



**Center for Health Transformation**  
Better health, lower cost

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# **A 21st Century Intelligent Healthcare Solution to Creating a 300 Million Payer System**

Center for Health Transformation

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## Introduction

The A 21st Century Intelligent Healthcare Solution to health and healthcare transformation requires establishing a vision and a process for change that wins over the hearts and minds of Americans with a message that this is a problem that can be solved with American ingenuity and entrepreneurship in a uniquely American way. This is a values issue where lives and the health of citizens are in danger. Family security and financial stability are at risk. Americans must demand a change from a world that does not work to a world that does work. Today we have the worst of all worlds. We have a costly government healthcare system that locks citizens into restrictive limited choices, and a private market that is overburdened with state and federal laws and regulations.

Change must include things that are real, tangible, and results oriented for real people with real health, healthcare, and health insurance problems. Solutions must be based on American values of financial freedom, personal responsibility, individual ownership, and choice. There are two camps of thought for our future. We will either move to a Washington-based insurance system or we will develop expanded market-based insurance solutions. Unless the free-market is given more flexibility to meet this problem, citizens will undoubtedly turn to the federal and state governments to “solve the crisis.”

The language and ideas for healthcare has mainly resided on the side of those who want expansion of Washington-based programs. Hence, we have seen expanded government and a decline of private market insurance. Government payments for healthcare now exceed 50% of all healthcare expenditures. The concentration of money and power is moving to Washington D.C. and away from individuals. Proponents of market-based solutions must adopt the language and ideas of a 21st Century Intelligent Health System or the country will drift ever more toward Washington-based healthcare and increased centralized financial and political power.

Others have written tomes about the problems, the statistics, the challenges of changing our \$2+ trillion health and healthcare system. In developing a 21st Century Intelligent Healthcare Solution the obvious is simply accepted. The problems are big, intransigent, and loaded with special interests. No stakeholder has clean hands. All are doing their very best to deliver care and provide coverage. They are not the problem. The system is broken and they are operating (literally and figuratively) to optimize their missions in a near impossible environment. Create a common vision, change the rules (laws and regulations) and the existing stakeholders (or entrepreneurial competitors) will change the existing dysfunctional market.

Governments have experience at regulating and even de-regulating markets. It is a unique challenge to create an efficient market from a dysfunctional market. Changes will not be minor tweaks or simple reforms. The changes needed are

transformational following the mantra that – Real Change requires Real Change. Change is the field upon which Americans play best. Americans rise to big challenges. There is no other domestic issue as important or as impactful that directly touches each and every American as the need to address health, healthcare, and health insurance.

The great debate over health and healthcare in the United States has at its center the issue of a large numbers of uninsured lives under our current system. The goal of creating a 300 million payer system can drive the discovery and implementation of changes needed to establish real market-based solutions. One can argue that the published numbers of uninsureds is distorted for various reasons. The fact remains that too many citizens are without the family health insurance and the financial security they desire for reasons beyond their control. Many more Americans are only a pink slip away from losing their jobs and their health insurance.

More than 47 million Americans are without Medicare, Medicaid, SCHIP, Tri-care or private health insurance. Clearly, the market is not working for far too many citizens. The pressure is mounting and the country will either move to effective market-based solutions or we will see a continued expansion of government-based health insurance

## **Start with Building Trust**

Unstated in the debate over healthcare is the issue of trust. Public policy is most successful if it follows the hearts and minds of the American people. If one tends to distrust big government, because the perception of government programs is waste, fraud, lack of inventiveness, and faceless bureaucracies, then market-based solutions are more desirable. If one sees big business as greedy, non-responsive to the needs of the poor, controlled by insensitive over-paid executives, and rife with corporate corruption, then Washington-based solutions are more attractive.

21<sup>st</sup> Century Intelligent Healthcare Solutions are founded on the belief that open competitive information-rich markets will yield the lowest cost, highest quality, with the greatest access to providers, unlimited choices, portable ownership, and consumer-demanded convenience. Unfortunately, many Americans do not believe or accept that premise. A 21<sup>st</sup> Century Intelligent Healthcare Solution must paint a clearer vision of workable solutions and practical timely processes for implementation.

A 21<sup>st</sup> Century Intelligent Healthcare Solution recognizes the Internet-UPS-FedEx-Google-Ebay world developing around us. Products and services in every other area of society are moving in favor of personal responsibility, self reliance, ownership, transparency, portability, and empowerment of the individual.

With individualism expanding in so many areas, basic principles and values consistent with the American culture can create a market-based 300 million payer system where everyone has the family protection and security of health insurance.

## **Establishing Basic Principles**

A 21<sup>st</sup> Century Intelligent Healthcare Solution must be founded on basic American principles and values.

1. **Market-based** – The U.S. Congress and States should establish a supportive legal and regulatory environment that will allow a creative open competitive entrepreneurial market to develop the health insurance products and services that will meet the needs of every citizen. Significant legal and regulatory barriers exist that must be brought down to establish the framework for a real market-based solutions. Once a viable robust market-based system exists, government-based programs of Medicare, Medicaid, and SCHIP should allow individual choice for transitions to market-based alternatives.
2. **Increased Competition** – Competition in an open free market is the best solution to lower prices, better services, higher quality, greater convenience, and more choices. New legislation and regulation is critical to increasing competition among insurers, providers, agents, and other service providers.
3. **Personal Responsibility** –Personal responsibility means taking ownership for good and bad health and healthcare decisions. Personal responsibility can not effectively occur without support tools for increased self-reliance. Support programs include patient financial involvement with incentives for participation, rewards for compliance, and educational supports for better personal health management. Support tools include social and cyber-networks of like individuals sharing common experiences and solutions.
4. **Ownership** – Ownership means control of the key decisions affecting coverage, choice of treatments, and selection of providers. Ownership means possession of financial assets, choices of how to spend personal funds, and the right to information regarding one’s own health. Ownership of one’s own health record is a critical need in a 21<sup>st</sup> Century Intelligent Healthcare Solution.
5. **Portability** – Portability allows individuals to continue coverage regardless of employment status and/or job changes. Policies that do not rely on employer-based insurance should be encouraged and expanded. Health insurance should not be dependent upon a job or lost when one changes jobs.

6. **Transparency** – Market-based systems can only be effective with an abundance of information that is easily available and understood by consumers. With good information, people can achieve better health outcomes at lower costs. With reliable information, consumers will be better equipped to fully accept their role in the world of healthcare consumerism.
7. **Use of Technology** – Health, healthcare, and health insurance all need an infusion of technology to lower costs, improve efficiency and effectiveness of coverage, and appropriately identify and distribute information. Whether it is personal care devices, personal health records, electronic medical records, or e-prescribing the world of health is lacking in the rapid adoption of new technologies.

## Achievable Outcomes

By creating a 21<sup>st</sup> Century Intelligent Healthcare solution based upon the above principles, the outcomes will include the following:

1. **Transformation** – If followed, the principles established lead to more than minor tweaking of the current non-system. Simple reform of the current insurance system will not work. With a bolder vision, transformation will emerge - one that builds a 21<sup>st</sup> Century Intelligent Health System.
2. **Consumer Empowerment, Including Individual Rights and Responsibilities** – Empowerment comes from financial and information sharing. Market-based systems engage consumers in meaningful ways to understand options available to them and the risks and rewards associated with choices. The individual has both rights and responsibilities when it comes to their health and healthcare.
3. **Behavioral Change, Not Cost-shifting** – Behavioral change includes wellness, prevention, early intervention, and compliance with proven care and treatments. It means providers delivering evidence and outcomes based care. It's about plans encouraging personal involvement in altering health and healthcare purchasing behaviors.
4. **Affordability** - Affordability in a 21<sup>st</sup> Century Intelligent Health System is no longer about the dollars one pays from a wallet. Affordability is also achieved through health choices and behavior changes. We are generally used to individuals paying less if they are non-smokers (or quit smoking). Similarly, a 21<sup>st</sup> Century Intelligent Healthcare solution makes insurance more affordable for individuals if they maintain healthy metrics for blood pressure, cholesterol, and body mass index. Affordability can also be achieved by rewarding Americans with serious health conditions for

adherence to disease management standards or compliance with good lifestyle diet and exercise standards that stabilize a chronic and persistent condition.

5. **Maximize Insurance, Minimize Third-party Reimbursements** – Third-party reimbursements foster an environment of entitlement and unlimited demand for healthcare services. A 21<sup>st</sup> Century Intelligent Healthcare solution minimizes third-party reimbursements by putting financial power in the hands of consumers. A 300 million payer system is based upon everyone having insurance coverage, regardless of their current or future health status. A 21<sup>st</sup> Century Intelligent Healthcare solution supports insurance designs that change the economics and mindset towards rewards and incentives to stay healthy by changing health and healthcare purchasing behaviors.
6. **Increase Choices** –Choice means personal decision options for insurance coverage, care, treatment, providers, participation, lifestyle options, wellness activities, disease/condition support programs, service conveniences, and education sources.
7. **Security for the Sickest** – No one can be left behind. Health insurance is about financial security when sickness or accidents strike. A 21<sup>st</sup> Century Intelligent Healthcare solution must help the sickest patients get the best care, treatment, and understanding of their condition through financial and information empowerment. Any system that works only for the young, healthy, and wealthy is a solution destined for failure.
8. **Eliminate Diversity of Outcomes** – Whether it is social, racial, geographical or other categories, the diversity of outcomes can only be addressed once the segmentation of the existing insurance system is eliminated and all Americans are covered in the same system, treated by providers who practice best standards of care, and empowered with the same information and decision support tools.
9. **A Culture of Health** – A culture of health focuses on wellness and prevention rather than on disease and treatments. Health activities should measure and reward participation in wellness assessments, compliance with a condition management programs (e.g. taking medications, diet, exercise, office visits), and maintenance of good health characteristics (e.g. blood pressure, cholesterol, nicotine use, body mass index)
10. **“Wholistic Care” (Physical, Mental, Spiritual, and Social)** – Health should be viewed as a dynamic state of well-being within an individual that includes physical, mental, social, and spiritual balance. A focus on *health* recognizes the potential to improve the status of an individual in need regardless of the diagnosis or condition.

