

Statement for the

**United States House of Representatives
Committee on Energy and Commerce**

June 25, 2009

**Hearing on the
Comprehensive Health Reform Discussion Draft**

Submitted by



**Janet Stokes Trautwein
Executive Vice President and CEO
National Association of Health Underwriters
2000 North 14th Street
Suite 450
Arlington, VA 22201
(703) 276-3806
(703) 841-7797 FAX
jtrautwein@nahu.org
www.nahu.org**



National Association of Health Underwriters

America's Benefits Specialists

The National Association of Health Underwriters (NAHU) is pleased to be able to play a constructive role in crafting bipartisan, comprehensive health care reform legislation this year. We have an historic opportunity to put in place real solutions to reduce costs, improve quality and ensure choice and access for all Americans in a way that will strengthen our health system and our economy.

As an association representing more than 100,000 health insurance agents, brokers and benefit specialists from every state in the country, the members of NAHU work with both individual and corporate health insurance consumers to help provide them with high-quality affordable health plans specifically suited to their unique needs. NAHU has analyzed the discussion draft and we have a number of questions and concerns about many aspects of the proposed legislation.

Market Reforms

The legislation creates significant market reforms to all health insurance markets. It would require all qualified health benefit plans (QHBP) to accept enrollees regardless of health status, and would eliminate the use of pre-existing conditions exclusions and limits on benefits (other than cost-sharing) that are unrelated to the clinical appropriateness of the covered treatments. All fully insured plans, regardless of size, would be guaranteed-issue and guaranteed renewable. These plans would also be subject to strict modified community rating standards consisting of variances only by family structure, geographic locations and age bands that would limit premium differences for the oldest insured individuals to differ from the youngest insureds by a ratio of two to one.

NAHU has very significant concerns about the proposed reforms, particularly that they provide no distinction between small- and large-employer groups, as there is in today's marketplace. Under current law, fully insured employer groups over 50 lives are treated very differently than the small-group market, and these groups are typically rated based on their past claims experience. This market is the health insurance market working best today, and the rating reforms proposed by this measure, which would apply to all fully insured groups regardless of their size, would significantly increase costs in this market. The bill would also create adverse selection to the fully insured market, as the larger groups that chose to fully insure under the proposed rating rules would only do so if they had concerns about their group's claims experience.

NAHU does agree that reforms need to be made to the individual and small-group markets concerning the way that premium rates are determined at the time of application. It is NAHU's view that these markets would benefit from greater premium standardization. But NAHU feels that the rating reforms proposed should only apply to individual health insurance products and fully insured small group plans of two to 50 lives. Furthermore, in order to protect against runaway costs, the federal government should ensure that wide-enough adjustments may be made for several key factors. At a minimum, variations need to be allowed for applicant age at the natural age breakdown rate of at least five to one (meaning that the rate of the oldest applicant may be no more than five times the rate of the youngest applicant). In addition to age, variations in premium rates should also be allowed for participation in wellness programs, smoking status and geography.

We specifically request that groups over 50 be permitted to use claims experience to determine their premium rates. This is in no way a discriminatory practice and is much different than prospective health status rating. All large groups today develop premiums based on the past claims experience of their entire group. When we hear

that large groups “community rate” their employees, what this really means is that the group develops rates that are the same for all participants in their employer group based on the employer’s claims experience. Eliminating the ability to develop premiums in this manner will result in significant rate shock for many employers and their employees. It will also remove employer incentives to reduce costs through implementation of wellness initiatives, since the results of such initiatives will not reduce health plan costs for the employer. It also means that employers and employees will not really be able to “keep the insurance coverage they have” because the structure and pricing of current coverage will be irrevocably changed by these proposed rating reforms.

We also urge caution in the elimination of lifetime limits on benefits. Lifetime caps are rarely met, even by the sickest individuals, but they do help provide a control on pricing for medical costs for all covered individuals. Private reinsurance for an unlimited maximum is expensive for both health plans and self-funded employers, and will impact premium levels. While we do not want any individual to have coverage arbitrarily cut off due to a lifetime limit, we wonder whether a federal financing/reinsurance backstop for those rare individuals whose medical expenses are so great that they would exceed lifetime caps might not better serve the affordability goals we share for all consumers.

Allowing People to Keep Their Current Coverage

While virtually all stakeholders agree that aspects of our health care delivery system are in desperate need of reform, millions of Americans are happy with the private health insurance coverage they already have. In order for comprehensive health reform to be successful, American individuals and employers providing health coverage to their employees must be able to keep their current coverage if they choose to do so. Unfortunately, NAHU feels that many of the requirements in the draft legislation would render this idea impossible.

