



NAHU's Federal Legislative Priorities for 2009

As the members of the 111th Congress debate comprehensive health care reform, NAHU feels the following issues are critical for their consideration:

Containing Health Care Costs and Improving Quality

By far, the greatest access barrier to health insurance coverage in America today is cost. NAHU believes that any successful comprehensive health reform plan will need to address the true underlying problem with our existing system: the cost of medical care. Constraining skyrocketing medical costs is the most critical—and vexing—aspect of health care reform. The cost of health care delivery is the key driver in rising health insurance premiums and it is putting the cost of health insurance coverage beyond the reach of many Americans.

NAHU knows how much the cost of health insurance coverage is impacting our nation's employers and economic growth, and we know that health insurance is expensive because of the high cost of health care. As such, we are supportive of federal action in a number of areas that would not only help contain health care costs but also improve the quality of care for all Americans.

Unhealthy behavior and lifestyle choices are two key factors in the increased cost of health care. Behavior is the most significant determinant of health status, with as much as 50 percent of health care costs attributable to individual behaviors such as smoking, alcohol abuse and obesity. We would like to see the federal government incorporate wellness and disease-management programs into the Federal Employees Health Benefit Program, Medicaid, Medicare, SCHIP and the Veterans Health System.

Furthermore, we are very supportive of federal action to encourage employers to adopt wellness programs so that employees and their families are incented to adopt healthier lifestyles. In particular, we would like to see the creation of tax incentives to businesses that provide opportunities for their employees to lead healthier lives and prevent chronic illnesses through wellness programs.

To further reduce costs, we support federal incentives for doctors and medical facilities to improve system efficiencies and eliminate errors with pay for performance, best-practice guidelines and support for evidence-based medicine, including comparative effectiveness research. There is widespread agreement among health experts that much of the health care delivered in America today lacks a basis in evidence. The end result is that patients may well be paying more for sub-optimal care.

Efforts to bolster the nation's reservoir of objective information on best medical practices and protocols through comparative effectiveness research is important to improving health care quality and improving the affordability of coverage. It can help better inform and educate providers and patients and produce better health outcomes. How we use comparative effectiveness research data in the private sector and in government for coverage decisions is an important issue, but in seeking needed improvements to health care quality, at some rudimentary level, we need to be able to distinguish the Advil from the aspirin or the MRI from the less-expensive X-ray if they are producing similar-quality outcomes.

Transparency of medical costs is another cost-reduction issue that is critical. We believe that the advent of a more consumer-directed approach to health insurance coverage is essential to reducing overall health care costs as it will help curb excessive utilization and claims, and drive down costs by increasing competition among providers. However, to be fully successful, American consumers need to be fully aware of the cost of the health care that they are purchasing. Since the vast majority of American health care expenses are paid by a third party through the administration of health insurance claims, most Americans have no idea what the health care that they receive costs, and they have been conditioned not to even ask. As a result, the ability for consumers to compare costs and quality when making decisions as to which providers to use and which health care services to select has been virtually eliminated.

NAHU strongly encourages health insurance carriers, hospitals, physicians and other providers to voluntarily disclose the prices they pay and charge for care to all consumers. However, because we believe increased medical transparency for health insurance consumers is so critical to reducing costs and promoting consumer-directed care, we support legislative and regulatory efforts at the state and federal levels to require increased transparency should voluntary efforts fail, provided that such governmental efforts are not overly burdensome. Encouraging the expansion of consumer-directed health insurance products, such as Health Savings Accounts, Health Reimbursement Arrangements and Flexible Spending Accounts, will also help reduce the over-utilization of health care services.

Ensuring Access to Health Insurance Coverage

NAHU believes that Americans deserve to see what can be done at the federal level to provide better access to health coverage for everyone who needs it, without taking away the ability of states to innovate in ways that are appropriate for their own citizens. Also, great care needs to be taken when implementing market reforms on a national level so that coverage is affordable. No matter how "fair" a market-reform idea might seem on its surface, it's not at all "fair" if it also prices people out of the marketplace.

The segment of the health insurance marketplace that NAHU believes has the most serious access issues is the individual health insurance market. Since each state's individual market is uniquely regulated, consumers in some states are faring better than in others, but no state's individual health insurance market is problem-free. NAHU has

developed 10 specific policy recommendations to ensure that all people, regardless of their health status and pre-existing medical conditions, have the ability to purchase affordable private individual coverage. Such requirements could either be enacted as part of a transition process to complete guaranteed issuance of coverage or they could be stand-alone requirements. Our recommendations are to:

- Require guaranteed access to individual coverage and create state-level financial backstops for catastrophic risks to keep coverage affordable.
- Give pre-existing condition credit for prior individual market coverage to ensure true health insurance portability.
- Standardize state requirements regarding the consideration of pre-existing conditions.
- Improve federal group-to-individual coverage portability provisions so that people can transition directly from employer coverage to individual coverage without hurdles.
- Stabilize individual market rates by requiring more standardization as to how individual market carriers determine pricing.
- Increase consumer protections regarding individual market coverage rescissions.
- Make it easier for employers to help people purchase individual health insurance.
- Provide federal financial assistance to keep individual health insurance coverage affordable, including enhanced deductibility, subsidies for low-income individuals and federal financial support for qualified state financial backstop programs.
- Ensure that all Americans have health insurance coverage.
- Allow state implementation of enhanced consumer protections with a federal fallback enforcement mechanism.