## Transformational Mega Trends

The mega-trends of individualism, personal choice, and sharing of information is underway in other parts of society. So, how does one start to change the \$2 trillion dollar healthcare segment of our national economy? The answer is simpler than one might expect, because the transformation of healthcare is already underway. We are about four years into a major shift in healthcare that, strangely enough, may be hard to recognize. But who knew when the Renaissance started or when the Soviet Union began to fall? Sometimes, major transformations occurring before our very eyes are discernable only in an historical perspective.

The old system of managed care is based on the assumption that demand for healthcare is unlimited. Therefore, the only way to control costs is to limit the supply of care. Services are deemed not medically necessary, not appropriate, not covered, excluded, limited, and patients are told they are not sick enough, must wait for treatments, and choices are limited by formularies. This can be referred to as a “Supply Control” insurance system. The 21<sup>st</sup> Century Intelligent Healthcare solution is based upon controlling demand for services by engaging participants in healthy behaviors and providing rewards and incentives for cost effective purchasing of healthcare services. This transformed world takes the very issue – demand – and instead of assuming it is unlimited, the approach is built on the ability to limit demand by changing behaviors. This can be referred to as a “Demand Control” insurance system.

It should be of no surprise that those with a traditional mindset will resist the movement to a demand control system and immediately respond with a “No, because...” attitude. Emerging facts are challenging that mindset. The promise of a demand control system is becoming evident with each new study released of actual experiences using healthcare consumerism. In the true spirit of American ingenuity, new approaches are being tried, new technologies are being implemented, and studies are being conducted of behavior, financial rewards, and information links. Lower cost and significant health trend reductions are developing that clearly separate these new product ideas from traditional insurance.

To be broadly successful, a demand control insurance system must be more than a change in plan design and financing of care. A demand control system must start with the recognition of personal responsibilities and new roles for each stakeholder. Health insurance must be viewed in a larger context of health, prevention, early intervention, and information. Health insurance must become an “accumulating asset” rather than a short term benefit package.

While mega-trends by definition will ultimately change markets and society, systems involve laws and regulations. Markets serve clients and products are developed within the laws and regulations set by governments. The governing rules, laws, and regulations of health insurance are unlike any other market-

based business in the United States. Without new public policies that encourage the development of 21<sup>st</sup> Century Intelligent Health System, the market will fail to deliver the benefits seen in other parts of our lives – better services at lower cost with higher quality, greater access and greater convenience. Healthcare is not like buying widgets, but a free open competitive market can deliver unimagined services and product improvements to every American.

## Creating a Multi-Stakeholder Collaboration

A 21<sup>st</sup> Century Intelligent Healthcare solution must be an inclusive strategy that establishes a “Healthcare Compact” with each of the stakeholders. It is important to meet their needs and implement market-based changes that allow them to function in a new and more effective manner. It will not be easy. Many are benefiting from the status quo. Others are fearful of change. However, the mantra must be “Real Change Requires Real Change.”

### **The Healthcare Compact Promise:**

**Individuals** – better health at lower cost

**Hospitals** – relief from uncompensated care

**Doctors** – health justice transformation and more involved patients

**Insurers** – larger and more stable marketplace for 21<sup>st</sup> century products

**Employers** – affordable health insurance and a healthier workforce

**Consumers** – increase choice, improve quality, lower costs

**Agents/Brokers** – competitive saleable market-based products

**Uninsured** – coverage and access to better health

Leadership is essential to creating a vision within which various stakeholders can come together to work toward a shared better future, even if they may not agree on every single project or action. President John F. Kennedy challenged America to “...take a man to the moon and return him safely.” The challenge sparked a change in science, mathematics, computers, medicine, and technologies that changed our then existing educational and economic systems. President Ronald Reagan challenged the Soviet Union and the world with, “Mr. Gorbachev, tear down this wall.” That challenge changed our military, defense, international relationships, and political systems.

The great leadership challenge for health coverage can be stated as follows:

*“Affordable Health Coverage for Every American by 2012 within  
A 21<sup>st</sup> Century Personalized Intelligent Health System.”*

We can achieve 100% coverage through market-based solutions, private/corporate efforts, tax incentives, direct public subsidies, strong community support, and faith-based outreach programs. Personal responsibility, individual ownership, portability, and healthcare consumerism are the hallmarks of such a system.

In a 21<sup>st</sup> Century Intelligent Health System, the individual has: accurate, timely knowledge of health needs; access to the best information about how to maintain personal health; knowledge of whom to see and where to go for health services, and confidence that health providers are practicing medicine using the best practices based on the most up-to-date understanding of outcomes-based medicine.

## **Transformation as a Movement Rather than a Single Leap**

Transforming into a 21<sup>st</sup> Century Intelligent Health System with 100% coverage will not happen in a single leap but instead through a constant migration from the current system to a new one.

It is a process that will be ongoing and will take 10-15 years or more. Welfare reform started in 1980 and wasn't completed in federal legislation until 1997. Public attitudes, political will, and legislative changes take time. Transformations are typically controversial and touch many existing entrenched interest groups who have managed to develop market share in the dysfunctional system. Often people prefer the “devil they know” to the uncertainty of change and increased competition.

One of the most important things to remember is that it's critical that there is a vision in place and each change is moving in the direction of that vision.

To create a 21<sup>st</sup> Century Intelligent Health System we must focus on strategic but incremental federal and state policy changes to increase competition, remove unnecessary legal barriers, and make insurance more affordable. An “upstream” analysis of where problems start will lead us to identify overburdening federal and state laws that create financial and legal barriers for new entrants and competition, limitations on product and service offerings, and restrictive bureaucratic rules that prevent rapid response to consumer needs. Removing government barriers to free-market solutions is a good start to a long process of transformation.

A focus on making insurance affordable and available to 300 million Americans can start with legal reforms allowing better products and services for those Americans that are currently insured in the private market. In addition, it can help those who are marginally uninsured and willing to purchase new products that better meet their needs.

The removal of barriers and legal restrictions allows markets to expand and citizens' needs to be served with new products and services. New market opportunities will evolve as product and price efficiencies are made available to Americans previously excluded or priced out of coverage. This has been the process used in the expansion of Health Savings Account (HSA) eligible High Deductible Health Plans (HDHPs) and the growth of Health Reimbursement Arrangements.

Federal and state laws and regulations changed in 2002 and 2004. New more affordable products were made legal that were previously not allowed. Employer groups providing insurance began to offer these lower priced options allowing more employees to be covered. As a result, the benefit has been to some Americans who were previously uninsured. Insurers now have health insurance products that are more responsive to the needs of more Americans. With 30+ percent lower premiums and tax advantaged accounts that accumulate over time, 35-40% of HSA eligible plans are sold to Americans who were previously uninsured.

This approach takes time and continuous refinement and changes in federal and state laws. Legislative changes designed to create transformation require dedication and diligence over many years. The HSA concept was started in 1997 with the passage of experimental Medical Savings Accounts (MSAs) that required legislative updating in 2004 to better meet the needs of Americans looking for affordable health insurance.

It is important to continue the transformation process by identifying legislative changes to open new markets and provide improved 21<sup>st</sup> Century Intelligent Healthcare solutions. It is an iterative process of change, monitoring, adjusting, and more change.

Ideas that have surfaced to move to the next generation of 21<sup>st</sup> Century Intelligent Healthcare solutions are listed below:

## **21st Century Healthcare Solutions – State Transformation**

Health and healthcare are enormous businesses affecting communities, jobs, and individual lives. Program and legislative ideas need to be multi-faceted to address the many dimensions of healthcare. A 21<sup>st</sup> Century Intelligent Healthcare Solution is a market-based approach that needs supportive State legislation to flourish. Passing programs to enable new markets is a difficult and

complex process. A state legislature can only do so much, but IT CAN DO A LOT.

Below is a list of potential legislative and administrative changes for “Creating an HSA State.” Building on the successes of HSA eligible plans is a good start to creating a 21<sup>st</sup> Century Intelligent Health System. An HSA eligible plan is the legalized plan design that most closely satisfies the basic principles set forth for a 21<sup>st</sup> Century Intelligent Healthcare Solution. It would be appropriate to apply many of the changes suggested below to all health insurance. It may be easiest -- and highly effective -- to implement changes first to HSA eligible plans.

Each state starts with a different history, culture, and level of political support for change. The list of programs is intended to spur the debate, spark creative ideas, and further the discussion on transforming health and healthcare to meet the uniqueness of each state. The public debate, legislative process, and creative thinking on these topics will bring forth a program of transformation appropriate for a state-specific 21<sup>st</sup> Century Intelligent Healthcare solution.

The following legislative actions are common to many states.