First of all, the grandfathering provisions proposed for existing plans are insufficient. Existing individual policies could only be retained if the only change to the policy was to add or delete a dependent. Individual policies based on annual contracts with changes of contract terms that benefit the consumer are common at plan renewals, such as a slight change to the deductible or coinsurance, but, under this legislation, individuals would be unable to exercise them. Also, while group plans would be allowed to phase in reform requirements over five years, eventually these plans would have to change to meet the terms of the proposed individual and employer mandates. The required changes to employer plans would change the way policies are rated as well as change their plan designs and included benefits. All of these changes could substantially increase the price of coverage. This all seems highly incongruent with previously stated goals of allowing individuals and businesses to keep their private health insurance coverage if they wished to do so.

Minimum Loss Ratios

The legislation specifies that all qualified health benefits plans will have to operate with a minimum loss ratio of 85%. If non-claims costs exceed 15%, beneficiaries must be rebated on a pro-rata basis for the excess.

NAHU has concerns about a minimum loss ratio requirement, as it does not address the true problem that is driving health insurance premium costs—the skyrocketing cost of medical care. The definition of administrative expenses in the bill is quite broad and may encompass many services that actually benefit consumers. In addition to profits and marketing, non-claims expenses include quality management, disease-management programs, health information technology investment, claims processing, legal compliance, federal and state taxes, employee salaries, consumer education, etc. A 2005 PricewaterhouseCoopers study found that health plan administrative costs were not a factor contributing to health care cost increase; rather, increased utilization of services, an aging population, lifestyle choices and new technologies were the primary cost drivers. In states that have adopted high loss ratio standards, consumers have suffered from less competition, fewer choices and higher premiums.

Essential Benefits Package

NAHU agrees that minimum standards of coverage, both for subsidy-eligible individuals and the general population, are a necessary part of health reform. But we are concerned that the essential benefit requirements proposed in this legislation are overly restrictive and complicated. Instead of the essential benefits package requirements this legislation would impose, we believe that there should be two benefit standards developed: First, a standard for minimum creditable coverage for purposes of an individual mandate and, second, a somewhat higher standard for essential benefits coverage for purposes of subsidized coverage.

We believe the standard for minimum creditable coverage should be one of ensuring that basic appropriate services are available. The quickest implementation standard for this would be to use an existing definition, like the definition for HIPAA creditable coverage. Using this standard would weed out limited-benefit packages and would allow states to be of immediate assistance in helping with enforcement because this is a standard that is already embedded in law for all states.

Working from the standard for minimum creditable coverage, a standard for an essential benefits package can be developed that would apply to subsidy-eligible individuals. This standard would include cost-sharing limits that could be based on a percentage of income. This would still allow for significant choice in product offerings and allow individuals and families to select the coverage most appropriate for their needs. If used in an essential benefits package, account-based plans like HRAs and HSAs could meet the cost-sharing requirements by a combination of the underlying health insurance plan and funds deposited into or available through the account.

Exchanges

The bill would create a national Health Insurance Exchange to purchase coverage. Individuals would be eligible to participate in the first year and employer eligibility would be phased in over five years beginning with the smallest employers. Once someone is deemed eligible to participate in the Exchange, they will remain eligible until they qualify for Medicare, regardless of their other coverage options. States would be allowed to transition their Medicaid populations to the Exchange—with appropriate supplemental wrap-around coverage—after five years. Also, states could establish their own Exchanges, provided that no more than one Exchange operates in any state. However, the new federal commissioner would retain enforcement authority and could terminate the state Exchange at any time.

The bill also requires the commissioner to establish benefit standards for Exchange plans: basic (covering 70% of expenses), enhanced (85% of expenses), premium (95% of expenses) and premium-plus (premium coverage plus additional benefits for an enumerated supplemental premium). Plans would be subject to strict cost-sharing limitations, which could limit plan innovations and designs.

NAHU has many concerns about the structure of the Exchange as proposed in this measure, chief among them that this structure would do little to reduce costs. In this type of arrangement where multiple plans from different insurers compete, there is no common pooling among plans. For example, a pool with 5,000 participants that has 500 enrollees in each of 10 different plans does not get a discount for having 5,000 participants. Even before the Massachusetts model, group purchasing arrangements like this were tried by many states, and few survived due to anti-selection issues among participating carriers and the fact that they were unable to offer a less expensive product through the grouped arrangement. That's why pools have historically not been very successful in lowering cost, although they may provide choices for individual employees in small-group plans. Of course, the cost of this choice has been more limited options than were available outside of the purchasing arrangement, resulting in most of these programs only being able to offer HMO coverage. The most successful state purchasing cooperative was operational in California for 13 years, and the costs for small businesses always exceeded what was available in the traditional private market. This pool, the Health Insurance Plan of California (HIPC), closed its doors on December 31, 2006, because it was not financially viable.

