Written Testimony
U.S. House of Representatives
Committee on Energy & Commerce
Subcommittee on Health Hearing
Wednesday, May 25th

Paul Howard, PhD
Manhattan Institute for Policy Research

"Expanding Health Care Options: Allowing Americans to Purchase Affordable Coverage Across State Lines"

First, I'd like to thank Chairman Pitts, Ranking Member Pallone, and the entire committee for holding the hearing today on the important topic of interstate insurance competition and H.R. 371, the Health Care Choice Act of 2011. I'm speaking today in my capacity as director and senior fellow of the Manhattan Institute's Center for Medical Progress, my experience writing and researching on health care policy issues, and from speaking to health insurance stakeholders (including large and small employers, insurers, and consumers) about the challenges facing the market today.

There is no doubt that the single most important issue facing American health care today is the high and rapidly rising cost of health care – and, directly related to it, the high cost of health insurance. There no doubt that the passage of the Patient Protection and Affordable Care Act in 2010 has done little to alter the unsustainable trajectory of health care inflation for the federal government, states, employers and consumers.[1] The high cost of care is the primary reason why many Americans lack health insurance, since they cannot find affordable coverage that meets their needs, and why more small employers are dropping coverage in the face of unsustainable coverage increases.

However, while there is widespread agreement that "something" has to be done to curb the high rate of health care inflation, policy solutions tend focus on the villain *du jour* (Big Pharma, Big Insurance, etc, as long as the industry is "Big") rather than facing the underlying forces contributing to our current woes. Let me briefly outline those forces:

1. Health insurance should function as protection for individuals and families against the potentially devastating financial impact of a catastrophic injury or serious illness, not the coverage of routine costs for families of moderate (and not so moderate) means. However, the tax advantaged status of employer-provided health insurance leads employees to prefer plans with high pre-tax premiums, and low-after tax deductibles and co-pays even for routine care.

[1] As CBO Director Douglas Elmendorf noted not long after the passage of the Patient Protection and Affordable Care Act: "Rising health care costs will put tremendous pressure on the federal budget during the next few decades and beyond. In the CBO's judgment, the health legislation enacted earlier this year does not substantially diminish that pressure." Presentation to the Institute of Medicine, Health Costs and the Federal Budget, May, 26 2010. Slide 2. Available online at http://www.cbo.gov/ftpdocs/115xx/doc11544/Presentation5-26-10.pdf.

Bipartisan economists recognize that the unlimited tax deduction for employer provided insurance increases health care inflation, and makes it more difficult to constrain the consumption of low-value services with marginal benefits. Individuals without group health insurance must also purchase insurance at significantly higher cost, since they must purchase insurance with "after-tax" dollars.

2. Providers are largely paid on a fee-for-service basis, with little competition based on price and quality. In every other sector of the U.S. economy, producers compete with each other to provide consumers with a wide variety of "bundled" products and services at a wide variety of prices. In health care providers have little incentive to compete based on price and quality. In fact, providers that offer lower cost, higher quality services are actively penalized for such improvements, and higher cost competitors can financially benefit from their inefficiency.

3. Government regulation in the health care sector often strays from its legitimate purpose of consumer protection and mandating basic standards to favoring particular groups of incumbent providers (traditional v. physician-owned hospitals; physicians v. nurse practitioners) against competitors who may be able to offer similar products and services at lower prices, or achieve higher quality outcomes. This is particularly true for our discussion today, since state health care markets are often captured by incumbents, particularly in the realm of insurance regulation. Such regulations often mandate the coverage of provider services or insurance benefits in the name of consumer protection, when in reality what such mandates provide is provider protection – or, I should say, provider income protection.

Obviously these issues are intimately intertwined. A limited tax exclusion or tax credit would give consumers a powerful incentive to demand that insurers and providers offer the most cost-effective bundles of health care products and services and contain health care costs. Empowered consumers would also drive hospitals, physicians, and pharmaceutical companies to offer better information on risk-adjusted quality outcomes. Policymakers facing cost-sensitive consumers would have a much greater incentive to consider the cost increasing effects of insurance mandates to determine if their benefits outweighed their aggregate costs.

In other words, if we begin by creating a more efficient market for health care goods and services, we can determine what consumers want and *are actually willing to pay for,* and induce providers and insurers to offer those services efficiently. At that point, we can determine what – if any – true "market failures" remain and act accordingly to provide additional regulations to improve the operation of those markets or consider targeted subsidies for consumers with very low incomes or very high cost health needs that aren't well served by the standard or most common insurance packages. If we make the market work well for 90% of the population, the task of assisting the remaining 10% will not only be easier, it will be less expensive.

The state regulation of health insurance is a particularly contentious political issue. State legislators often justify additional insurance mandates by pointing to isolated anecdotes where coverage of a

particular service or provider appears, at least after the fact, to be critical to the health and wellbeing of a particular policyholder. But legislation via anecdote is not a justification for adding additional costs to standard insurance packages, particularly when increasing the cost of standard insurance packages inevitably prices some consumers out of the market because they cannot afford to buy the "Cadillac" coverage that legislators (or the providers who argue for such coverage) believe they must pay for. As a joint 2004 Federal Trade Commission and Department of Justice report noted

> For mandates to improve the efficiency of the health insurance market, state and federal legislators must be able to identify services the insurance market is not currently covering for which consumers are willing to pay the marginal costs. This task is challenging under the best of circumstances – and benefits are not mandated under the best of circumstances. In practice, mandates are likely to limit consumer choice, eliminate product diversity, raise the cost of health insurance, and increase the number of uninsured Americans. [2]