### **Tax Policy**

1. Eliminate state and other municipal premium taxes on HSA-eligible high-deductible health plans.
2. Equalize the state income tax deductibility of premiums for individually purchased HSA-eligible HDHPs.
3. Incentivize newly formed small retail, service, and restaurant businesses to initiate HSA/HDHP coverage for employees by providing a lower graduated sales tax submittal rate of their first four business years (e.g. 25%, 50%, 75%, and 100%).
4. Provide tax credits to small employers offering HSA-eligible HDHPs.
5. Provide tax incentives to accelerate the use of electronic medical records (EMRS) and other electronic (non-paper) systems through investment tax-credits or other similarly-situated tax incentives. Hospitals, physicians, and pharmacies could be incentivized to invest in health information technology.

### **Insurance Reform**

1. Allow HSA/HDHP approval reciprocity across state lines.
2. Expand the number of health insurers offering HSA-eligible HDHPs by removing financial and bureaucratic barriers to new market entrants.

3. Remove state legal and regulatory conflicts to offering flexible HSA-eligible HDHPs.
4. Remove legal and regulatory restrictions on providing incentives and rewards for compliance with health management and disease management programs.
5. Allow list billings through employers for individual policies.
6. Allow state approval of limited use Health Reimbursement Arrangement Only plans so pre-tax employer contributions can be used to purchase HSA eligible HDHPs.

### **Transparency (Right to Know)**

1. Support the development of a “Health Travelocity” model for insurance products that would allow consumers to compare services provided by selling agents, covered benefits, and premium costs of products.
2. Require hospitals receiving state funds to release information on risk-adjusted death rates and complication rates, with a guarantee that use of the data will include a fair risk adjustment.
3. Support the “right-to-know” initiative, requiring providers to disclose cost and quality information on all discharges as a condition of participation in the Medicaid or other state-sponsored programs.
4. Provide quality comparisons of hospitals with simplified consumer-friendly analysis capabilities.

### **High-risk Pool**

1. Establish an HSA/HDHP “high-risk” insurance pool that requires participation in disease management programs and provides varying benefits based upon compliance with care and health outcomes.

### **Low-income Uninsured**

1. Support charity-subsidized HSAs for the low-income uninsured.
2. Provide “health scholarships” for the low-income uninsured using subsidized HSA/HDHPs.

Details and further project descriptions for these ideas can be found in Appendix A.

## **21st Century Intelligent Healthcare Solutions – Federal Transformation**

The McCarran Ferguson Act of 1945 permits states to regulate the business of insurance. As such, many ideas for a 21<sup>st</sup> Century Intelligent Healthcare solution focus on changing state laws and regulations. There are key areas that only federal laws and regulations can address. Recent federal actions to encourage market-based solutions have focused on HSA eligible plans. The following list of federal reforms would increase the value of HSA eligible plans for Americans seeking these products.

1. Remove income and employment taxes on HSA eligible HDHP insurance premiums
2. Allow the use of HSA funds for the payment of health insurance premiums.
3. Allow HSAs to be attached to any health insurance plan.
4. Allow annual HSA contributions to be the maximum out-of-pocket expense under HDHP guidelines.
5. Allow HSA eligible policies approved under the laws and regulations of any state to be sold in other states.
6. Allow prescription drug benefits to be offered with co-pays.
7. Allow employers to voluntarily designate employer funded HSAs to be used only for healthcare while employed.
8. Provide tax incentives to accelerate the use of electronic medical records (EMRs) and other electronic (non-paper) systems through investment tax-credits or other similarly-situated tax incentives. Hospitals, physicians, and pharmacies could be incentivized to invest in health information technology.

## **The Uninsured Challenge**

The need for action is clear. Nationally 16% of Americans, totaling over 47 million, have no health insurance coverage. Uninsured adults have a 25% greater rate of dying than adults with insurance. Uninsured trauma victims are less likely to be admitted to the hospital or receive the full range of needed services. They are 37% more likely to die of their injuries. The Institute of

Medicine states that there are 18,000 excess deaths each year because people do not get the care they would if they were insured. A Health Affairs report projected that by 2013 the number of uninsureds will rise from the current 47 million to over 56 million lives.

The uninsured are a symptom of a dysfunctional system. Underlying systemic changes are clearly needed. But, directly taking up the enormous task and challenge of the uninsured will demand that the system change. Such a challenge will give the country hope for a better tomorrow and pressure federal and state policymakers to focus on changes in laws and reforms to encourage market innovations.

The uninsured do not have a single profile. Legislative action and targeted programs should be developed by considering four major categories:

Category	Percentage	Number of Uninsureds
1. Uninsured Not Needing Financial Assistance	40%	18,400,000
2. Uninsured Needing Financial Assistance	30%	13,800,000
3. Uninsured Eligible for Existing Government Programs	18%	8,280,000
4. Uninsurable	12%	5,520,000
Totals	100%	46,000,000

A 21<sup>st</sup> Century Intelligent Healthcare solution needs an aggressive outreach to the many low income families who qualify for government subsidized programs who have not enrolled. In addition, it needs a robust competitive private market that offers better products, with more choices, lower costs, and improved access to quality care. State and federal laws and regulations need an overhaul to release the power of the free-market to improve both government and private market insurance.

Current federal and state funds used to cover the uninsureds should provide direct subsidies to low income uninsureds. Disproportionate share costs, uncompensated care payments, tax credits, SCHIP, and other government subsidies should be used for insuring many of the currently uninsured. By using existing federal and state funds to “privatize” this segment of the population, the approach will create a market for all Americans.

An outline for a 21<sup>st</sup> Century Intelligent Healthcare solution to solve the uninsured problem is as follows:

**Vision** – Create market-based solutions that insure all American with care provided in a 21<sup>st</sup> Century Intelligent Health System.

**Mission** – Pass laws in the U.S. Congress and State legislatures that support and invest in the transformation to competitive open free market-

based health insurance with care provided in a 21<sup>st</sup> Century Intelligent Health System.

**Goal** – 100% insurance coverage by 2012 using private/corporate efforts, tax incentives, direct public subsidies, strong community support, and faith-based outreach programs.

## 1. Uninsured Needing Some Financial Assistance

Medicaid is the government insurance program providing coverage for the poor. Medicaid is a federal-state financed coverage with varying eligibility and coverage standards by state. The uninsured needing financial assistance are the working poor. Generally, they are families making in excess of 200% of the poverty level. This population is estimated to be approximately 30% of the uninsured or about 14 million Americans.

A federal program to infuse the insurance market with billions of new funds for purchasing health insurance will generate a commensurate amount of venture capital to meet the interests of purchasers. New companies, more competition, product choices, expanded services will result from the growth and interest in selling government subsidized private market health insurance policies to low income customers. A 21<sup>st</sup> Century Intelligent Healthcare solution would require that the products and offerings be consistent with the principles of a 21<sup>st</sup> Century Intelligent Health System. The low income uninsured, ignored by the current system, would become the new customers of an expanded market.

A good beginning is to allow “health scholarships” or subsidies for HSA eligible plans. In 2005, President Bush proposed an initiative to use HSAs as a vehicle to dramatically reduce the then 45 million uninsured. With roughly one-third of the proposed scholarships to HSA accounts and two-thirds to insurance premiums, insurers and banks would expand their interests in reaching the working poor with new products and services.

With an invigorated market for HSAs, affordable products, coverage choices, and responsive services would be created and available for all Americans (previously insured or uninsured)

The following are key elements of a 21<sup>st</sup> Century Intelligent Healthcare solution that would affect affordability, access to, and the expansion of market-based private portable health insurance.

**1. HSA subsidy for non-Medicaid eligible Low-Income Families.** Extend the benefits of HSAs to the working poor. Provide low income families a \$1,000 contribution made directly to their HSA. Subsidies grade down for families with \$25,000 annual income to those with \$60,000. Families can use the money to pay for doctor visits, medicines, and other routine medical expenses. What the family does not spend in a year can be saved and carried

over into the next year, earning interest tax-free. Each year that the family remains eligible, the government will deposit another \$1,000 into their HSA. The family owns the HSA and keeps it even when a family member changes jobs.

**2. HDHP Premium Tax Credit for non-Medicaid eligible Low-Income Families.** In addition to the \$1,000 contribution to an HSA, a family of four would also be able to get a \$2,000 refundable tax credit to help them buy an HSA eligible HDHP insurance policy that covers them for major medical expenses. Tax credits grade down for families with \$25,000 annual income to those with \$60,000.

**3. HSA subsidy for non-Medicaid eligible Low-Income Individuals.** Extend the benefits of HSAs to the working poor low-income individuals. Provide low income individuals a \$300 contribution made directly to their HSA. Subsidies grade down for individuals with \$15,000 annual income to those with \$30,000. Individuals can use the money to pay for doctor visits, medicines, and other routine medical expenses. What the individual does not spend in a year can be saved and carried over into the next year, earning interest tax-free. Each year that the individual remains eligible, the government will deposit another \$1,000 into their HSA. The individual owns the HSA and keeps it keeps it even when the individual changes jobs.

**4. Premium Tax Credit for non-Medicaid eligible Low-Income Individuals.** In addition to the \$300 contribution to their HSA, the same low-income individual will be able to get a \$700 refundable tax credit to help them buy an HSA eligible HDHP insurance policy that covers them for major medical expenses. Tax credits grade down for individuals with \$15,000 annual income to those with \$30,000.

**5. Low-income families will not have to wait until tax time to get their tax credits.** The low income health care credits will be advance-able and available immediately to qualifying families.