With these facts in mind, we are concerned about any expectations some may have that the Exchange is going to lower costs, and, even more important, to be sure it is not structured in such a way that it might increase costs. For this reason, we urge caution in any attempts to create a single pool of risk within the Exchange for individual and group purchasers. Our experience in states that permit self-employed individuals to be a part of their small-employer market is that small-group rates are higher in those markets. This seems an unfair burden on small employers and we hope that if both individuals and employer groups are permitted to participate in the Exchange, it will continue to be permissible to pool them separately.

We feel strongly that subsidies for lower-income individuals should be available both inside and outside the Exchange. The same holds true with any of the “national” benefit packages. National experience with purchasing pools of all kinds shows that pools that operate at the state level that also fairly compete with plans outside the pool are the least disruptive to the market and are able to provide more long-term value to consumers.

The bill requires the commissioner to establish “a mechanism whereby there is an adjustment made of the premium amounts payable” to plans to reflect differing risk profiles in a manner that minimizes adverse selection—and leaves the commissioner to determine all of the details of this mechanism.

NAHU has concerns that this system of risk adjustment may be insufficient, and feels that there should be a mechanism to cover all aspects of the market, not just the Exchange. Given the new market reforms, there will initially be two types of adverse selection that must be addressed. The first is caused by people who can enter the market with no barriers due to the new guaranteed-issue/no preexisting conditions rules. It will take time to ensure enforcement of an individual mandate, and not all people will initially enter the market before they feel the need to seek medical care. The best way to deal with this type of adverse selection would be through a system of reinsurance at the state level with some federal funding assistance. This would ensure a much more stable transition to the new system. Once all of the reforms are in place, the issue of risk adjustment among participating plans in the exchange can be readdressed to determine the best approach to long-term risk selection issues.

New Health Care Regulatory Entities

The measure provides for the creation of several new government entities to regulate the purchase of health insurance coverage, including a new government agency, the “Health Choices Administration,” governed by a commissioner who would be appointed by the president and charged with governing the Exchange, enforcing plan standards and distributing taxpayer-funded subsidies. There would also be a health insurance ombudsman appointed by the new commissioner to: receive and provides assistance with complaints, grievances and requests for information; handle disenrollment problems; provide assistance to individuals selecting plans; and give assistance to individuals with affordability credits. Finally, the bill would establish a new government health board called the “Health Benefits Advisory Committee,” chaired by the surgeon general, to make recommendations on minimum federal benefit standards and cost-sharing levels. NAHU has concerns about a creation of a new government-run entity tasked with making coverage determinations for the American people. In addition, we are unsure that this is an appropriate role for the surgeon general, who would generally have no expertise in the area of private insurance.

NAHU has concerns that the creation of these new regulatory bodies will simply waste government resources that would be better directed at subsidies and establish the role of the government as the health care gatekeeper or the controller of prices and the provider of coverage. Health care decisions will be increasingly be made in Washington, DC, and be subject to political pressures that take into account neither patient needs nor economic realities.

Government-Run Public Plan

The measure would create a government-run public plan option that would be made available to consumers purchasing coverage through the Exchange. The bill states the public plan shall comply with requirements related to other Exchange plans, and offer basic, enhanced and premium plan options. Premiums will be established according to Exchange rules. The Exchange will be initially financed by unlimited start-up funding provided by the secretary, but eventually it must be self-sustaining, including establishment of reserves. For the first five years, Medicare participating providers will be compelled to participate, but eventually the plan is to link to a newly created provider network. For up to the first three years of Exchange operations, providers will be reimbursed at Medicare levels, but then the intent is to move to a more flexible payment system.

NAHU strongly opposes the creation of government-run plans to compete with the private insurance market. The government-run public plan proposed in this measure could never compete fairly with the private market, nor would it be financially feasible in the long run. The legislation, as proposed, would give the public plan the power to dictate prices and indemnify the government-run plan for unexpected costs. This could guarantee, at least temporarily, that the government-run plan would offer insurance at below-market costs. Based on the provisions described in the discussion draft, the result would likely be over 100 million happily insured Americans displaced from the conventional marketplace.

