Statement for the

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Hearing on Health Care Reform Legislative Options

Submitted by

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Executive Summary

The National Association of Health Underwriters 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.

There are a number of desirable improvements to our health care delivery system that are included in *The Affordable Health Choices Act,* however other proposals should be considered further, as our experience reveals they could pose unforeseen and unintended problems in health insurance marketplaces.

Our first concern is the rating reforms that have been proposed. NAHU believes that these should only apply to individual health insurance products and fully-insured small group plans of 2-50 lives. The rating rules need to allow variations for applicant age at the natural age breakdown rate of at least five to one with additional variations allowed for participation in wellness programs, smoking status and geography. We also specifically request that groups over 50 be permitted to use claims experience. This is different than prospective health status rating and is the way all large groups develop premiums today. 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 that 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.

NAHU is unclear on the purpose health insurance navigators will serve and feels that their functionality is duplicative of some of the role licensed agents and brokers already serve in the marketplace. Many services provided by agents and brokers would never be able to be assumed by a navigator because they lack the expertise to perform those functions. NAHU questions the wisdom of entrusting organizations with no prior health insurance background with the authority to advise individuals on their insurance decisions. It is doubtful that community organizations with no relevant health care background can deliver the policy knowledge, service, value, and accountability that distinguishes the professionally licensed and trained agent, broker, and benefit specialist. If a state feels the need to establish navigators as part of its *Gateway*, then NAHU feels that such navigators should be subject to the same rigorous licensing and continuing education requirements that

licensed agents and brokers are required to abide by. Concerning the proposed *Gateways*, any subsidies or other insurance requirements should mirror to the largest extent possible existing state laws and regulations. This is discussed further in our primary testimony.

NAHU has significant concerns about the creation of a government-run public health insurance plan and the likely corrosive consequences it would have on private insurance markets because a "level playing field" cannot be established or maintained. Would a government plan comply with the many requirements placed on private plans, such as state licensure, capital requirements, financial solvency, provider network adequacy standards, rate approval, and federal and state taxes and assessments, just to name a few?

The idea of an enforceable and effective individual responsibility requirement for all Americans to purchase health insurance could help with adverse selection issues which exist in our current system and we support this concept. A mandate to force employers to provide health insurance to their employees is another matter. While well intentioned, this could actually hurt American workers and health insurance coverage levels. It would decrease jobs and economic growth and do little to address the current uninsured population compared to other initiatives.

Our full testimony follows.

As an association representing more than 100,000 health insurance agents, brokers and benefit specialists from every state in the country, the members of the National Association of Health Underwriters (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 proposed *American Health Choices Act* and has the following questions, comments and concerns.

There are a number of desirable improvements to our health care delivery system that are included in *The Affordable Health Choice Act*, such as promoting health prevention initiative, enhancing nutrition labeling, increasing our health care workforce, setting up more mechanisms to combat health care fraud and abuse, and providing for the development of follow-on or generic biologics.

Proposed Market Reforms

The legislation creates significant market reforms to both the individual and group insurance markets. It would require all health plans, whether fully insured or self-funded, to accept enrollees regardless of health status, and would eliminate the use of pre-existing conditions exclusions and annual or lifetime limits on benefits. For all fully insured plans, regardless of size, it would impose strict modified community rating standards consisting of variances only by family structure, community rating area (defined by the HHS Secretary based on the recommendation of the NAIC), actuarial value of the benefit and age bands that would limit premium differences for the oldest insured individuals to differ from the youngest insureds by a ratio of 2 to1. No premium variations would be permitted for health status, gender, class of business, claims experience or any other factor not specifically described in the legislation.

NAHU has very significant concerns about the proposed reforms, particularly that there is 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. It also would create adverse selection to the fully insured market, as the larger groups that chose to fully insure 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. The first step should be a uniform application for coverage. A clear and understandable uniform application would ensure full

disclosure of accurate and consistent information, and it would make the process easier for consumers applying for coverage with several different insurance carriers.

The second issue is that the rating reforms proposed should only apply to individual health insurance products and fully-insured small group plans of 2-50 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.

Finally, we specifically request that groups over 50 be permitted to use claims experience. This is different than prospective health status rating and is the way all large groups develop premiums today. 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.

We are pleased that the 250 employer size limitation on self-funding was removed from the bill and we hope that change is permanent. The decision whether or not to self-fund or partially self-fund an employer group plan is based on many financial and other factors, group size being only one of them. A financial business decision of this magnitude should be left to the individual discretion of the employer, and should not be subject to an arbitrary cap imposed by the federal government.

We do urge caution in eliminating annual limits on benefits. This could be a problem for services that have appropriate durational limits. It would be important if this is done to have a strong provision to allow limits based on medical necessity to avoid overuse of some services. We feel similarly about the elimination of lifetime caps. 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 they would exceed lifetime caps might not better serve the affordability goals we share for all consumers.