Different consumers will have different preferences for insurance coverage and terms – as a 25 year-old male may opt for very different insurance than a 38 year-old married father of two. Telling the younger man that he must opt for the older man's coverage is likely to price him out of the market entirely.[3]

Congresswoman Blackburn's bill (the Health Care Choice Act) would help create a viable interstate insurance market that would begin the vital process of making the marginal costs of regulation and mandated insurance benefits transparent to uninsured individuals who are the most in need of more affordable insurance options. It may also spur innovation in insurance products as states compete to offer the best combination of cost and coverage terms. Finally, once the added costs of regulation were visible to consumers through regulatory competition, providers who wanted to maintain insurance coverage of their services would have to find ways to lower their costs or increase their value of their services to make them more attractive to the majority of insurance consumers. This exactly the type of competition that we should be encouraging in health care and insurance markets.

Many objections to the interstate sale of health insurance rest on a purported "race to the bottom" that would supposedly ensue if consumers could purchase products across state lines. It is unclear what, if any, justification there is for this assertion since products sold in a "secondary state" under H.R. 371 would also have to be sold within their "primary state". Policymakers and insurance regulators in the primary state would still have powerful incentives to ensure that such coverage sold to state residents was not deceptive, and of high quality. Also under H.R. 371, insurance departments in the "secondary state" could still collect premium taxes and high risk pool assessments from plans sold across state borders, ensuring the financing necessary to maintain their primary role of protecting consumers against fraud and supporting high risk pools for individuals with high cost pre-existing conditions.

---

[2] Executive Summary, "Improving Health Care: A Dose of Competition," p. 24. Available online at http://www.ftc.gov/reports/healthcare/healthcarerptexecsum.pdf.

[3] See also David A. Hyman, Health Insurance: Market Failure or Government Failure? Connecticut Insurance Law Journal, vol. 14:2008 (316).

This objection also ignores the fact that, although under the McCarron-Ferguson Act states have the primary responsibility for regulating insurance sold to state residents, employers that self-fund health insurance coverage under ERISA are not subject to state regulation. More Americans receive coverage that is exempt from state insurance regulation – about 90 million covered lives – than receive regulation that is subject to both state and federal regulation (about 70 million lives). Insurance regulation under ERISA has been generally light (except for regulations mandating minimum hospital maternity stays; mental health parity; and limits on pre-existing condition exclusions). Indeed, employers have nearly complete freedom under ERISA to design their own insurance coverage, and employees are overwhelmingly happy with the quality of employer-provided coverage. Since there has been no "race to the bottom" in the ERISA-protected employer market and one would expect similar outcomes from the evolution of a national market for health insurance.

A more legitimate concern may be that in very highly regulated states that mandate comprehensive insurance coverage in addition to community rating (like New York), healthy consumers will opt for less regulated but also less expensive policies, leaving the "secondary state" with a less healthy risk pool – and facing ever increasing premiums.

However, we should note that adverse selection is largely the result of regulatory policies (like community rating and guaranteed issue) that prevent insurers from offering younger or healthier consumers affordable policies – leading them to exit insurance markets. In New York, which has had community rating and guaranteed issue regulations in place since the early 1990s, the individual "direct pay" insurance market has almost completely collapsed.

As recently as 2001, more than 128,000 individuals were enrolled in HMOs in the direct-pay market. By 2010, enrollment had plummeted to just 31,000. Premiums have approximately tripled during the same period. *The New York Times* noted: "New York's insurance system has been a working laboratory for the core provision of the new federal health-care law—insurance even for those who are already sick and facing huge medical bills—and an expensive lesson in unplanned consequences. Premiums for individual and small-group policies have risen so high that state officials and patients' advocates say that New York's extensive insurance safety net ... is falling apart."[4]

As long as insurers can charge premiums that accurately reflect policyholders underlying risk, they should have no disincentive to offer plans that meet the needs of policyholders with less than pristine health. Rather than constraining the prices insurers can charge the vast majority of healthy consumers, legislators who are concerned about maintaining access for individuals with very costly pre-existing conditions should consider long-term federal funding for state high risk pools that helps make coverage affordable for such populations. (As noted earlier, under H.R. 371, states would still be able to collect premium taxes for state-funded high risk pools from plans sold across state lines.)

Policymakers should also not forget that rising health care costs are the single greatest barrier to accessing health insurance for uninsured individuals, regardless of health status, and that reducing unsustainable health care cost increases is the single most important thing we can do to ensure that

[4] Anemona Hartocollis, "New York Offers Costly Lessons on Insurance," *New York Times*, April 17, 2010.

coverage remains affordable. Mandating "Cadillac" coverage as the only option for individuals locked into state markets is the surest way to continue the vicious cycle of cost increases, dropped coverage, and large (and expensive) increases in public coverage programs like Medicaid.

Let me offer one final observation by way of conclusion. The U.S. economy is as dynamic and innovative as it is because firms are forced to compete across state lines for everything from cell phones to stock trades. The ensuing competition drives innovation and productivity through many American industries, to the enormous benefit of consumers. Health care is one of the very few sectors where competition and consumer choice is restrained, as federal and state regulations insulate inefficient providers from potentially more nimble competitors. Until we create a successful national market for health care – not only for health insurance, but at least starting there – health care will continue to exhibit the uneven quality and high costs associated with "protected" industries.

Thank you for the opportunity to comment on this important issue and I look forward to you questions.