Each of these premium support initiatives has enormous implications for lowering the number of uninsured. While current HSA eligible plans offer the best match with the principles outlined, it is critical that the state and federal legislative and regulatory changes be made concurrent with subsidy programs. It makes little to no sense to subsidize current policies burdened with excess state taxes, uneven income and employment tax treatments, archaic restrictions on the use of incentives and rewards, and excessive state regulations that limit choice of plans.

Certainly, there can be no rational discussion of mandated coverage or alternative bonding for potential health costs until the market is freed from the shackles of state and federal restrictions and allowed to deliver cost effective health insurance that meet the needs of individuals in a 21<sup>st</sup> Century Intelligent Health System with 21<sup>st</sup> Century Intelligent Health Plans.

## 2. Uninsured Not Needing Financial Assistance

More than 18 million Americans can afford insurance but choose not to buy it. One might say they have the right to not buy insurance. However, when they are injured or stricken with a disease, we all pay for their care.

This group of Americans is sending many messages. Some are young and healthy and do not see a reason to buy health insurance. But, many are sending a message that the products available in the market do not meet their needs. They do not see value in buying expensive products that do not reflect their concerns.

There are many ways that the principles of a 21<sup>st</sup> Century Intelligent Healthcare solution can make insurance more affordable and a better buy. States add unnecessary premium taxes to the cost of fully insured individual and small group health insurance. Typically, premium taxes add from 2-3% to the cost of insurance. In some areas premium taxes can add as much as 7%.

There are many ways that Federal and State policy changes can begin to eliminate the pricing, development, and marketing burdens placed on the private purchase of insurance. For example, States can:

1. Eliminate state and other municipal premium taxes on health plans.
2. Equalize the state income tax deductibility of premiums for individually purchased policies.
3. Incent newly formed small retail, service, and restaurant businesses to initiate insurance coverage for employees by providing a lower graduated sales tax submittal rate of their first four business years (e.g. 25%, 50%, 75%, and 100%).
4. Provide tax credits to small employers offering insurance coverage.
5. Change antiquated rebate laws to all rewards and incentives for healthy choices.
6. Allow fast track approval of policies approved under the laws and regulations of another state.

(See Appendix A for more details and ideas for making healthcare more affordable and available).

Second and third generation plan and product designs are evolving. For example, In Florida Humana has an individual HSA policy that provides reward points for healthy behaviors. These points can be exchanged, like frequent flyer points, into premium reductions. In Rhode Island, Pennsylvania, Ohio, and Colorado United Health Group has a product that offsets up to \$2000 of a high

deductible for plan members who maintain acceptable levels of blood pressure, body mass index, cholesterol, and nicotine use. People who do not meet these standards are encouraged to use the plan benefits to improve their health and then qualify for the rewards. Under these plans individuals get the low cost of a high deductible insurance plan with the greater coverage provided by a lower deductible.

New developments and products are being introduced to make plans more affordable. One of the major changes includes rewards and incentives that either lower premiums, lower the high deductible or add to a Health Savings Account. 25-35% of HSA policies sold today are to people who were previously uninsured. These products are 30-40% lower in cost than traditional insurance products. As in the products described above, they may be lower in cost, but with incentives and rewards – they are not necessarily lower in coverage.

In some states, behavior incentives and rewards are considered “rebates” or inducements to buy insurance. As such they are illegal and not allowed to be sold. State laws need to reflect modern product designs that are working in other states to lower costs and reach the needs of uninsureds.

Approaches that combine personal responsibility with patient financial involvement to incent program participation and reward compliance can help reinforce behavioral changes and better personal health management. The possibilities are many and depend on what type of behavior a plan is trying to encourage. Incentives that reinforce a culture of health, well-being, self help, and shared responsibility have been shown to have a significant effect on cost and health outcomes. Humana studies indicate that for every 1 point drop in body mass index, there is a 7% drop in healthcare costs.

### **3. Uninsured Eligible for Existing Government Programs**

We have costly government health insurance that locks citizens into restrictive limited choices. These programs need the infusion of market-based products and services. However, until effective market-based changes occur, we need an aggressive outreach to the many low income families who qualify for government subsidized programs who have not enrolled.

An aggressive outreach and education campaign is needed to assure that 8,280,000 Americans who qualify for Medicaid and the State Children’s Health Insurance Program (SCHIP) are signed up. Legislators should not wear blinders that narrow their vision and ignore the needs of this population of uninsureds. The suggested strategy of maintaining existing Medicaid and SCHIP is a temporary bow to the realities of an ingrained social welfare system that can and should be changed once broader market improvements are in place.

As an interim step, 21<sup>st</sup> Century Intelligent Healthcare solutions would suggest reauthorizing SCHIP with the following requirements:

1. The primary focus of SCHIP should be to cover children in families with incomes at or below 200 percent of poverty. States that wish to expand coverage to children in higher-income families are free to do so with their own state funds.
2. The program's subsidies should be re-structured to encourage the purchase of private health insurance. SCHIP subsidies could be used to allow parents to purchase the health coverage that they believe is best for their children, including adding them to policies that may be offered at their workplaces.
3. The federal-state matching ratio for SCHIP funding should be changed to eliminate the distortions that exist in today's system. States receive a higher federal matching rate for covering SCHIP recipients (which today include many adults) than they receive for covering children eligible for Medicaid, even though these Medicaid children are in families with lower incomes.
4. Congress should focus on fixing the perverse incentives that reward states at a higher level for enrolling higher-income SCHIP children over poorer Medicaid children. The current funding formulas also mean more federal SCHIP dollars will go to wealthier states that can afford to expand the program than to poorer states that do not have sufficient state funds to expand their programs.

This interim solution is not intended to minimize potential improvement in the health and lives of these participants. Much like welfare reform of the 1990's, families can be freed from unresponsive government dependency on health insurance.

There seems to be an unstated position by some politicians that those who don't sign up keep our federal and state costs down by minimizing enrollments. The reality is that these costs are picked up through uncompensated care and cost shifting to the private market. Government created problems of cost shifting makes the private market costs increase unnecessarily thus creating a perverted demand for more government solutions.

The federal government and state legislatures should consider supporting outreach through faith-based organizations, community charities, and other private social support organizations. Prior to 2012, a 21<sup>st</sup> Century Intelligent Healthcare solution would be to allow individuals to voluntarily buy into private market coverage with risk adjusted premium equivalent subsidies.

Ultimately, by 2015 all Americans would be covered under the same private market insurance system. Diversity of care and outcomes can never be adequately addressed if segments of the population are forced into coverage with a limited number of quality providers of care because government mandated reimbursements are too low. By 2015 all government programs would be

converted to private market insurance through “insurance scholarships”, health insurance “Pell Grants”, or other advanced tax credit voucher programs.

#### **4. The Uninsurables**

This is typically the most expensive category of uninsureds. States vary in their creation and funding of high risk pools. Some states have argued for years on how to fund high-risk pools. The historical annual funding debate has been a roadblock over taxing self-insured plans and/or hospitals through an assessment, fee or increased tax. The discussion has rarely gotten into describing how and what to cover. A 21<sup>st</sup> Century Intelligent Healthcare solution would generate a discussion of cost-effective designs and a debate on the responsibility of patients with chronic and persistent diagnoses to be compliant with treatments and alter lifestyles to stabilize their condition in order to minimize expensive hospitalizations.

There are new designs and approaches to establishing state high-risk pools. One concept involves redirecting hospital subsidies for uncompensated care to the uninsured. New approaches can encourage personal responsibility and compliance with evidence-based medicine. New ideas incorporate market-based structures in a creative combination of high-risk pools and an assignment process to encourage insurers to accept more lives through their underwriting process.

A new approach is to establish HSA eligible HDHPs as the basis for providing health insurance to individuals who are uninsurable (can not meet current insurer underwriting standards). “Truly uninsurables” represent about 12% of the uninsured population or about 6 million lives (3% of the entire population).

A study by AHIP showed a significant number of applications for individual health insurance never make it to the medical underwriting process. Overall, approximately 15 percent of total applications received are either not processed or denied for non-medical reasons; the remaining 85 percent go through the medical underwriting process and result in an “offer of coverage.”

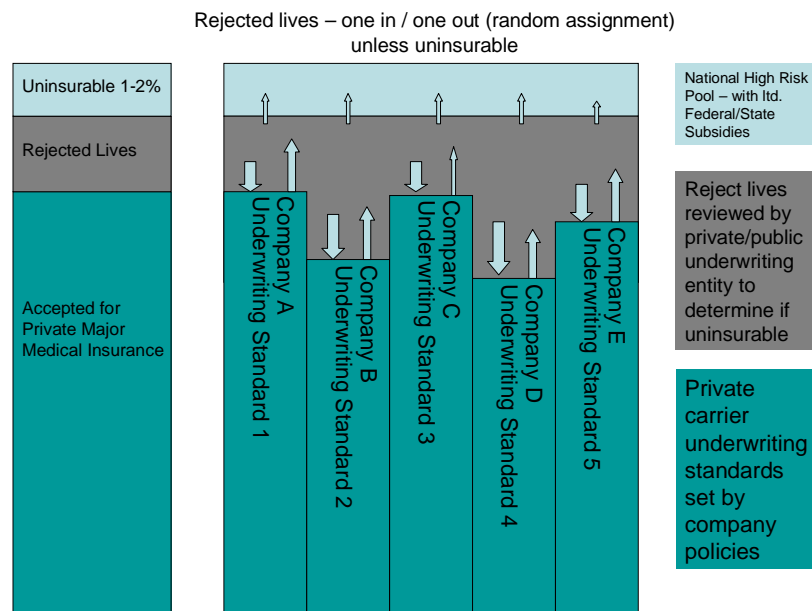
87.6 percent of those processed through medical underwriting are offered coverage. Rates vary by age, ranging from 95 percent for people under age 18 to 70 percent for people aged 60-64. Only 2-3% are truly uninsurable, yet more than 12% are rejected for coverage.