National Health Insurance Connector and Pooling of Risk

In 2006, Massachusetts policymakers enacted a far-reaching health reform plan, creating what is known as the Massachusetts health insurance “connector,” along with other reforms. Now many policymakers are exploring whether a national connector, or exchange, concept is an effective means of reducing the number of uninsured Americans.

NAHU has thoroughly evaluated the policy ideas behind health insurance connector and Exchange proposals, and our examination has yielded serious concerns for a number of key reasons. Many proposed connectors or exchanges are just a variation of a purchasing cooperative. Historically, the creation of health insurance purchasing cooperatives has not resulted in the reduction of costs or improved access to coverage. The California Health Insurance Purchasing Cooperative (HIPC), our nation’s largest group health insurance purchasing pool experiment, lasted for more than 10 years before closing its doors in 2006 when the three final health insurance carriers participating in the program pulled out due to financial losses.

There are several reasons why large-scale health insurance purchasing cooperatives have failed, including adverse selection (the “death spiral”) and an inability to reduce administrative costs. Purchasing cooperatives are generally unstable, with groups and

individuals transitioning in and out of them at a much faster rate than, for example, a comparably sized large-employer group. Voluntary pools also suffer from adverse selection, because the groups and individuals most likely to seek coverage through these pools are those who could not obtain coverage cheaper or elsewhere

Purchasing cooperatives also have failed to yield significantly lower administrative costs for employers, employees and insurers, and the same will likely hold true for an Exchange. The Massachusetts connector's administrative budget is approximately \$40 million this year, just to oversee the program and independent of other costs borne by the insurer and beneficiary.

Depending on an exchange's potential structure, there may be conflicts with a number of federal laws, including ERISA, COBRA and HIPAA. Many exchange proposals would require participating employers to create Section 125 cafeteria plans, and mandate coverage of certain benefits and employer contributions. This could trigger potential ERISA challenges.

Potential conflicts with HIPAA and COBRA also exist. In Massachusetts, all policies sold through the connector are individual policies even if they are offered through an employer. This raises important COBRA and HIPAA questions for employees of companies that previously offered traditional group health insurance coverage but are now offering such coverage through a connector:

- Do employees forfeit their COBRA rights?
- If not, when is COBRA eligibility triggered – upon termination of employment or at the time of the employer group enrollment in the connector individual policy?
- When would group-to-individual portability guaranteed-issue rights under HIPAA be triggered?

HIPAA group health provisions also appear to be problematic for connector proposals. HIPAA requires that health plans that involve an employer must comply with all of the group health insurance protections the law mandates. Connector plans sold through employer groups would seem to clearly fall under the category of employer involvement, particularly if employer contributions or the creation of a Section 125 plan were involved. Therefore, connector policies would have to be compliant with all of the HIPAA group health insurance protections even if they were technically individual policies. These requirements include mandatory guaranteed issue, limitations on preexisting condition look-back and exclusionary periods, and non-discrimination rules. The private health insurance market in Massachusetts has always been regulated very heavily and already required individual policies to meet most of these requirements prior to the creation of the connector. As such, a connector and associated market reforms have been much less disruptive in Massachusetts than they would be in virtually any other state.

What service would an exchange provide, and why should we replace services currently being provided by the private health insurance market with a government entity? Individual health insurance products are readily available for private sale through

licensed professionals and insurance carriers in all 50 states. They are sold through the Internet, over the phone and in person. Licensed agents answer questions, provide advice and options, resolve claims issues and help millions of American consumers navigate often confusing health care bureaucracies.

Furthermore, we feel that great emphasis should be placed on the economic impact of an exchange, including the possible unsustainable costs of public program growth and the effect that the potential loss of insurance-related jobs could have on the economy. Finally, an exchange would do nothing to address the rapidly rising costs of providing medical care in this country, which is the true source of high health insurance premiums.

Public Plan Option

Many proponents of a national connector also support the creation of a public health insurance program to be offered alongside private plans. A top concern about a public program buy-in option that competes with the private insurance market is the potential for an unlevel playing field between the two coverage options. Even if extreme care was taken to ensure that factors like subsidies, rating and issuance requirements were the same relative to the public and private plan options, because the public plans reimburse providers at lower rates and account for other administrative costs differently, the playing field would never truly be level. Over time, it is a fundamental insurance principle that this will lead to adverse selection and long-term market damage.

Another concern is that state-level experiments with public program buy-ins have not been particularly successful. States allowing for SCHIP buy-ins are only seeing an eight- to 11-percent take-up rate, perhaps because unsubsidized premiums are very high to pay for state-mandated rich benefit packages. In addition, states with such programs are reporting adverse selection against the public plan.

