

Oral Testimony
U.S. House of Representatives
Committee on Energy & Commerce
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Thank you Congressman Pitts and members of the committee for this opportunity to speak to you today.

My name is Steve Parente. I hold the Minnesota Insurance Industry Chair in Health Finance at the University of Minnesota. There, I serve as professor in the Finance Department at the Carlson School of Management and Director of the Medical Industry Leadership Institute, a growing MBA program. My areas of expertise are health insurance, health information technology and medical technology evaluation. I also have an appointment at the Johns Hopkins University School of Public Health.

Most recently, I and my colleagues Roger Feldman, Jean Abraham and Wendy Xu at Minnesota completed a study on the impact of allowing consumers to purchase insurance across state lines. This peer reviewed study was accepted for publication last winter and is forthcoming in the *Journal of Risk and Insurance*¹. I

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have provided a copy of the final pre-released publication with these remarks for your consideration.

In this study, we find evidence of a significant opportunity to reduce the number of uninsured under a proposal to allow the purchase of individual health insurance across state lines using three different policy scenarios.

The best scenario to reduce the uninsured, numerically, is competition among all 50 states where one or more states emerge as dominant players. This scenario would yield a reduction in the uninsured by 8.1 million people. This idea is not without precedent outside the health care industry, where Delaware has become the most favored state for incorporating a firm.

The most pragmatic scenario, with a good impact, is one state dominating each regional market. In this case, the uninsured would be reduced by 7.4 million. This is a compromise since the U.S. health insurance industry is only 'half-way' national (through national employers contracting with insurers that offer national provider panels) and this could provide a practical, more politically palatable approach.

Finally, the 'five large state' scenario is the least effective policy for increasing the number of insured people. This is likely due to the fact that only

one state of the five, Texas, had a combined regulatory burden that is less than the 50th percentile of all states. The estimated reduction from the 5 large state scenario is 4.4 million individuals.

It is important to note that these reductions in uninsured would be achieved without the premium subsidies or Medicaid expansion policies proposed in the Patient Protection and Affordable Care Act - ACA. In the paper, we did model the impact of combining interstate purchase of insurance with subsidies for private insurance and found additional reductions in the uninsured were possible – albeit at considerably greater federal cost.

The changes we found also took into consideration the different market prices between communities for medical care. For example, the costs of living for nurses in Manhattan are higher than those living in Missouri. These differences were factored out. As a result the impact is almost entirely due to differences in regulatory burden and mandates between the states. In one of the most telling illustrations we found premium quotes for the same family from the same insurance company for the same insurance benefit to be more twice as expensive in a New Jersey town, Lambertville compared to New Hope Pennsylvania. These two towns are separated by ¼ mile of Delaware River but whose citizens are likely to use many of the same medical providers.

It is understood that policy simulations simplify many political barriers. But the opportunity cost of not allowing interstate sales might motivate the development of legislated or contractual agreements to divide regulatory powers between primary and secondary states. Of course, adequate disclosure to consumers of the primary and secondary states' obligations will be paramount for this to work.

One possible outcome is that consumers who buy insurance in one state, but live in another, could have two insurance regulators looking out for them rather than just one. This would address a substantial concern that 'de-mandating' the market could leave consumers without adequate protection. At the same time, if the effect of mandates on premiums substantially reduces the probability that someone would buy insurance, one must ask: which is the worse outcome, lack of coverage for a given service or no coverage at all due to higher premiums?

Although we have modeled the person-level impact of a national market on coverage, we are unable to assess the impact of such a migration on provider access or quality of care. Nevertheless, a national market would lead to substantially more health insurance coverage, which should improve access to health care among the vulnerable populations who currently find health insurance unaffordable. In addition, development of a national market requires no additional

federal resources other than support for legislation to permit the development of such a change.

In closing, I hope these new finding will be considered by the Congressional Budget Office if and when this topic is considered formally as a legislation. CBO frequently uses peer-reviewed studies as the basis for policy impact. I hope this new study will be considered and that any opportunity with such potential to reduce the uninsured gets serious consideration amidst the fiscal constraints that can handicap so many of the other coming health reforms to be implemented under ACA in 2014.