Uninsurable individuals do not come from any particular sector of society. Mostly, they are hard working individuals and families seeking to provide for and pay for their own health insurance, but for many through no fault of their own find themselves in a situation where they cannot obtain coverage at any price. The insurance underwriting process of “cherry picking” must be altered for the consumer to truly have options in a 21<sup>st</sup> Century Intelligent Health System.

No one wants to legislate underwriting standards. Companies should be able to continue to develop proprietary internal standards. However, a viable individual market can not exist if only the young and/or healthy can purchase insurance. One approach that could be considered to resolve this dilemma is to establish a private/public partnership that reviews rejected applications to determine if the applicant among the 12% of the uninsured that are truly uninsurable.

If the applicant is truly uninsurable, they will be offered coverage in the state or federal high-risk pool. If not, they will be assigned to a private market carrier. Carriers rejecting applicants would be required to accept an equal number from the screening process for the high-risk uninsurable pool. Carriers rejecting relatively good risks may find that they get a much worse risk in return. By using market forces in this way, carriers will begin to accept more applicants and underwriting standards will be moderated in favor of the consumer without state laws or regulations setting company underwriting procedures.

This process would maximize private market coverage of health insurance and minimize the number of lives qualifying for the high-risk pool. In an ultimate system of expanded access to insurance in a competitive market, there will be no uninsurables because everyone will have coverage that is portable and sustainable as an individual policy.



Because of the higher costs associated with those qualifying for the high-risk pool, there will probably need to be some level of subsidized government premiums. With traditional insurance and regular high-risk pooling plan designs and administration, the cost of high-risk pool subsidies seems financially and politically difficult to establish. While several states have a state high risk pool in place, many others have not established a high risk pool or have established one, but do not fund the pool.

There is a new approach. Using the principles of a 21<sup>st</sup> Century Intelligent Healthcare solution, an HSA eligible HDHP model can be implemented that transforms the concept of a high-risk pool into a more realistic solution.

An example of what an HSA eligible HDHP high-risk pool coverage might include is the following:

1. Plan Design – Using federal HSA/HDHP requirements, provide a choice of HDHPs with deductibles from \$2,900 to \$5,600 per person. Maximum OOP: \$5600. Maximum coverage from \$250,000 to \$1,000,000.
2. Health Management – Provide a deductible credit of \$500 for each condition satisfied: (1) Body Mass Index; (2) Blood Pressure; (3) Cholesterol; and (4) Nicotine use.
3. Disease Management – Compliance awards for participation, engagement, and outcomes.
4. HSA Amounts – No initial contribution by the state, but open to individual and charity contributions. State could make compliance awards based upon improved health outcomes and “shared savings.”
5. Distribution system – traditional agent/broker sales and non-profit brokerage operations with faith-based outreach partners.
6. Administration – Carrier based networks, best of practice wellness and disease management, enrollment, account management, and integration of program through a general manager / health plan integrator administrator.

This 21<sup>st</sup> Century Intelligent Healthcare solution would lead to a different insurance market, where individuals could apply for coverage knowing they would at least qualify for some type of high deductible plan provided by insurers directly or through a federal/private subsidized high risk pool. Citizens would no longer avoid the application process because an agent informed them of their unlikelihood of passing strict carrier underwriting and/or have to worry that any poor health characteristics would become a part of a national Medical Information Bureau data base that could affect other personal or business needs.

Ideally, with true transformation over time, and affordable multi-year products, everyone would become covered at a young age so that very few individuals would be without coverage and locked out of the insurance system. Until that time, a bridge to the future could utilize a high risk pool for those currently uninsurable and encourage through market forces a greater underwriting acceptance rate.

## **The Savings from a 21st Century Intelligent Healthcare Solution**

Economists and actuaries may analyze and debate assumptions and costs of the proposed 21<sup>st</sup> Century Intelligent Healthcare Solution to Creating a 300 Million Payer System. The reality is that the models used by both professions are reflective of the current system not a 21<sup>st</sup> Century Intelligent Health System. Congressional Budget Office (CBO) and the Office of Management and Budget (OMB) do not have in place a model reflecting dynamic scoring of health costs in a changed world.

Behavior modification savings are not “scored” for wellness, compliance with disease management programs, provider choices based on value purchasing, the value of transparency, and any number of savings from a consumerism approach to healthcare. Economic models use the 1978 Rand Health Insurance Experiment (HIE) and the then dominant fee-for-serve plan designs. The economic utilization modeling and assumptions on “moral hazards” is outdated and not reflective of a 21<sup>st</sup> Century Intelligent Healthcare solution. Actuarial models often lag the reality of results generated by inventive approaches to consumerism plan designs.

These models do not reflect choices made once third party reimbursements are changed to individually controlled account balances. Neither economic nor actuarial models reflect the movement to shared savings and multi-year accumulations. Pricing and tax models still consider health insurance as a benefit to be used rather than an accumulating asset to be self managed. Supply control models for healthcare do not reflect the changes inherent in a demand control system.

Employer group plans and individual health policy savings from a 21<sup>st</sup> Century Intelligent Healthcare solution would mean that more compensation and earnings would shift from non-taxable to taxable income. State savings and allocations in federal budgets for Medicare and Medicaid would be dramatically reduced as cost effective value driven purchasing habits of the private market would bleed over into provider practices of government based programs. Under a 21<sup>st</sup> Century Intelligent Healthcare solution, market-based inventive ideas would be rapidly adopted by government-based programs. Efficiencies imposed on the providers of private health and healthcare services would accrue to traditionally lagging government plans.

With better products and services for all Americans, the State Employee Benefit Plans would be able to implement effective health management and disease management programs that have been shown to lower costs and reduce healthcare cost trends by at least 2%. There are enormous financial and budget implications for the Federal and State budgets if 21<sup>st</sup> Century Intelligent Health Plans were allowed and offered. Some states need changes so that the state employee plan can implement reward and incentive impact programs.

If a State Health Plan had a health trend of just 2% lower than current projections, the outlays over the next 5 years would be lowered by 10% of

current year outlays. If expanded consumerism was implemented, the savings could reach 33-50% of the current year expenditures (over 5 years). The biggest saving of a 2% lower trend would be in a State's post retirement health benefit liability. That number for must be disclosed to the public and bond investors starting 1/1/08. A 2% lower trend developed by incorporating the above changes into the broader insurance market and implementing them into the State Health Benefit Plans would lower a State's post retirement liability by Billions. Freeing a state from the excess current a future costs associated with the current dysfunctional health system would release monies into higher taxable compensation. In addition, savings from state health care funding would provide states with a better financial base to address many citizens' non-health issues creating demands on federal funds.

The federal government's unfunded liability as of 2005 for Medicare is \$68.1 trillion. A 2% change in health trend costs could translate into a federal savings of over 15 trillion dollars. The debate on cost using outdated modeling may delay the inevitable. Cost is not the issue. We currently pay for healthcare for all, either directly or indirectly. We are either going to be in a 21<sup>st</sup> Century Intelligent Health System using the power and market force of an entrepreneurial America or a national election will generate an aggressive federal movement. The federal government is the only entity with the audacity to assume the costs of healthcare without worrying about the financial impact. The politics of power will trump the reasonableness of responsibility.

Vacuums are soon filled. The uninsured has been left unattended nationally and in states for too long. Deal with it now in using solutions supported by basic principles of a 21<sup>st</sup> Century Intelligent Health System or others will take us in less desirable directions.

## Appendix A - Project Descriptions

### *Tax Policy*

Tax policy is a key tool that state legislatures can use in order to support and encourage beneficial programs. In some cases it may be the elimination or reduction of an existing tax or the granting of new tax credits. The following tax policy changes would support the “Creating an HSA State” movement, where health insurance is made more accessible and affordable.

#### **1. Eliminate state and municipal premium taxes on HSA-eligible high-deductible health plans.**

State premium taxes average more than 2% of premiums, and can be as much as 7+% of the premium, as policies sold in some states also add municipal taxes from cities and counties. Premium taxes imposed by the state, counties and/or cities are similar to a sales tax. Premium taxes apply only to individual and insured group policies (generally small employers). Large self-insured employer plans, governed under federal ERISA laws, do not pay state premium taxes.

Premium taxes, collected from insurers, artificially drive up the cost of individual and small group insurance. Insurers simply build the cost of the tax (and the cost of collecting the tax) into product premiums. States with high premium taxes disadvantage their own state-based companies. Those domestic state companies become subject to retaliatory premium taxes in other states where lower taxes would otherwise apply. High premium taxes have added to the reasons that some states have lost insurers and jobs. Insurers have moved operations to states with lower premium taxes. More importantly, high premium taxes unnecessarily increase premiums, create more uninsured Americans, and disadvantage consumers seeking affordable health insurance.

