

HEALTH REFORM FOR NORTH CAROLINA

Making Health Care Reform Work

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The health care reform laws enacted as the Patient Protection and Affordable Care Act (ACA) and the Health Care and Education Reconciliation Act of 2010 will have widespread and in some cases seismic impacts that will unfold and evolve over more than a decade. This new legislation will transform the health insurance industry, and its impact will be felt by citizens, state governments, and every organization involved in the health care delivery system.

Now that health care reform is law, it is in the interests of all health insurers and organizations and professionals that provide health care (hereafter, “providers”) to navigate through the changes and make sure the law works for all North Carolinians. It took decades for our current health care payment system to develop and evolve, and it will take some time to move in a new direction that addresses costs, improves quality, and benefits patients. But even with the changes brought on by the ACA, the system is not sustainable. Doing nothing is not an option.

This commentary discusses the factors leading to our current health insurance system, how the ACA might affect that system, the role of medical costs in driving up health insurance premiums, and the need for everyone in the health care system to work together in order to fulfill the letter and spirit of health care reform and overcome some of the challenges to achieving sustainable reform.

Blue Cross and Blue Shield of North Carolina (BCBSNC), a not-for-profit insurer, has worked for years to reform the health care system in North Carolina through initiatives that encourage improved quality and efficiency from providers. But the ACA requires substantial new insurance reforms in the future, and much more progress in improving our health care system must be made to support these reforms.

BCBSNC believes that, going forward, real reform can only be successful if there is collaboration among stakeholders from across the health care spectrum, including insurers, physicians, hospitals, pharmaceutical companies, employers, patients, and others. To that end, BCBSNC is already having conversations with leaders from around North Carolina to lower costs and ensure that health care reform works in our state. This collaboration is occurring in many forms. Some will be creative arrangements within BCBSNC’s provider network, but significant collaboration must occur across the wide range of stakeholders in the public and private sectors.

Factors Affecting Premiums

One critical requirement of health care reform—covering all applicants without regard to health or other risk factors—is familiar territory for BCBSNC, for most plans that are part of the Blue Cross Blue Shield system, and for other older nonprofit and not-for-profit health plans. Understanding where BCBSNC came from and how its rating practices evolved can help put certain aspects of health care reform in perspective.

Effects of rating and underwriting. BSBCNC got its start in 1933 selling prepaid hospital plans designed to help the lower and working classes. Later, publicly held, for-profit insurance companies began to sell health plans in North Carolina. These new entrants introduced underwriting and rating to health insurance, which had long been mainstays of other insurance types.

Practices such as charging lower premiums for people at low risk for need of health care services, refusing to cover people with the highest risk, excluding coverage for people with preexisting adverse health conditions, and segmenting the book of business on the basis of individual, small-group, and large-group markets were used to make coverage more affordable for *most* people. Of course, as insurance

became more affordable for most people, it became more costly or even unavailable for people who were not in good health.

Over time, not-for-profit companies, such as BCBSNC, and nonprofit companies found they had to adopt the practices of for-profit insurers, resulting in a movement from *prepaid* health products to health insurance. The primary motivation for the change was to compete for healthy customers, who were attracted to the low premiums that for-profit insurers could offer. But even higher-risk individuals benefited because practices that encourage healthy people to buy into the insurance pool lower the average claim cost and help contain premium growth for everyone. Insurers with more customers can negotiate more-favorable payment rates with health care providers and spread the cost of administrative expenses.

But no insurer gains when premiums increase because of spiraling health care costs. Nor do consumers gain. As health care costs rose over the years, especially over the past decade, the cost to people in poor health increased. When premiums rise, healthier individuals are more likely to leave the market, adding to the number of uninsured individuals and raising the average cost of coverage. This is known as a “rate spiral.”

Health care reform represents a new social policy. In enacting health care reform, the American people—through their federal legislative representatives—rejected the de facto social policy that current insurance practices embody, which is to keep rates as low as possible for the largest number of individuals and to accept the consequence that some individuals will pay higher premiums or be denied health insurance. Beginning in 2014, federal law will reduce the spread between premiums charged, and no one will be turned down for health insurance. BCBSNC and the insurance industry in general indicated early in the health reform debate that such a system could be workable if everyone was required to have insurance. An individual mandate would enlarge and diversify the risk pool, thereby spreading costs throughout the population. Although the income-based premium subsidies for some individuals and the tax credits for certain small employers will mask the effect for some groups, implementation of this new policy means that some insured people will pay a higher premium than before so that other people can pay less than before—which heightens the importance of a strong coverage requirement.