One of our most serious concerns about the public plan proposed in this measure is its potential to further exacerbate the cost-shift that already drives up average health care spending by \$1,788 (or 10.7%) annually per family. Cost-shifting is hidden tax on private payers that occurs when government payment rates are too low and providers shift costs to the privately insured to make up the difference. A government-run plan reimbursing at the rates contemplated by the legislation would actually result in a net **\$70 billion decrease** in provider reimbursements, even after accounting for the newly insured. At least some of those costs will be shifted directly onto the backs of those already privately insured, which would be crippling to Americans struggling to obtain affordable coverage in this economy.

We also have concerns about what kind of coverage the public plan would be able to offer to Americans. Existing public plans also provide less coverage and restrict provider access more than the average employer-sponsored plan. The Congressional Budget Office estimated that the benefit package for Medicare is 15% below the average employer-sponsored plan. Under Medicaid, specialists are often inaccessible without long waits. Under a new government-run plan, Americans will find it more and more difficult to make appointments with physicians and other health care providers. This is because lower payments will make it increasingly unaffordable for providers to see patients—particularly the increasing number of patients with public coverage.

Private insurers must combat fraud or go out of business. Indeed, these payers have every incentive to invest in antifraud personnel and strategies down to the point where return and investment are equal. But anyone who thinks that a public plan could serve as a "yardstick" for the private sector needs to consider Medicare's dismal record with regard to fraud, waste and other abuse.

Private administrative costs cover important services like disease-management programs and research to determine which interventions actually work. It is ironic that the same advocates who frequently cite the need for the government to spend billions in taxpayer dollars to improve health outcomes are the same who decry the high administrative costs in health care plans.

NAHU feels that the government-run public plan proposed in this measure would exacerbate the worst elements of the current system: gross inefficiency, high costs and bureaucracy. NAHU believes that a far better use of federal efforts and monies would be helping lower-income Americans afford the cost of private coverage.

Subsidies

The legislation creates a complicated system of sliding scale tax credits for people purchasing coverage through the Exchange with incomes between 100% and 400% of the Federal Poverty Level (FPL).

NAHU has serious concerns about limiting the use of the credit to products purchased through the Exchange. The credits should apply regardless of the place of purchase; otherwise, the result will be an unlevel playing field of some kind. If subsidies are available only inside the Exchange, “crowd out” from existing private plan coverage will be dramatic and could destabilize the market. Subsidies only available in the Exchange can also result in higher-than-expected costs for those in the Exchange and an apparent larger number of uninsured than actually exist.

Past market-reform experience clearly shows that whenever an unlevel playing field is created through a financial incentive or other means, one of the coverage options is always selected against, which ultimately harms the viability of all coverage options in the market. By allowing for an unlevel playing field between the Exchange and the rest of the private market, we are concerned that these options set the stage for long-term market failure.

NAHU also objects to subsidies for families earning up to 400% of the FPL, which, for a family of four, would be \$88,200. We believe that this is far too great of an expansion of government assistance, particularly considering the current state of the federal budget deficit.

Similarly, we have concerns about the provisions that would expand Medicaid to 133% of the FPL. The current Medicaid program is financially unsustainable, particularly considering that the cost of this expansion would be borne solely by the federal government and will further contribute to the soaring federal budget deficit. NAHU believes that any expansion of this program should be limited to the truly needy—no more than 100% of the FPL. Furthermore, to reduce the crowd-out of the private market that could occur with a Medicaid expansion, NAHU supports mandatory premium assistance when private coverage is available.

Individual Mandate

The legislation creates an individual mandate to maintain acceptable coverage with a federal income tax penalty equal to two percent of the excess of the taxpayer’s adjusted gross income over the threshold amount. The tax shall not exceed the applicable national average premium for individual or family coverage pro-rated for partial year failures. Acceptable coverage includes QHBPs, a grandfathered plan, Medicare, Medicaid, TRICARE and VA coverage. Anyone providing acceptable coverage to individuals must provide them with annual documentation of coverage, and regulations will be promulgated relative to hardship waivers and waivers for people with minimal lapses in coverage.

NAHU supports the concept of individual responsibility in health coverage reform and believes that, in order to achieve universal coverage and ensure that market reforms are successful, an enforceable and effective individual mandate to obtain health insurance coverage is necessary. For individuals with incomes of under \$100,000, the cost of complying with the mandate would be under \$2,000, which is far less than the cost obtaining health insurance coverage. Clearly, this raises questions as to how effective the mandate, as proposed, will be. To improve this mandate’s chance of success, we believe the federal reporting by individuals and insurers should be accompanied by measures at the state level, including enforcement through schools and drivers license bureaus, late enrollment penalties, and auto-enrollment and requirement of proof of coverage through employers.