In a similar vein, we would advise that a different mechanism be used than the risk adjustment system proposed. Especially during the time that market reforms are being put into place and the individual mandate is being enforced, a better system would be 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 can be readdressed to determine the best approach to long term risk selection issues.

Minimum Loss Ratios

For all fully insured health plans the legislation specifies minimum loss ratios. The measure requires insurers to track reimbursements for clinical services, activities that improve health care quality and all other non-claims costs. The Secretary will determine what ratios are appropriate for the individual and group markets. If non claims costs cannot exceed those percentages, 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 Price Waterhouse Coopers study found that health plan administrative costs were not a factor contributing to health care cost increases, 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.

Gateways

This provision requires each state to establish a variation of a health insurance connector or exchange which is termed a *Gateway*. If a state does not establish a *Gateway* within four years, the Secretary must establish one for them. The *Gateways* will use risk adjustment mechanisms to remove incentives for plans to avoid offering coverage to those with serious health needs. The stated purpose of the *Gateway* is to facilitate the purchase of health insurance coverage and related insurance products at an affordable price by qualified individuals and qualified employer groups (including self-employed individuals). The legislation specifically allows for group and individual private market coverage to exist outside of the *Gateway*. If individuals like their current coverage, they can keep it. State insurance regulators will perform their traditional obligations regarding consumer protection and market conduct.

NAHU believes that if *Gateways* are part of greater health reform, it is critical that they be structured in such a way that does not damage or eliminate the traditional private insurance marketplace. While we appreciate the state-level approach concerning the structure of the Gateways, NAHU is concerned that this measure may still result in the creation of multiple state-level bricks-and-mortar institutions. This approach has proven costly in Massachusetts and is duplicative of existing private-market functions.

It is important to keep in mind that a *Gateway* would not truly pool the risk of all participants. The structure of a *Gateway* would be more as an aggregator of plans. 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 a *Gateway* is going to lower cost, and even more important, to be sure it is not structured in such a way that it might increase cost. For this reason, we have grave concerns about attempting to create a single pool of risk within the Gateways 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 small groups are permitted to participate in *Gateways* it will continue to be permissible to pool them separately.

We feel strongly that *Gateway* subsidies and other requirements should mirror state laws outside the *Gateways*, otherwise adverse selection will be rampant. 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.

Navigators

The legislation allows states to enter into contracts with "navigators" and provides them with federal support to do so. Health coverage navigators could be private and public entities that could assist employers, workers, and self-employed individuals seeking to obtain quality and affordable coverage through Gateways. Entities eligible to become navigators could include trade, industry and professional organizations, unions and chambers of commerce, small business development centers, and others. The navigators will conduct public education activities, distribute information about enrollment and premium credits, and provide enrollment assistance. Health insurers or parties that receive financial support from insurers to assist with enrollment are ineligible to serve as navigators.

NAHU is troubled by a number of aspects of these recommendations. Many of the roles described for navigators are already performed by licensed agents and brokers in every state. We know that the services of agents and brokers will be needed more than ever in a *Gateway*, and that they will continue to be needed to serve as counselors and advocates for the American consumer. Since agents and brokers are clearly an integral part of the health insurance market regardless of the setting, and are already performing these services as a normal course of business, we question the wisdom of spending precious financial resources on a new system such as the navigators described in the bill.

Licensed specialists design benefit plans, explain coordination issues of public and private benefits to individuals/employees, and solve problems that may occur once coverage is in place. They are also at the forefront of helping to design and implement cutting-edge health promotion and wellness programs for employers—a focus that everyone agrees is key to combating increasing health care costs.

Agents and brokers are subject to rigorous licensing and continuing education requirements and serve a proud and important role as advocates for their clients. They perform extensive needs analyses for their clients, and help them gain coverage matched to their unique needs. After coverage is placed, they provide extensive assistance to ensure that claims are paid on a timely basis, that questions are answered, and that their clients' specific needs are met.

NAHU is unclear on the purpose of health insurance navigators will serve and feels that their functionality is duplicative of some of the role licensed agents and brokers already serve in the marketplace. And many services provided by agents and brokers would never be able to be assumed by a navigator because they lack the expertise to perform those functions. If a state feels the need to establish navigators as part of its *Gateway*,

then NAHU feels that such navigators should be subject to the same rigorous licensing and continuing education requirements that licensed agents and brokers are required to abide by. In addition, NAHU feels that navigators if used should be limited to entities with prior experience in this area such as the SHIPs that provide seniors with assistance relative to the Medicare program.

Medical Advisory Council

The measure provides for the creation of a Medical Advisory Council by the Secretary of HHS, in consultation with NIH, CDC and others for the purpose of making recommendations on: (1) the schedule of items and services that constitute the essential health care benefits eligible for credits including the amount, duration, and scope of such items and services; (2) the coverage that should be considered minimum qualifying coverage and (3) the conditions under which coverage shall be considered affordable and available coverage for individuals and families at different income levels.