Premiums: what drives them, and how are they addressed by health care reform? Premium increases and benefit changes are more visible than medical cost increases, because people with insurance are shielded from seeing the rise in actual medical costs. Employers, families, and governments have struggled to keep up with rising premiums. Since 1999, average family premiums have increased by 131%, compared with a 38% increase in wages during the same period.¹ Premium growth, especially the size of premium increases at the individual level, will continue to receive a lot of attention because many people will judge the success of health care reform on the basis of the affordability of premiums.

Some people attempt to compare growth in premiums with the rate of medical inflation and conclude that any premium increase above medical inflation is evidence of a problem with insurance rates. However, this simple comparison does not take into account the complexity and number of premium drivers, many of which are summarized in Table 1. Of note, although several of these factors interact with each other, the interactions are not strictly additive.

The ACA contains provisions designed to address unreasonable increases in premiums in several ways. The secretary of the US Department of Health and Human Services is required to work with states to establish an annual review of unreasonable rate increases, to monitor premium increases, and to award grants to state insurance regulators to review their state’s rates.² In North Carolina and many other states, current law holds that premiums must be adequate, must not be excessive, must not be unfairly discriminatory, and must bear a reasonable relationship to the benefits covered. The North Carolina Department of Insurance must review and approve insurers’ individual rates before the rates can be used. Regulation of small-group and large-group plans varies for initial and renewal rates and by type of carrier. Rates and rate revisions for hospital and medical-service corporations (of which BCBSNC is one) are subject to the highest level of regulation.^{3,4}

The ACA also requires a definition of the phrase “unreasonable premium increase,” which may change the rate-review work performed by state insurance regulators. BCBSNC believes that strong, actuarially based regulation of premiums is critical to avoid unreasonable rate increases and to ensure that neither

Table 1.
Important Drivers of Health Insurance Premiums

Driver	Remarks
Price per service	Practitioners and health care organizations may set higher prices for health services and products.
Health services utilization	Emergence of new technologies and changes in treatment patterns are important factors.
Demographic characteristics of the insured pool	Age and sex are important factors.
Leveraging	Leveraging affects the relationship between member cost-sharing (ie, deductibles, coinsurance, and copayments) and total cost of a service. For example, if the average cost of a primary care office visit increases but the office visit copayment remains unchanged, the difference is accounted for by an increase in premiums.
Selection criteria for inclusion in the insured pool	Selection criteria affect the relative mix of healthy and unhealthy individuals within a pool.
Additional benefits	Adding benefits increases the premium. Benefit reductions are sometimes used to mitigate premium increases.
Regulatory requirements	Requirements may include benefit mandates and can affect other terms of coverage or insurer operations.
Baseline adjustments	Adjustments account for differences between estimated and actual experience for the past period by increasing or decreasing rates for the future period. They are made one time rather than on a continuing basis.

political considerations nor concern over public perception (apart from consumer fairness) lead to rates that are inadequate and jeopardize the financial solvency of an insurer.

BCBSNC also believes that ACA implementation will likely accelerate rather than suppress the rate of premium increases. The most significant impact will be on the selection and demographic characteristics of the insured pool, particularly in the individual and small-group markets. Several factors will likely contribute to accelerated premium increases. First, gender rating will be prohibited. Females of childbearing age will pay less in the future, but males in the same age range, who typically have lower utilization rates, will pay more. Males in later life will pay less in the future, but women at the same stage of life will pay more. Second, age rating will be limited to a ratio of three to one. As a result, the negative impact of age on rates will be less for older adults than it is today, but young adults who are typically healthy will receive a smaller discount than they do today. Third, rating based on health conditions will be prohibited. Individuals with health conditions will no longer be charged a higher rate, but people with no health conditions will not receive a discounted rate.

The bottom line is that younger, healthier people will be charged more for coverage, whereas older, less healthy people will be charged less. If young individuals react to these higher premiums by declining insurance (at least until they need it), then the average per-person cost of the insured pool will increase. The requirement that insurers sell coverage on a guaranteed issue basis, without waiting periods for coverage of preexisting medical conditions, will intensify the likelihood that rates for young, healthy people will increase. New taxes on insurers to help pay for reform, which goes into effect in 2014, will add to the premium pressures,^a as will new benefits required under law.

a. Under the ACA and the Health Care and Education Reconciliation Act of 2010, insurers will be assessed a tax that is based on their share of covered lives. Nationally, insurers will be assessed \$8 billion in 2014. The amount of the assessment will grow to \$14.3 billion by 2018 and will be indexed thereafter.