Employer Mandate

The discussion draft stipulates that all employers must offer coverage through either QHBPs or a grandfathered plan as permitted. Employers would be required to pay 72.5% of acceptable coverage for individuals and 65% for family coverage, and part-time employees must be covered on a pro-rata basis based on average hours worked. In lieu of paying for coverage, the measure creates a “pay or play” option allowing the employer to pay instead eight percent of wages to the commissioner. After five years, if an employee declines the traditional employer-sponsored coverage and obtains coverage in the Exchange, the employer will be required to make a contribution

on behalf of the employee to the Exchange, even though the employer still has to bear the costs of maintaining its employer-sponsored plan for other employees. Not only will this be a double tax on employers, but it will make traditional employer plans more expensive by undermining employer risk pools. The result will be many employers being left with older and sicker individuals in their traditional plans, while paying taxes on other individuals to finance the Exchange.

Employers that fail to substantially comply with health coverage requirements can face an employment tax or an excise tax and/or civil penalties. The bill notes that small businesses would be exempt from the payroll tax, but provides no details as to the size and scope of this exemption.

Although NAHU is a strong proponent of employer-sponsored coverage, we believe that the employer-based system must continue to be voluntary. A mandate to force employers to provide health insurance to their employees, while well-intentioned, could actually hurt American workers and health insurance coverage. A mandate of this magnitude would substantially decrease jobs and economic growth, and undermine the existing private market. A mandate would have a negative impact on wages and job creation, and discourage production – often in firms with the most vulnerable employees and employers. Recent NFIB research data shows an employer mandate would cause the already shaky economy to lose 1.6 million more jobs.

Employers that can afford to sponsor health insurance typically provide generous benefits – and most large employers do. Employers that cannot currently afford to offer health insurance benefits will not be able to do so simply because they are mandated to do so. Small employers, seasonal employers and businesses that operate on very small profit margins will still be unable to afford to provide benefits. The Massachusetts employer mandate failed to have a meaningful effect on the uninsured, and actually exempted most of the businesses that did not offer insurance – but it was disruptive to existing plans. In fact, reliance on that employer mandate has, in part, contributed to serious funding problems in the Massachusetts plan, because more employers “played” with insurance offerings rather than “paid” the penalty to the state (an occurrence the Massachusetts budgeting experts got wrong).

NAHU believes that the employer-based system must be at the core of any health reform effort. However, we believe that the provision of benefits must be a voluntary action on the part of the employer. We are opposed to the employer mandate provisions in the discussion draft as they would suppress job availability, suppress wages and impose a crippling economic burden on our nation’s employers, which is unacceptable, particularly considering the current economic climate.

Medicare Advantage

This legislation would reduce Medicare Advantage payment benchmarks to traditional Medicare fee-for-service levels over a three-year period. NAHU believes the significant funding reductions proposed in this measure would jeopardize the health security of more than 10 million seniors enrolled in Medicare Advantage and would turn back the clock on innovative payment incentives to improve the quality of care that patients receive. Seniors enrolled in Medicare Advantage should not be forced to shoulder the costs to reform the health care system. Also, these funding changes to Medicare Advantage, which could jeopardize the future of the program, fly in the face of the pledge that if Americans like the coverage they have, they will be able to keep it under health reform. The 10 million seniors enrolled in Medicare Advantage plans should be able to keep their current coverage without change if they wish too.

Conclusion

The United States health care system works for the vast majority of its citizens, yet we can do better. Improvement will require strong leadership, a thorough debate of all proposals and, ultimately, difficult compromises and decisions. All stakeholders will feel some pain in order to achieve a universal gain. NAHU

agrees that the status quo is no longer acceptable, and we pledge full participation in meaningful reforms as this legislation moves forward.

Ultimately, we believe the time is right for a solution that controls medical care spending and guarantees access to affordable coverage for all Americans. We believe this can be accomplished in an affordable manner without limiting people's ability to choose the health plan that best fits their needs and without creating expensive and unneeded new government bureaucracies. We look forward to working with the Committee and all interested parties in achieving our common goal: a world-class and affordable health care system for all Americans.

For questions following the hearing, please contact me at either (703) 276-3800 or jtrautwein@nahu.org, or contact Jessica Waltman, senior vice president of government affairs, at jwaltman@nahu.org or (703) 276-3817.