes there is a continued need for reform in the following areas to accomplish a sustainable health care system:

- Improving the quality and safety of health care while controlling costs in the delivery system
- Implementing insurance market reforms that ensure a vibrant, functional marketplace
- Ensuring that public and private rates for services and coverage reflect true costs
Improving Quality, Safety and Cost in the Delivery System

The primary goal of The Patient Protection and Affordable Care Act (ACA) was to make coverage more accessible to all Americans. WellPoint believes that a focus on cost and quality is more important than ever as more consumers access care. Hospitals, physicians, nurses, long-term care facilities and insurers, in partnership with consumers as well as the government, must address the unsustainable rate of growth of underlying health care costs. High costs affect all areas of the health care system and are the ultimate drivers of other systemic problems, including access to care. As more elements of the ACA take effect, we will continue to make improvements to the system and hope to be a trusted resource for policymakers in these areas. We are actively providing information and sharing our expertise as America’s health care system continues to change and improve. Through the development of programs that reward physicians for quality over quantity, empower consumers with better information and other important innovations, WellPoint has already made significant progress in the areas of cost and quality. Our efforts are focused on the following principles:

- Promote evidence-based medicine and determine real-world outcomes
- Advance health care quality by sharing information throughout the system
- Focus on prevention and manage chronic illness
- Improve effective use of drug therapies to prevent and manage illness
- Promote strategies to reduce medical errors and adverse drug events
- Reduce costs by eliminating fraud and reducing litigation
- Explore opportunities for improving payment incentives
- Drive administrative simplification

By increasing coordination with government at both the federal and state levels, we can further drive initiatives already underway to improve quality and control costs.

Implementing Insurance Market Reforms that Ensure a Vibrant, Functional Marketplace

Improving quality and controlling costs are the best ways to create a sustainable health care system. The goals of health care reform cannot be achieved without them. At the same time, there is additional work that needs to be done to meet the needs of consumers in a reformed health insurance marketplace. Specifically, WellPoint believes that thoughtful implementation of certain key reforms will be critical to optimizing consumer choice while ensuring a functional marketplace. A focus on the regulatory structure of the insurance marketplace and certain aspects of health care financing would enable insurers and others to respond to the ongoing needs of consumers, improve affordability and help expand coverage. We look forward to working with state and federal policymakers to advance, in particular, the following:

Insurance Market Reforms that Reflect whether Coverage is Voluntary or Mandatory

- This is critical to the success of reform. The guaranteed issue requirement and rating rules in the ACA will only work if there is an effective individual mandate. Otherwise, reforms will create a dysfunctional marketplace that disrupts coverage for the millions of insured Americans who have coverage today. Without this element, given the other market reforms in the ACA, there is no incentive to purchase coverage before it is needed — a critical incentive for any type of insurance. If the individual mandate is not effective, the guaranteed issue requirement, along with the insurance rating reforms, must be re-evaluated to ensure stability and longevity of the insurance marketplace.
If there is not an effective individual mandate, reforms must be modified to meet the goal of guaranteed issue. This can and should be done in a way that avoids the unintended consequences of adverse selection. Following are two ways to achieve this goal:

1. Establish improved “high-risk pools” or “guaranteed access plans.” These plans spread the costs of high-risk applicants who are unable to obtain coverage in the private health insurance market across a single pool of high-risk individuals that is subsidized by external funding. To be successful, the costs for these high-risk individuals must be spread over a broad funding base. Currently, 33 states have established such pools. Many do not work well and need to be reformed to be more consumer-friendly. In many cases, more sustainable funding sources are also required.

2. Create an “invisible high-risk pool.” This design provides access to products by requiring all carriers (including group-only carriers) to offer guaranteed issue products in the individual market. The premium for these products would be capped based on the current underwritten market and subsidized through a broad-based funding mechanism. The state would be required to establish insurer-specific enrollment caps based on an insurer’s market share to ensure that no single insurance carrier — and its members — carry a disproportionate amount of risk. In this way, all consumers would have the ability to purchase private coverage while spreading the costs of high-risk individuals broadly to maintain a functional insurance pool.