The ACA aims to counter these forces by requiring individuals to have coverage (subject to an annual financial penalty) and by offering income-based premium assistance. For many young adults, the annual penalty (calculated in 2014 as the greater of \$95 or 1% of household income and in 2016 as the greater of \$695 or 2.5% of household income) will be less than the cost of insurance, even for those whose premium is subsidized. Thus, the individual mandate under the ACA is not nearly strong enough to ensure that everyone buys and keeps coverage.

The ACA's new limits on cost-sharing, elimination of annual and lifetime benefit maximums, and new standards for "essential benefits" (ie, the services and conditions that must be covered, as well as the share of expected, fully covered medical costs paid by the plan) will drive premium increases through increased utilization, increased benefits, and an undercutting of the ability to leverage out-of-pocket costs against rising charges for care. All of these provisions can be viewed as more protective of people with insurance, but they will come at a cost.

As premiums rise, the cost of care goes largely unaddressed. National data show that the majority (\$0.87) of the health insurance premium dollar goes toward paying for covered medical care, with the balance split between profits (\$0.03) and administrative costs (\$0.10), including government taxes and fees.⁵ BCBSNC data from 2009 show that it spent nearly 87% of the average premium dollar on medical care.⁶ Although this medical loss ratio is not uniform across all market segments because of differences in cost structures (eg, administrative costs run higher for nongroup policies than they do for group policies), the mathematical truth is that increased medical care spending per insured individual is the main driver of premium increases.

Increased medical costs threaten access to affordable health insurance coverage and to medical care. Health reform legislation begins to make strides in improving our health system, but it does not control the rising cost of health care delivery. BCBSNC applauds the establishment of pilot and demonstration projects to improve quality, the creation of an independent payment advisory board (IPAB), and the funding of comparative effectiveness research, but the outcomes of these efforts are unknown, and we believe they do not go far enough to address rising costs.

The ACA includes provisions for the testing of new payment models, which have the potential to reduce costs. However, because many of these models will be implemented on a pilot basis, often without a clear path to expanded or permanent use, the Congressional Budget Office generally does not consider them to be money-saving efforts.⁷ Although future actions by Congress and the US Department of Health and Human Services based on findings from these pilot projects may reduce costs, such savings cannot be counted on.

An IPAB was set up to oversee health care system costs by establishing target growth rates for Medicare and ensuring that expenditures stay within these limits. The IPAB will also make general recommendations to Congress on how to control health care costs.⁸ The Congressional Budget Office concluded that the IPAB will reduce Medicare spending by \$28 billion during 2010-2019, with significant savings continuing beyond 2019.⁷ However, a report from the Centers for Medicare and Medicaid Services actuary questioned whether this goal was achievable and expressed concern that providers would have difficulty remaining profitable and might leave the Medicare network.⁹

The ACA also included \$3 billion for comparative effectiveness research and the creation of a new entity—the Patient-Centered Outcomes Research Institute—to oversee the program. BCBSNC supports comparative effectiveness research as a tool for improving health outcomes, which in general also promotes increased cost savings, and the quality of care. However, restrictions are placed on the use of published findings of comparative effectiveness research as the sole basis for denying coverage of items or services under Medicare.¹⁰ Therefore, the effect on future health care costs nationwide is uncertain.

The Massachusetts experiment: increased coverage, little cost control, and rising premiums. The experience in Massachusetts provides a cautionary tale against implementing health reform without controlling underlying medical costs. Massachusetts, which historically had a low percentage of uninsured people in the general population, has had the lowest percentage of uninsured individuals in the nation since the enactment of major health reform legislation in 2006. A survey conducted in Fall 2009 revealed that

95.2% of people aged 18 to 64 years were insured. This value was virtually unchanged from 2008 and represented an increase since 2006, when 87.5% reported having health insurance during a survey conducted before the state's health insurance mandate was implemented.¹¹

Despite the passage of health reform legislation, the state has struggled with rising health care costs. During 2006-2008, the average price of a family insurance premium in Massachusetts increased by more than 12%, and premiums increased by approximately 10% statewide.¹² In 2008, Massachusetts was among the top four states in terms of highest average employer-based family premiums.¹³ Overall health care spending rose by 23% during 2005-2007. The state's per capita average is approximately 33% higher than the national average, although some of the difference may be attributed to the high cost of living in the state.¹⁴ A 2010 report from the Massachusetts attorney general indicated that price increases, not increases in use, caused most of the accretion in health care costs during 2004-2008.¹⁵