Although we are supportive of new research that could be done to gather more information about best practices and better information on the efficacy of different treatments, 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 NIH and CDC, as they have no expertise in the area of private insurance.

Concerning the standard for minimum creditable coverage, we believe the goal should be one of ensuring that basic appropriate services are available. The standard should merely list those services, rather than the quantity of those services to preserve plan, employer and individual consumer flexibility. Just as an example, the standard should require inpatient and outpatient hospital services, physician services, lab and x-ray, and prescription drugs. The quickest implementation standard would be to use an existing definition, like the definition for HIPAA creditable coverage. Using this standard would ensure comprehensive coverage 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.

Government-Run Public Plan

The legislation leaves the structure of a public plan option to be determined. The initial draft of the legislation included a public plan option to be known as *Affordable Access* to be sold through the *Gateway*. If a provider accepts Medicare it must accept as payment in full the amount of the payment from an Affordable Access plan and the Affordable Access plans will pay Medicare rates plus 10%. The measure specifies that Affordable Access premiums must be an amount that will cover the costs of the plan.

NAHU strongly opposes the creation of government-run plans to compete with the private insurance market. A government-run public plan could never compete fairly with the private market, nor would it be financially feasible in the long-run. The legislation, as proposed, would likely displace tens of millions of happily insured Americans from the conventional marketplace and 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.

Individual Subsidies

The legislation creates a complicated system of sliding scale subsides for people purchasing coverage through the Gateway with incomes between 100-500% of the federal poverty level (FPL).

NAHU has serious concerns about limiting the use of the credit to products purchased through the *Gateway*. The credit 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 *Gateway*, "crowd out" from existing private plan coverage will be dramatic and could destabilize the market. Subsidies only available in the *Gateway* can also result in higher-than-expected costs for those in the *Gateway* 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 *Gateway* 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 500 percent of the Federal Poverty Line (FPL), which for a family of four would be $110,000. 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 also have concerns about the provisions that also would expand Medicaid to 150% of the FPL when the current Medicaid program is financially unsustainable, particularly for the individual states. NAHU believes that any expansion of this program should be limited to the truly needy—no more than 100% of the FPL. Furthermore, to prevent 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 for coverage with a federal income tax penalty on any individual who does not have in effect qualifying coverage for any month during the year. Health plans must provide a return to individuals as documentation of coverage.

Exemptions will also be made for individuals for whom affordable health care coverage is not available or for those for whom purchasing coverage creates an exceptional financial hardship. The Secretary of the Treasury in consultation with DHHS will determine the minimum penalty needed to accomplish the goal of substantially increasing coverage. The mandate is not applicable in states where Gateways are not yet operating.

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.

Concerning the consequences of non-coverage, NAHU believes these penalties may not be sufficient to ensure adequate compliance. An individual mandate needs to be both effective and enforceable to make other market-reform ideas work. 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 measure establishes definitions for an employer mandate or some other form of shared employer responsibility but leaves the policy details of this section to be determined. There is an exemption for employers in Hawaii.

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 an employer mandate as it would impact job availability, suppress wages and could result in some employers actually contributing a lower percentage of the premium for their employees' coverage than they had in the past.

Health IT

NAHU supports the measures efforts to extend health IT financial incentives to a broader range of providers as we feel that increased utilization of health IT will help reduce health care expenses and lead to higher-quality care for American consumers by reducing errors and improving patient satisfaction. In addition, we support the

specification that interoperable technology be used, so that all record systems and providers are able to communicate with one another and individual health records are always up to date and complete.

Long-Term Care/Disability Program

The bill creates a new national insurance program to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities. Financed through voluntary payroll deductions (with opt-out enrollment similar to Medicare Part B), this program will provide a cash benefit to individuals unable to perform two or more functional activities of daily living.

To promote the purchase of private long-term care insurance, the bill allows LTC insurance premiums to be included in section 125 plans.

NAHU believes the cost of providing long-term care to our aging population is one of the greatest burdens on our national medical safety-net. But rather than the creation of a large-scale government program, NAHU would prefer to see Congress enact some simple reforms and tax incentives to make it easier for people to purchase private long-term care insurance and ease the strain of providing long-term care coverage on the Medicaid system. In addition to the inclusion of LTC insurance premiums in section 125 plans, NAHU also believes that Congress should allow a tax deduction from gross income for long-term care insurance premiums and include long-term care insurance in flexible spending arrangements.

We appreciate the opportunity to provide comments and look forward to any questions you may have.

For questions following the hearing, please contact me at (703) 276-3800, jtrautwein@nahu.org, or contact Jessica Waltman, Senior Vice President of Government Affairs, jwaltman@nahu.org, (703) 276-3817.