Effective, Sustainable Health Insurance Exchanges
WellPoint supports the states’ development of “facilitator” exchanges — exchanges that allow any qualified health plan (per federal and state law) to be offered through the exchange. This is needed to reduce the risk of creating greater administrative burdens, higher costs and less choice for individuals and small employers. Exchanges are intended to be new competitive markets for health insurance that will enable individuals and small employers to meaningfully choose among competing health plans. As such, they will be most effective in this role if they are open to all coverage options approved for sale by insurance regulators that meet Qualified Health Plan standards.

Effective Risk Adjustment
In an environment where insurers are required to accept all applicants for coverage with significant rating constraints, WellPoint believes it is critical to create a system which includes effective risk adjustment to ensure that carriers, and, consequently, their members, are not unjustly penalized for enrolling a disproportionate share of high risk individuals. WellPoint supports a national standard for risk adjustment, based on diagnostic and procedural coding, to ensure consistency across states and maximize efficiency. Such standards are critical in any environment where individuals may select any health insurance company on a guaranteed issue basis, as the uncertainty and risk associated with that new dynamic are substantial.

A Successful Rate Review Framework
WellPoint supports state departments of insurance retaining jurisdiction over rate review and the criteria and process for reviewing rates based on actuarial criteria. This ensures the same entity responsible for ensuring solvency of insurers is responsible for reviewing rates and would thus reduce instances of coverage disruption for consumers. Review of insurance rates must also be based on actuarial assessment of the true, underlying costs of health care services. This will help prevent any artificial capping of rate increases that can result in fewer consumer offerings.
and insurers withdrawing from markets, which further reduces consumer choice. In establishing a rate review framework with potential new administrative burdens, it is also important to remember that the medical loss ratio requirements will already require insurers to pay rebates to customers to the extent the MLR thresholds are not achieved.

Any Medical Loss Ratio (MLR) Framework Must Avoid Unintended Consequences

WellPoint does not believe a standard MLR is an appropriate metric for regulating health insurers. Loss ratios naturally vary by type of insurance product, and a standard MLR penalizes insurers for offering low-cost products while having the unintended consequence of discouraging insurer activities designed to help control costs. However, given the existence of MLR requirements in the law, WellPoint believes careful thought must be given to the design of any federal MLR framework to ensure that the requirement does not reduce consumer choice, obstruct broad pooling of risk, inhibit innovation and activities that improve quality and control costs or penalize insurers for paying taxes. Specifically, WellPoint believes that any MLR framework must do the following:

1. Ensure consistent application across carriers and includes a uniform transition period for insurers to meet the federal targets;
2. Allow for the aggregation of experience of affiliated legal entities within a state;
3. Provide a credit to insurers for quality expenses related to fraud prevention, ICD-10 and utilization review; and
4. Include a provision for insurers to exclude all federal and state taxes and regulatory fees from the calculation.

Improvements in Medicare and Medicaid

- Medicare provides millions of seniors with the ability to choose among insurance products that suit their individual needs. Protecting consumer choice for seniors should remain a priority for lawmakers and the Administration, especially given cuts outlined for the program under the ACA. WellPoint remains committed to serving the senior market and looks forward to working with state and federal policymakers to secure the best possible care for America’s seniors by focusing on these and other key issues, including the thoughtful transition to new benchmarks, criteria for quality bonus payments and restoration of rebates to 75 percent of the difference between the bid and the benchmark (80 percent for high quality plans).
- Similarly, the Medicaid expansion included in the ACA requires consideration of innovative care delivery approaches. Medicaid-managed care must be utilized to maintain a sharp focus on providing the right care, at the right time, in the right setting. This equates to improved health outcomes and decreased state and federal costs. WellPoint supports state efforts to expand the penetration of Medicaid-managed care to improve quality and better control costs, including a focus on the Aged, Blind, and Disabled (ABD) population, which represents about 25 percent of Medicaid enrollment, but almost 70 percent of total Medicaid spending. Since a majority of the ABD population remains in Medicaid fee-for-service, managed care holds real potential for improving beneficiary health outcomes while reducing cost trends through increased access to primary, preventative and specialty care and proper care coordination.
Changes to Tax Credits and New Taxes

- Tax credit subsidies should be available to all purchasers of health insurance, regardless of how they purchase their coverage. For example, the current tax system generally only allows for deductibility for coverage purchased through employers, and tax credits created by the ACA are only provided for certain individuals and small employers if that coverage is purchased through an insurance exchange. Tax credit subsidies should be available inside or outside of exchanges, and all coverage — regardless of its source — should be a tax deduction against an individual’s gross income, versus an itemized deduction subject to limits. This will put taxpayers on a more level playing field, regardless of how they obtain coverage.