Additionally, it has been reported that Massachusetts residents are buying coverage for short periods and incurring high medical bills while they are covered. One insurer, Harvard Pilgrim, discovered that, during a 12-month period, approximately 40% of people who bought an individual plan left after less than five months. While these individuals were covered, they incurred an average of \$2,400 in monthly medical bills, or six times the plan's projections.¹⁶ In 2009, Blue Cross and Blue Shield of Massachusetts (BCBSMA) had 936 people sign up for coverage for three months or less, and each individual had claims of more than \$1,000 per month while in the plan. This value is more than four times the average claim for BCBSMA consumers who buy coverage on their own and retain it. The typical monthly premium for these short-term members was \$400, but their average claim exceeded \$2,200 per month. BCBSMA reports that the problem was even worse in 2008 and resulted in millions of dollars of costs during 2008-2009.¹⁷

In response to concerns about the effects that short-term retainment of health insurance have on premiums, the Division of Insurance (DOI) in the Massachusetts Office of Consumer and Business Affairs contracted with Oliver Wyman Actuarial Consulting to study individual health coverage before and after the July 2007 merger of small-group and nongroup health insurance markets.¹⁸ The study had several notable findings. First, the number of individuals who purchased and retained insurance for only a short period increased. Between 2006 and 2008, the percentage of persons who purchased insurance and terminated the policy within 12 months increased by 75% (from 13.8% in 2006 to 24.2% in 2008), and the number who purchased insurance and terminated the policy within 6 months increased by 390%. Second, the number of individuals who had high-cost medical conditions, which drive up average claims costs, and terminated their coverage within six months increased by 249% (from 364 in 2006 to 1,272 in 2008). Third, the number of healthy individuals, whose departure from the insurance rolls is accompanied by removal of their premiums from the pool, increased by over 400% (from 3,145 in 2006 to 15,991 in 2008).

The study also found that the merger led to a greater than expected increase in premiums for small groups. Calculations performed before the merger projected that small-group rates would increase by 1.0% to 1.5% after the merger. However, calculations performed after the merger revealed that, after adjustment for higher premiums paid by individual subscribers because of factors such as group size and age, the per-carrier cost increased by 2.6% (range, -4.3% to 5.9% per carrier). Moreover, the study revealed that adverse selection added 0.5% to 1.5% to the cost of the merged market, prompting the consultant group to recommend that the state strengthen the mandate in order to reduce adverse selection.

The difficulties with high rates experienced by small employers in particular led Governor Deval Patrick to direct the state insurance commissioner to issue an emergency regulation in February 2010 requiring insurers to file proposed changes in small business premiums with the DOI. This regulation allows the commissioner to review and disapprove rates that are excessive or unreasonable in relation to the benefit provided.¹⁹ In April, the DOI rejected 235 of 272 rate increases submitted by insurers, primarily because of insufficient justification for reimbursing providers at the increased rates and because the increases exceeded the medical consumer price index.²⁰ Six insurers filed a lawsuit seeking to reinstate their proposed increases but were instructed to exhaust administrative appeals with the DOI. The first ruling on appeal issued by the agency overturned its earlier decision to freeze the rates of the appealing insurer, on the grounds that proof of valid reason for providing different reimbursement rates to different providers was given. The hearing officers also determined that medical inflation is an unacceptable barometer for

increases because it is a “backward-looking measure of past expenses and does not measure or forecast future costs.”²¹ The remaining appeals were pending at the time of writing, and decisions were expected in the late summer of 2010. Insurers are concerned with financial stability related to selling policies at a loss. Bills introduced by Senate President Therese Murray²² and by Governor Patrick²³ would both place a cap on increases in insurers’ base premiums and establish requirements regarding increases in payments to providers, although neither has passed the House of Representatives.

Massachusetts has also seen considerable support for annual global payments rather than fee-for-service payments to providers, which could result in such a change in the future.²⁴ However, plans to file legislation to change the system have recently stalled because of “the logistical and political complexity of changing a system that has been in place for decades,” according to Senator Murray.²⁵ If these challenges can be overcome, and if reimbursement methods are implemented that reward providers on the basis of improvements in quality and better health outcomes rather than in quantity of care, a significant step toward controlling costs would be taken.

Promoting Health, Controlling Costs, and Improving Quality in North Carolina

During the health care reform debate, BCBSNC advocated for building on the private health insurance system that is already in place. One reason for taking this position is that private insurers have been particularly active in promoting the health of their customers, health care quality, and cost-effectiveness. But it is clear that much more must be done to make health reform work.

No single segment of the state’s health care system—insurer, employer, physician, hospital, or pharmaceutical company—can stem rising costs alone. Instead, a cooperative effort that focuses on reducing medical costs offers the best opportunity to improve the system in North Carolina.