Another significant factor relative to the creation of a public plan option is the indirect costs that privately insured people will bear due to its existence. Existing public programs like Medicare and Medicaid pay providers a reduced rate as a financing mechanism. There is a great deal of evidence to show that providers then shift these costs onto private payers. Any expansion of a public program or buy-in plan would only increase the amount of cost being shifted to the privately insured. Cost-shifting occurs when providers and hospitals charge privately insured individuals more to make up for the lower reimbursement rates they receive for taking care of Medicare, Medicaid and SCHIP beneficiaries. A recent national actuarial study released by America's Health Insurance Plans, the Blue Cross Blue Shield Association, Premera and the American Hospital Association found that annual health care spending for an average family of four is \$1,788 higher than it would be if Medicare, Medicaid and private employers paid hospitals and physicians similar rates, with total provider reimbursement unchanged.

Mandates to Purchase Coverage

Two other market-reform ideas that are routinely discussed are government mandates that all individuals and/or employers purchase coverage. NAHU has historically approached

the idea of an individual mandate to obtain health insurance coverage with great caution. Similar mandates for auto insurance coverage have failed to reduce the number of uninsured motorists. Subsidies, as well as benefit standards and enforcement mechanisms, would need to be created to fairly implement such a mandate. However, if such barriers could be overcome, enough people would be covered to mitigate the problem of adverse selection and its resulting cost consequences.

If the federal government were to require an individual mandate to obtain coverage, NAHU feels that it must be structured appropriately. The following elements are crucial to an effective and enforceable individual mandate:

- While the mandate may well need to be phased in over time, starting with perhaps select populations like children age 25 and under, ultimately it must apply to all populations equally.
- An individual mandate must be accompanied by a national qualified guaranteed access mechanism with a financial backstop so that all individuals have cost-effective private health coverage options available to them. This is especially critical during the transition period, when the mandate is being put into place and the entire population is not yet insured.
- An individual mandate should not be accompanied by overly rigid coverage standards that would make coverage unaffordable and inhibit private plan design innovations.
- Subsidies in the form of direct private coverage premium assistance or refundable advanceable tax credits for the purchase of private coverage must be made available to low-income consumers.
- An effective coverage verification system must be created with multiple points of verification.
- An effective enforcement mechanism would need to be implemented with multiple enforcement points and effective penalties for noncompliance.
- Each state must be responsible for enforcement of the mandate for its own population. The United States is too large and diverse a country for such a mandate to work otherwise.

With regard to a mandate that employers provide their workers and dependents with coverage, instead of our current voluntary system, NAHU has grave concerns. We believe that a mandate compelling employers to provide health insurance will actually do more to hurt American workers than it will to help them. Numerous studies have indicated that an employer mandate for health care expenditures will have a negative impact on wages, job creation and general economic growth.

No matter what form an employer mandate takes, it always has the potential to harm American businesses and employees. Legislation specifically targeting our nation's largest companies may change its scope to encompass smaller employers, impacting their ability to stay in business in the future. Measures that would force an employer to spend certain dollar amounts or percentages of their payroll on health care costs merely provide a disincentive for responsible spending and health insurance rate containment.

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The ability to offer, or to not offer, health insurance coverage and other employee benefits helps our nation's businesses attract the best workers, motivate and reward their existing employees, and compete with one another. Legislation that would make health insurance coverage an employment right rather than an employee benefit would hinder business-to-business competition, thereby driving up prices and driving down the quality of services and products for all Americans. With the current state of the global economy, an employer mandate is a health insurance reform idea we simply can't afford!

Long-Term Care

Many leaders in Congress have expressed interest in including long-term care reform provisions in a more comprehensive health reform effort. NAHU has long sought legislation to include long-term care insurance premiums in Section 125 plans to encourage group long-term care insurance sales. Long-term care insurance premiums are between 20 and 30 percent less in the group market, and these products are also fully portable. Plus, buying private coverage guarantees consumers the greatest possible degree of choice when it comes to their long-term care needs. Finally, if more individuals were able to privately finance their long-term care needs, the cost savings to both the federal government and the states in reduced Medicaid expenditures would be enormous, as Medicaid is currently the primary payer of American long-term care costs.

Preserving Private Medicare Choices

When looking for funding options for broad-scale health care reform, funding for the private Medicare Advantage program is frequently brought up as a pay-for. NAHU does not feel that funding for other health care reforms should come at the expense of private Medicare coverage options. Medicare private plans may not be the right choice for every senior, but there are millions Medicare beneficiaries who are very happily insured under these plans. They often provide vision, dental and prescription drug benefits that might not otherwise be available to them. It is not surprising that many seniors on a fixed income with no supplemental coverage find these plans particularly attractive, and sales have increased recently. It is critical that all Americans, including Medicare beneficiaries, have a wide range of health plan choices available to them.

It is just as important that Americans have access to a licensed and ethical health insurance professional who can help them pick the policy that best suits their needs. The way that we can make sure that all producers selling Medicare-related products are able to advise their clients in the most ethical manner is through education. It is critical that anyone selling any type of Medicare product – be it Medicare Advantage, Part D or a Medigap plan – be thoroughly trained.