Unfortunately, premium taxes become ingrained in the political system and are difficult to eliminate. HSAs are still at a beginning stage, but they are the basis for a 21<sup>st</sup> Century Intelligent Health System; state legislatures can eliminate state premium taxes on HSA-eligible high-deductible health plans (HDHPs) without losing any significant existing tax revenue. By taking this action now, a foundation for the future will be set for more affordable HSA products: new companies targeting HSA sales will find your state a business-friendly environment from which to develop and sell HSA-eligible HDHPs.

## **2. Equalize the state income tax deductibility of premiums for individually purchased HSA-eligible HDHPs.**

Individually purchased health insurance does not receive the same federal or state tax advantages as employer-purchased health insurance. Federal legislation has been proposed to equalize the tax advantages by eliminating both federal income taxes and employment taxes for HDHP premiums. The proposed federal legislation would allow a reduction for HDHP premiums in the federal Adjusted Gross Income (AGI). For many states, the federal proposal would generate an automatic reduction in state income taxes. A state legislature can get out in front of this tax equalization proposal by passing state income tax deductibility for individually purchased HSA-eligible HDHPs. Adding the tax deductibility of HDHPs, HSA/HDHPs allow individual health policies to more closely parallel the tax advantages offered under employer-based coverage. This would be another step toward advancing individual policy sales and moving toward “Creating an HSA State.”

## **3. Incent newly formed small retail businesses to initiate HSA-eligible HDHPs for employees by providing a lower graduated sales tax submittal rate of their first four business years (e.g. 25%, 50%, 75%, and 100%).**

Service and labor jobs are less likely to provide workers with health insurance. About 63% of uninsured workers hold service and labor jobs, although these jobs only make up about 40% of the workforce.

Encouraging new small businesses to offer health insurance begins a process of dealing with the working uninsured. Incent newly formed small retail businesses to initiate health coverage is a good investment in small business development and setting a state’s business tone for a “Culture of Health.”

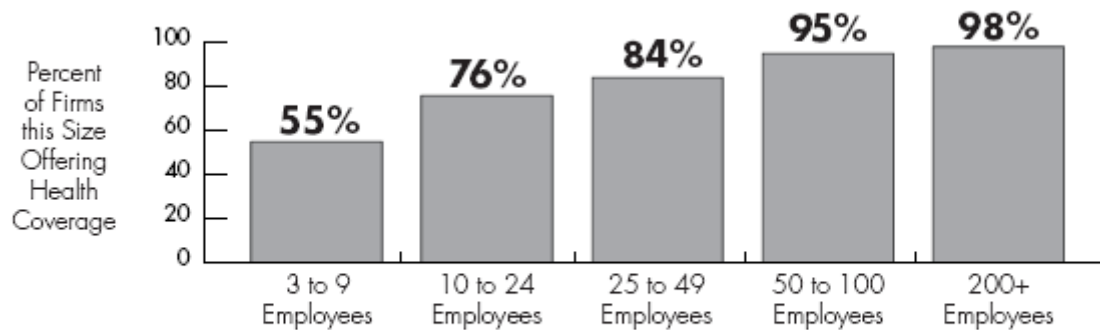
Supporting small business insurance coverage has payoffs for the state. Low employer-sponsored coverage can have significant impact on public programs, such as Medicaid and SCHIP, as well as state and local safety net providers that offer the services to the uninsured.

## **4. Provide tax credits to previously uninsured small employers offering HSA-eligible HDHPs.**

The State Legislature should study ways to support small groups in purchasing HSA/HDHPs through tax credits or other subsidies. A three-part contribution process of state, employer, and employee matching could be highly beneficial in seeding funds to leverage the market to meet the needs of uninsured citizens. An effective program of tax subsidies could lower other government supports dealing with Medicaid and/or uncompensated care.

Most uninsured are in working families. Among the majority of the uninsured, at least one person in the family works either full- or part-time. Smaller employers are less likely to offer health insurance to their employees. Nationally, about 30% of workers in firms with fewer than 25 employees are uninsured.

## 6. SMALL FIRMS LESS LIKELY TO OFFER COVERAGE THAN LARGE FIRMS



**Source:** Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: 2003" ([www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=21185](http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=21185))

Federal legislation has been suggested to provide a \$500 tax credit to employers who offer an HSA-eligible HDHP. States can develop their own subsidy policy to encourage small businesses to offer HSA/HDHPs.

Evidence continues to mount regarding the market acceptance and success of healthcare consumerism. Milliman, one of the nation's leading actuarial firms that prices health plans for major employers and insures, showed in its 2005 annual study of healthcare premium increases:

- HMO premiums increased 8%
- PPO premiums increased 8%
- Consumerism plans with HSAs and HRAs increased 1%

The Milliman study is important verification of what proponents of healthcare consumerism have been predicting – greater member empowerment, engagement, and lower premiums. Personal responsibility, ownership, and healthcare consumerism can lead us to a 21<sup>st</sup> Century Intelligent Health System.

**5. Provide tax incentives to accelerate the use of electronic medical records (EMRS) and other electronic (non-paper) systems through investment tax-credits or other similarly-situated tax incentives. Hospitals, physicians, and pharmacies could be incentivized to invest in health information technology.**

## ***Insurance Reform***

### **6. Allow HSA/HDHP approval reciprocity (or fast-track approval of HSA/HDHPs) to increase individual health policy competition and choices from carriers operating in good standing under the laws and regulations of the state.**

Legislatures should work with insurance commissioners to identify and accept policy approvals from other states with laws and regulations consistent with their own state. The legislature should encourage the insurance commissioner to develop a regional HSA market of reciprocal agreements. In addition, the insurance commissioner should have the authority to identify states with laws and regulations so egregious that those policies should not be sold to residents of that state.

The legislatures should allow internet purchasing of HSA/HDHPs approved for sale in other states but not otherwise sold in their state. Allowing individual consumers to shop for a better deal in a competitive marketplace across state lines will increase the availability of healthcare coverage and drive down costs.

An alternative approach would be to create a “fast track” approval process so new HSA/HDHP policies with creative incentives and rewards would get immediate insurance department attention for rapid approval.

Nationally, in 2002, about 6.6% of the non-elderly population (16.5 million people) purchased individual health insurance, compared with 65.0% (163.7 million people) covered by employer-based health insurance and 16.2% (40.8 million people) covered by Medicaid or other public coverage. Another 43.3 million non-elderly Americans lacked health insurance for the entire year. The availability and prices for individual health insurance is the key to reaching the uninsured.

The biggest challenge facing the insurance market is the lack of choices for individual health insurance. New laws can change the difficult individual market into a more conducive area for all carriers to sell services. The right policies can encourage more creative products, better services, and lower prices.

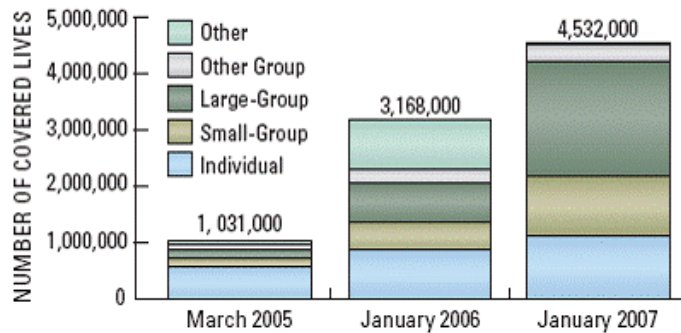
Under current laws, it is illegal to cross state borders to buy health insurance; consumers can only buy health plans approved in their own state. However,

- New HSA/HDHP products are more likely to be marketed to a region where approval is widely accepted. Banks are targeting the sale of HSAs

and would likely team up with carriers to offer competitive HSA products with features not currently available.

- 82% of Americans would cross state lines in order to reduce their insurance premiums.
- 86% of Hispanics, and 85% of African Americans, were greatly in favor of this option.
- 80% of single adults and low-income families support crossing state lines.
- Those with annual household incomes of \$15,000 to \$24,999 believe that crossing state lines to find lower cost health insurance is a perfectly acceptable option.

**FIGURE 1.**  
Growth of HSA/HDHP Enrollment from March 2005 to January 2007



**TABLE 1.**  
HSA/HDHP Enrollment (Covered Lives)

	March 2005	January 2006	January 2007
INDIVIDUAL MARKET	556,000	855,000	1,106,000
SMALL-GROUP MARKET	147,000	510,000	1,057,000
LARGE-GROUP MARKET	162,000	679,000	2,044,000
OTHER GROUP*	88,000	247,000	291,000
OTHER**	77,000	878,000	34,000
<b>TOTAL</b>	<b>1,031,000</b>	<b>3,168,000</b>	<b>4,532,000</b>

\* For this census, companies reported enrollment in the large- and small-group markets according to their internal reporting standards. The "other group" category contains enrollment data for companies that could not break down their group membership into large- and small-group categories within the deadline for reporting.

\*\* The "other" category was necessary to accommodate companies that were able to provide information on the number of people covered by HSA/HDHP policies but were not able to provide a breakdown by market category within the deadline for reporting.