- New taxes scheduled to go into effect under the ACA will significantly contribute to the cost of coverage, working against a key goal of health care reform, and should be reconsidered. Additionally, some of these new taxes will create an un-level playing field for the health insurance market by treating certain specific health insurance companies differently, which could have the unintended consequence of reducing consumer choice.

Ensuring Public and Private Rates Reflect True Costs

In addition to a commitment to managing overall system quality and cost while thoughtfully implementing the new reform law, WellPoint also supports efforts to ensure adequate rates in both the private and public market are established to allow services to be available and to limit further cost-shifting and distortions within the market — distortions which have the potential to put the promise of affordable coverage out of reach for some consumers. Rates in the public and private sectors should reflect the true costs incurred by health care providers and insurers to provide necessary services.

Public Sector

In the public sector, policymakers have responded to budget challenges and a desire to cover more individuals for less money by reimbursing providers for less than the cost of providing care. This is occurring in both Medicare and Medicaid programs that cover over 100 million Americans and accounts for almost two thirds of hospital revenue. Medicare and Medicaid reimburse hospitals only 90.9 percent and 88.7 percent of costs, respectively, for providing services. This means Medicare and Medicaid providers must shift some of their un-reimbursed costs to private payers, including those with commercial health insurance coverage. Specifically, hospitals are forced to run a higher than otherwise necessary profit margin — what some have referred to as a “hidden tax” on private payers to offset public program underpayments. A Milliman study found that commercial payers spent 15 percent more in reimbursements to hospitals to make up for the deficit created by public program underpayments.

Challenges associated with public sector underpayments are growing. Not only are baby boomers rapidly expanding Medicare rolls, but the ACA will also result in the addition of approximately 16 million more Americans to Medicaid due to revised eligibility criteria. The ACA also cuts the growth rate of payments to providers in the Medicare program by over $200 billion over 10 years. WellPoint urges policymakers to consider these facts when evaluating reimbursement rates for public programs, which must reflect the true costs of health care.
Private Sector
In the private sector, policymakers are increasingly using artificial caps on rates for commercial health insurance coverage to try to control premium increases. Similar to underpayments in public programs, artificial caps on private health insurance premiums that fail to take into account the real costs of providing health care do nothing to control costs but instead create challenges for consumers. For example, artificial rate caps can create access problems for consumers when some insurance carriers are forced to leave markets in which it is no longer viable for them to operate and remain solvent. This dynamic occurred in Washington State in the early 1990s, where rate caps contributed to insurers withdrawing from the individual market to such an extent that insurance was unavailable to consumers in several counties. Additionally, artificial caps can result in scenarios where rate increases in subsequent years (following the imposition of an arbitrary cap) are needed to permit the price to “catch-up” to its true cost. WellPoint urges policymakers to avoid such “band-aid” attempts to control costs, which only mask the true cost of health care. Real solutions to improve cost and quality, such as those outlined in our “Improving Quality, Safety and Costs in the Delivery System” section above, are what are readily available and they are sustainable.

Conclusion
Sustainable, consumer-focused reform must address cost and quality while expanding coverage through a vibrant and functional marketplace. By continuing to focus on quality, safety and cost, and by coordinating with state and federal governments to facilitate thoughtful implementation of key reforms under the ACA, WellPoint is working to ensure that affordable health care is available for all Americans through a vibrant and functional marketplace. These efforts, coupled with a focus on ensuring that public and private rates reflect true costs, will allow us to collectively build on what works in our delivery system and make it sustainable for the 21st century. As the nation’s largest health benefits company, WellPoint is committed to meeting this challenge.

1 WellPoint analysis based on total membership from 2009 Annual Report.
2 WellPoint Q4 2009 Fact Book
3 Kaiser State Health Facts: Distribution of Medicaid Enrollees by Enrollment Group, FY2007; Distribution of Medicaid Payments by Enrollment Group (in millions), FY2007
4 Kaiser State Health Facts: Total Number of Medicare Beneficiaries, 2010; Total Medicaid Enrollment, FY2007