BCBSNC is eager to collaborate with providers to stem the tide of increasing medical costs. This is consistent with BCBSNC’s efforts to address costs. For example, BCBSNC already works with providers to develop methods of encouraging high-quality, efficient medical care, and in addition, BCBSNC works with business customers to design products that encourage value-based decisions. Over the years, BCBSNC also looked internally to slow the growth of its own administrative costs. BCBSNC recently announced plans to actually reduce administrative costs by 20% by the end of 2013.²⁶

As stated above, the current system, even with the new reforms, is not sustainable. BCBSNC believes that it is up to the company and the providers to work together to address rising medical expenses and give employers an affordable health insurance option, for BCBSNC also believes that employer-based coverage will always be more rewarding for its providers and customers than government-run coverage.

Provider incentives for quality can improve health. Paying for quality care is not a new concept. Three years ago, BCBSNC initiated the Bridges to Excellence pilot program, which provided financial rewards and recognition to physicians who met national standards for quality. During the pilot’s three-year run, BCBSNC paid more than \$4.2 million to over 190 primary care physicians. The results of the program were encouraging for patients of Bridges to Excellence physicians (BCBSNC, unpublished data).²⁷ First, patients of participating physicians spent less on health care than patients of other physicians. Second, they were 34% less likely to visit the emergency department and 24% less likely to see a specialist, compared with other patients. Third, among patients with diabetes, those receiving treatment by participating physicians were more likely than those treated by other physicians to have a good blood pressure reading (defined as 130/80 mm Hg or better).

In October 2009, BCBSNC built on the success of the Bridges to Excellence program by launching the Blue Quality Physician Program for primary care physicians, including family medicine physicians, internists, pediatricians, obstetricians, and gynecologists, who generally are not affiliated with large hospital systems or academic medical centers. Similar to the Bridges to Excellence effort, this program offers higher reimbursement levels to practitioners who meet standards for quality.

Provider payment is not the only avenue. Patient involvement in their health care is a necessary component of a comprehensive effort to improve health and address medical costs. In 2009, BCBSNC again offered its free generic medication program to reduce the out-of-pocket expenses for prescriptions and help its customers remain compliant with their prescription drug therapy. Customers who qualified had

no copayments for generic medications obtained from January through June, saving them more than \$15 million (BCBSNC, unpublished data). As a result, the number of prescriptions filled for generic drugs rose more than 6%, and patients were 3% more likely to fill their prescription and take their medicine.

Care-associated information technology is a key enabler of improved quality and a reformed health care delivery system. In 2006, BCBSNC was the first insurer in North Carolina to actively support and promote the use of electronic prescriptions. The program has grown rapidly in popularity, with over 2,000 physicians using the system and 87% of pharmacies accepting electronic prescriptions at present. Since 2006, more than 4 million electronic prescriptions have been written, each saving about \$250 per physician per month because of increased use of generic drugs and avoidance of unnecessary or inappropriate prescriptions (BCBSNC, unpublished data).

Ensuring good health and providing quality care are critical to the success of health care reform. Healthier people not only live longer, happier lives, but they spend less on health care. When BCBSNC delivers effective, innovative programs to improve its members' health, and when individuals take personal responsibility for a healthier lifestyle, BCBSNC can hold down premiums so more people can afford to purchase quality coverage. By paying physicians and hospitals for providing high-quality care, not just more care, we help ensure that every dollar spent goes to work improving health. All of these programs have been shown to work, but for health reform to be effective, much more needs to be done.

Conclusion

The passage of the health care reform bill signals a massive shift in how health coverage is delivered, bringing everyone into the risk pool and covering millions more Americans. Although BCBSNC holds that the current individual mandate to have insurance is not nearly strong enough, it is still a new paradigm far different from the current system, in which costs and risks can be shifted from one population to another. BCBSNC also believes that the ACA did not take sufficient steps to address medical costs, despite including provisions that will raise premiums. Although the current bill is not ideal, BCBSNC strongly supports it as a step in the right direction, even as the company recognizes that more revisions are likely as elements of the law are implemented. Failure is not an option. All stakeholders must redouble their efforts to hold down costs so we can be successful.

In a sense, BCBSNC is going back to its roots in covering everyone regardless of their health status. BCBSNC has always had an interest in good health, lower costs, and the best quality care. These objectives allow BCBSNC to offer better products at lower prices. Now, with passage of health care reform legislation, everyone shares this interest. The way forward to realizing the dream of accessible and affordable health care for all is for insurers, providers, citizens, and government officials to collaborate to promote health, control costs, and improve the quality of care. **NCMJ**

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