### Average Annual Premiums by State – Single Coverage, 2004

State	Policies in Survey	Average Annual Premium
New Jersey	29,198	\$6,048
Massachusetts	14,104	\$5,257
New York	5,932	\$3,743
Arkansas	1,633	\$3,435
South Carolina	6,156	\$3,328
Maryland	1,285	\$3,279
West Virginia	941	\$3,141
New Hampshire	3,348	\$3,134
South Dakota	1,944	\$3,133
Oklahoma	3,748	\$3,047
Connecticut	4,358	\$2,963
Georgia	5,742	\$2,910
Louisiana	2,541	\$2,858
Tennessee	7,647	\$2,851
Texas	27,132	\$2,836
Wyoming	1,586	\$2,734
Mississippi	3,100	\$2,729
North Carolina	13,953	\$2,623
Illinois	22,035	\$2,591
Alabama	2,415	\$2,548
Florida	162,992	\$2,539
Arizona	9,529	\$2,440
North Dakota	1,579	\$2,420
Montana	4,077	\$2,418
Wisconsin	11,876	\$2,373
Nevada	10,239	\$2,364
Virginia	50,952	\$2,332
Indiana	15,402	\$2,330
Ohio	20,043	\$2,304
Missouri	9,031	\$2,299
Nebraska	5,848	\$2,295
<b>National</b>	<b>1,227,147</b>	<b>\$2,268</b>
Kansas	3,835	\$2,260
Idaho	1,247	\$2,207
Colorado	16,482	\$2,198
Oregon	6,706	\$2,162
Minnesota	12,846	\$2,121
Kentucky	13,066	\$2,033
Pennsylvania	6,814	\$1,989
New Mexico	4,812	\$1,982
Iowa	6,915	\$1,965
Michigan	12,051	\$1,926
California	680,338	\$1,885

Source: America's Health Insurance Plans.

Note: Results from states with fewer than 500 policies are included in the totals, but not reported separately.

## 7. Expand the number of health insurers offering HSA-eligible HDHPs by removing financial and bureaucratic barriers to new market entrants.

A study to identify existing barriers to market entry needs to be performed, one that can challenge existing the status quo and present a consumers' view of "needed" protective regulations and barriers to selling products in your state.

Financial and bureaucratic barriers to new products being offered should be minimized. Barriers such as banking deposits, excessive licensing costs, minimum number of employees located in the state, or any similar restrictions should be reviewed for effectiveness and appropriateness. States should create an easy environment in which to create jobs, sell health insurance, and offer new products. Needed protections for policyholders should not be compromised, but any barriers not meeting a strict standard of benefiting the consumer should be removed.

## **8. Remove state legal and regulatory conflicts to offering flexible HSA eligible HDHPs.**

Certain state policy requirements and mandates should be removed so that the citizens of the state can purchase cost-effective HSAs. For example, some states require out-of-network (OON) benefits to be paid at a coinsurance level of at least 60%, regardless of the level and access to care within a negotiated discount network. Other states allow from 50% to 0% for OON reimbursements under a HDHP/HSA eligible plan design. The OON coinsurance requirement in a state can raise the cost of purchasing HDHPs.

A study may be needed to identify other areas where state regulations adversely affect premiums. In some cases, mandates may prevent a more cost effective product from being offered. Some states allow “bare-bones” policy designs, but few sales have been developed using this flexibility. Consumers expect certain core benefits in a “comprehensive medical plan.” The actuarial truth is that mandates do not add much to costs, and the elimination of coverage for inter-related conditions may increase overall costs of care to the affected policyholder (e.g. depression as a co-existing condition with diabetes).

## **9. Remove legal and regulatory restrictions on providing incentives and rewards for compliance with health management and disease management programs.**

Some states disallow financial incentive and rewards under HSA eligible HDHPs due to anachronistic laws that consider such incentives and “inducement to purchase” or classify these designs under law as “illegal rebates.”

## **10. Allow list billings through employers for individual policies.**

There may be some federal HIPAA restrictions, but employers should be allowed to provide a list billing service to remit premiums for employees purchasing individual policies. The ability for small employers to list bill is unclear in many states. This inhibits the sale of individual portable coverage.

## **11. Allow state approval of limited use Health Reimbursement Arrangement (HRA) Only plans so pre-tax employer contributions can be used to purchase HSA eligible HDHPs.**

Limited use HRA Only plans allow employers to set up a tax advantaged process to contribute to an employee savings account where the contributions can be used by the individual to purchase individual health insurance. This

type of plan is not allowed under many state laws that were written before HRAs were established by the U.S. Treasury ruling in 2002.

## ***Transparency (Right to Know)***

### **12. Support the development of a “Health Travelocity” model for insurance products that would allow consumers to compare services provided by selling agents, covered benefits, and premium costs of products.**

The legislature could provide for a state managed and/or privately run consumer “Health Travelocity” that offers complete and transparent health insurance information on premiums, benefits, coverage, and network providers. Clear comparison of products, exclusions, limitations, and other plan design comparisons should be as available as airline and hotel information on Travelocity or Orbitz.

Recent surveys of uninsured individuals and small businesses indicated a major problem is the lack of knowledge about affordable HSA/HDHPs. When asked how much the employee and employer could contribute to a health insurance policy, the answer turned out to be more than enough to purchase HSAs available in the market.

Carriers are now developing new healthcare consumerism products at lower costs with more choices. In 2004, Aetna consumerism plans showed cost increases of only 1.5% versus increases of more than 10% for traditional health plans. Employers that offered only consumerism plans had an average decrease in premiums of 2.9%. Similarly, UnitedHealthcare showed average cost increases of less than 1% for consumerism plans. Humana, Blue Cross Blue Shield, and other health insurers are finding similar results from their new consumerism products.

Insurers and large employers have shown the way to healthcare consumerism. Now small employers and individuals are beginning to experience the benefits of as well. Assurant Health reports that 43% of HSA applicants were previously uninsured. Affordability is the key. A reported 71 percent of people who bought HSAs from Assurant Health paid premiums of \$100 per month or less. Golden Rule, another company offering HSAs, stated the majority of enrollees (52.83%) paid between \$51 and \$100 a month. On average, Golden Rule’s customers saved 45-55% on annual insurance premiums. Forrester Research predicts 24% of Americans will be covered under consumerism plans by 2010.

Healthcare Consumerism can only work in a free competitive market with an abundance of comparative information. Information on cost, quality, service, and knowledge of health insurance is needed to reach consumers in a plain

and simple way. Other industries have been using consumerism for years; it is time for healthcare to be included. The state legislature can support these efforts to benefit all citizens

**13. Require hospitals receiving state funds to release information on death rates and complication rates, with a guarantee that use of the data will include a fair risk adjustment.**

The state legislature could provide all citizens with critical risk-adjusted mortality and complication rate information on providers for over 259 separate conditions requiring hospitalization. Citizens could have unlimited access to quality information on hospitals, whenever the need arises. Independent monitoring services and the media would have unlimited access to quality results to assure public knowledge and understanding of best practice facilities.

The data is publicly available for all Medicare discharges (based on hospital-required submittals for Medicaid patients). Similar information is available for all hospital stays, but in many states the information has been held as proprietary by the individual hospitals and the hospital associations. It is time that the consumer's "right to know" be recognized as more important. Hospitals can be ranked based upon their performance as compared to the average performance of all hospitals in the state.

There are four basic quality indicators used by insurers to rank hospital quality:

- 1) Volume: the more often a hospital performs a certain treatment, the better it gets
- 2) Mortality: deaths that occur in the hospital during a procedure or treatment
- 3) Major Complications: the occurrence of problems such as blood clots and infections
- 4) Failure to Rescue: deaths that occur in the hospital after a major complication

Many hospitals treat very sick patients that other hospitals cannot treat. To be fair, all of the metrics should be risk-adjusted to account for the age of the patient and severity of the case. In healthcare, we have tolerated a shrouding of the variance in quality that is unacceptable. If the system can be driven to consistently deliver the quality that it is capable of, there will be tremendous savings in lives and money. A successful transformation strategy must deal with the forces which have kept the provider adoption rates of best quality practices 25-35 times longer than industries which must compete on value.

**14. Supporting the “right to know” initiative, managed care organizations could be required to disclose cost and quality information as a condition of participation in the Medicaid.**

Following the 2006 Presidential executive order for federal programs to disclose cost and quality information, states should make available all payment information to providers based on contracts with state employee benefit programs and state Medicaid programs. Providers not willing to release this information should be excluded from the program(s).

**15. Provide quality comparisons of hospitals with simplified consumer-friendly analysis capabilities.**

Consumer-friendly and simple-to-use tools are available to help make important healthcare decisions. If a patient needs hospital care, they can use this information (along with advice from doctors and other trusted sources) to help choose the facility that is right for them. If a patient is concerned about the rankings, they can ask their doctor for more information and what they can do to make sure they get high-quality care. Patients can call hospitals to find out what is being done to improve performance. This information and quality results are meant as a tool to help individuals make choices and manage their health and healthcare. It is not meant to generalize about the overall quality of a hospital. Instead, it is meant to be used to examine hospital performance in specific categories.

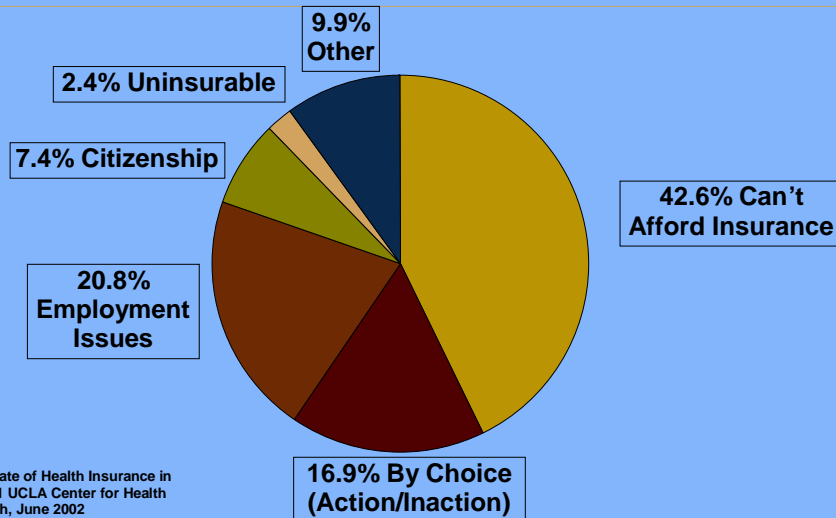
Consumers are taking a more active role in managing their own healthcare. In order to make informed decisions, such as where to get high-quality and cost-effective care, consumers need access to accurate, timely information and tools. Some states, like Florida, create a state agency to provide this type of information. Others can outsource the quality comparison tool to one of the commercially available sources that are already used by providers and insurers. There is no need for a state to create a bureaucracy to get this information into the hands of its citizens.

### ***High-risk Pool***

**16. Establish an HSA/HDHP high-risk insurance pool that requires participation in disease management programs and provides varying benefits based upon compliance with care and health outcomes.**

States can establish HSA/HDHPs as the basis for providing health insurance to individuals who are uninsurable (i.e. cannot meet insurer underwriting standards). “Truly uninsurables” represent a relatively small percentage (3-5%) of the population.

## Breakdown of Uninsured Affordability is the Key



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A significant number of applications for individual health insurance never make it to the medical underwriting process. Overall, approximately 15% of total applications received were either not processed or denied for non-medical reasons; the remaining 85% went through the medical underwriting process and resulted in an “offer of coverage.”

A full 87.6% of those processed through medical underwriting are offered coverage. Coverage offerings vary by age, ranging from 95% for people under age 18 to 70% for people aged 60-64. Only 2-3% are truly uninsurable, yet more than 12% are rejected for coverage.

Uninsurable individuals and those eligible under HIPAA and HCTC do not come from any particular sector of society. Mostly, they are hard-working individuals and families seeking to provide for and pay for their own health insurance – people who through no fault of their own find themselves in a situation where they cannot obtain coverage at any price. The insurance underwriting process of “cherry picking” must be altered for the consumer to truly have options in a 21<sup>st</sup> Century Intelligent Health System.

No one wants to legislate underwriting standards. Companies should be able to continue to develop proprietary internal standards. However, a viable individual market cannot exist if only the young and/or healthy can purchase insurance. One approach to resolve this dilemma is to establish a

private/public partnership that reviews rejected applications to determine if the applicant among the 3-5% is truly uninsurable. If the applicant is truly uninsurable, they will be offered coverage in the state high-risk pool. If not, they will be assigned to a private market carrier.

Carriers rejecting applicants will be required to accept an equal number from the screening process for the high-risk pool. Carriers rejecting relatively good risks may find that they get a much worse risk in return. By using market forces in this way, carriers will begin to accept more applicants and underwriting standards will be moderated in favor of the consumer without state laws or regulations setting company underwriting procedures. This process will maximize private market coverage of health insurance and minimize the number of lives qualifying for the state high-risk pool. In an ultimate system of expanded access to insurance in a competitive market, there will be NO uninsurables because everyone will have coverage that is portable and sustainable as an individual policy.

Because of the higher costs associated with those qualifying for the high-risk pool, states generally subsidize premiums. Some states have resisted this approach as too expensive. With traditional insurance and regular high-risk pooling plan designs and administration, the cost of high-risk pool subsidies seems financially and politically untenable in some states.

There is a new approach. Using Healthcare Consumerism and new federal laws and regulations, an HSA/HDHP model can be implemented that transforms the concept of a high-risk pool into a more realistic and cost-effective solution.

An example of what an HSA/HDHP high-risk pool coverage might include is the following:

- 1. Plan Design** – Using federal HSA/HDHP requirements, provide a choice of HDHPs with deductibles from \$2850 to \$5,650 per person. Maximum OOP: \$5500 (2007 standards). Maximum coverage: from \$250,000 to \$1,000,000.
- 2. Health Management** – Provide a deductible credit of \$250 for each condition satisfied: (1) Body Mass Index; (2) Blood Pressure; (3) Cholesterol; and (4) Nicotine Use.
- 3. Disease Management** – Compliance awards for participation and outcomes.
- 4. HSA Amounts** – No initial contribution by the state, but open to individual and charity contributions. State could make compliance awards based upon improved health outcomes and “shared savings.”

**5. Distribution system** – Traditional agent/broker sales, no- or low-commission internet sales, and faith-based outreach.

**6. Administration** – Carrier-based networks, best of practice wellness and disease management, enrollment, account management, and integration of program through a general manager/health plan integrator administrator.

## ***Low-income Uninsured***

### **17. Support charity-subsidized HSAs for the low-income uninsured.**

HSAs are structured so that any interested party can contribute to the HSA with the covered individuals receiving the tax deduction. Charities and other eleemosynary organizations can add to the HSA subsidy. By including these and faith-based organizations in helping low-income uninsured a community-wide effort can be enlisted to energize a unique approach to the uninsured.

**Saving Health  
Less Care for the Uninsured**

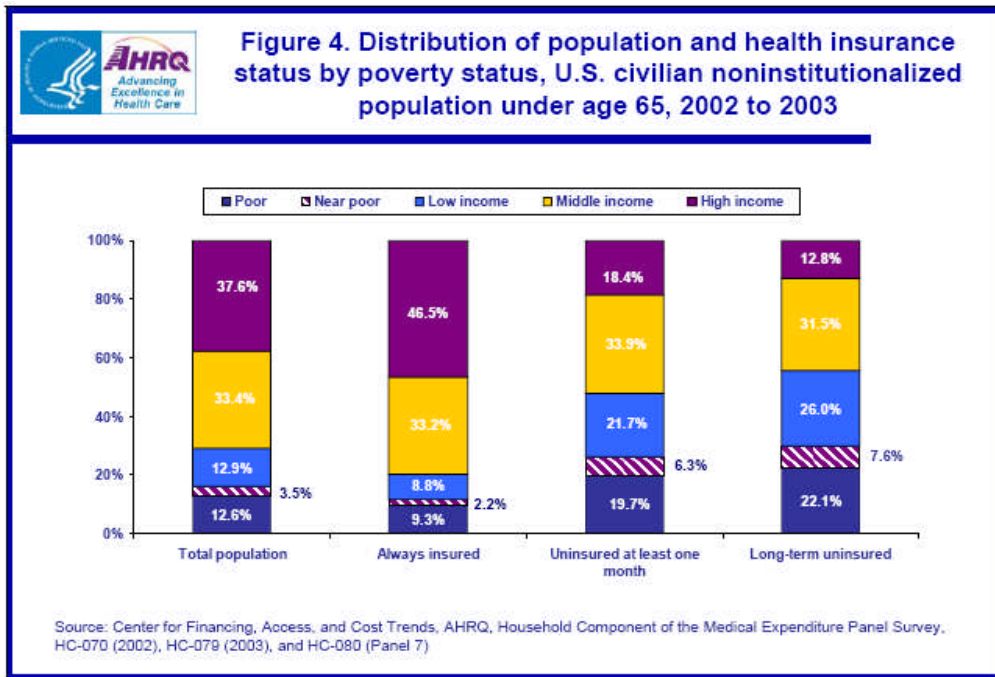
- Children** - 70% more likely to go without care for common childhood conditions such as asthma, ear infections, and sore throats
  - 5 times more likely to have an unmet need for medical care each year
- Women** - 36% less likely to get a pap smear, and 60% less likely to get a mammogram
- Men** - 40% less likely to get a prostate examination
- General** - 33% less likely to get a routine physical exam, and 25% less likely to visit a doctor for an illness.

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### **18. Provide “health scholarships” for the low-income uninsured using subsidized HSA/HDHPs.**

Individuals with lower incomes (i.e., persons in families with income up to 200% of the poverty line) were disproportionately represented among the long-term uninsured over the two-year period 2002 to 2003. While poor, near-poor, and low-income individuals represented 12.6, 3.5, and 12.9%, respectively, of the population, they represented 22.1, 7.6, and 26.0%, respectively, of the long-term uninsured population.

In contrast, individuals with high incomes (i.e., persons in families with income over 400% of the poverty line) were disproportionately represented among those having health insurance throughout 2002 and 2003. Those with high incomes represented 37.6% of the population, but they accounted for 46.5% of the always insured.



**Poor:** income less than or equal to the poverty line; includes those who had negative income.

**Near-poor:** income over the poverty line through 125 percent of the poverty line.

**Low-income:** income over 125 percent through 200 percent of the poverty line.

**Middle-income:** income over 200 percent through 400 percent of the poverty line.

**High-income:** income over 400 percent of the poverty line.

Low-income status, by itself, does not qualify a person for most public programs. For example, low-income childless adults who are not veterans may not qualify for public assistance. The “Low Income Not Eligible for Public Programs” (Not Eligible) category includes those who fail to meet non-financial criteria that these programs require.

Listed below are some of the non-income eligibility criteria that may be required by public programs:

Low Assets	6. Under an Age Limit for Children
Large Family Size	7. Disability or Blindness
State of Residence	8. Citizenship or Residency Status
Pregnancy for Women	9. Military Service

Federal legislation has been proposed that would provide the low-income uninsured a subsidy to purchase as HSA-eligible HDHP. States can take the lead by establishing a healthcare consumerism a program for “health scholarships” that include private, charity, and state-subsidized coverage for low-income participants.

