Statement for the

United States Senate
Committee on Health, Education, Labor and Pensions

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Addressing Insurance Market Reform in National Health Reform

Submitted by

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Executive Summary

The National Association of Health Underwriters (NAHU), a professional trade association representing more than 20,000 health insurance agents, brokers and benefit specialists nationally, whose members help individuals and businesses purchase private health insurance coverage on a daily basis, feels that we must keep private individual health insurance coverage accessible and affordable for all Americans. Although we strongly feel that any health reform effort should be centered on employer-sponsored plans, it is critical that we look first at the individual market to be certain that it functions effectively and affordably for those who purchase coverage there. 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.

Americans deserve to see what can be done at the federal level to provide better access to individual coverage for everyone who needs it, and great care needs to be taken when implementing these 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.

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. It should be noted that some of these requirements may need to be present only during a transition process to complete guaranteed issuance of coverage. However, they still are quite important to achieving the affordability of coverage so crucial to getting everyone in the system. Our proposed 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:

1. Require guaranteed access to individual coverage and with state-level financial backstops for catastrophic risks.
2. Give pre-existing condition credit for prior individual market coverage to ensure true heath insurance portability from one individual market policy to another.
3. Standardize state requirements regarding the consideration of pre-existing conditions.
4. Improve federal group-to-individual coverage portability provisions so that people can transition directly from employer coverage to individual coverage without hurdles.
5. Stabilize individual market rates by requiring more standardization as to how individual market carriers determine pricing.
6. Increase consumer protections regarding individual market coverage rescissions.
7. Make it easier for employers to help people purchase individual health insurance.
8. 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.
9. Ensure that all Americans have health insurance coverage.
10. Allow state implementation of enhanced consumer protections with a federal fallback enforcement mechanism.

NAHU urges Congress to carefully consider these ideas and we look forward to working with policymakers to fill the gaps in our nation's coverage system and to make private individual health insurance coverage more affordable and accessible for all Americans.

NAHU's Solutions to Create Accessible and Affordable Individual Health Insurance Coverage Nationwide

The National Association of Health Underwriters (NAHU), a professional trade association representing more than 20,000 health insurance agents, brokers and benefit specialists nationally, feels that American policymakers must do everything they can to keep private individual health insurance coverage accessible and affordable for all Americans.

As an association of benefit specialists who help individuals and businesses purchase private health insurance coverage on a daily basis, we know that the vast majority of Americans are happy to receive their health insurance coverage through the employer-based system. Our association believes that any health insurance market reform effort should include the employer-based system as its core. But even though it works well for many people, the employer-based system isn't an option for everyone. Approximately 14.5 million Americans have private health insurance coverage that is not connected with an employer-sponsored plan.[1]

Background about Individual Health Insurance Coverage

Since the individual market is so small nationally (only about five percent of the non-elderly population has such coverage) and each state's individual market is separate, the ability of an insurer in any given state to spread costs and risks across a large pool is very limited. Individual-market risk spreading is even more complicated because that market is prone to a phenomenon known as adverse selection. Adverse selection occurs when a person delays buying an insurance product until he or she anticipates an immediate need for the benefit. Since individuals always know more about their own health status than anyone else does, and because all of the cost of buying individual health coverage is generally borne by the insured, the amount of adverse selection and poor risk spreading occurring in the individual market is very high. This has a direct impact on the pricing of individual-market policies.

The states are the primary regulators of individual health insurance policies. This is in contrast to the group health insurance market, where fully insured plans are governed primarily by state law but self-funded health plans are governed federally under the Employee Retirement Income Security Act of 1972 (ERISA). Since each state's health insurance regulatory requirements vary, state-specific regulations often impact the types of individual policies available in each state and their cost. The cost variance from state to state is dramatic. Some of the states that have gone to the greatest lengths to ensure equal insurance access actually have the highest coverage costs.[2]

Our states have proven to be an excellent laboratory for health reform and have given us some great examples of what does and does not work when it comes to providing choice and affordable premiums for individual health insurance buyers. Unfortunately, the great innovations provided by the states have not produced much consistency. Furthermore, state-level consumer protections have sometimes proven to be inadequate, resulting in some people not being able to obtain the coverage they need at all or at an affordable price.

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[1] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements) http://www.statehealthfacts.org/comparebar.jsp?ind=125&cat=3

[2] For example, a PPO individual health insurance policy for a 37-year-old male living in Haddonfield, NJ, (a suburb of Philadelphia) with a $1000 deductible and 80/20 percent coinsurance would be $514/month for coverage beginning on February 1, 2009. New Jersey guarantee issues all individual health insurance policies and prices them based on a modified community rate. A comparable policy could be issued to the same male living in Wayne, PA, (also a Philadelphia area suburb 22 miles away from Haddonfield, NJ) for $170 a month. Pennsylvania medically underwrites its individual policies and imposes pre-existing condition look-back and exclusionary periods.

Coverage for Everyone

One of the greatest problems with individual health insurance today is that not all Americans are able to purchase coverage. In some states, people with serious medical conditions who do not have access to employer-sponsored plans cannot buy individual coverage at any price.

One of the simplest ways to address the access issue in the individual market would be to require that all individual health insurance policies be issued on a guaranteed-issue basis without regard to pre-existing medical history. However, in addition to being accessible to all Americans, individual coverage also must be affordable. It would be unwise to require insurers to guarantee-issue individual coverage to all applicants unless a system where nearly all Americans have coverage and full participation in the insurance risk pool has been achieved. Due to their small size and the propensity towards adverse selection, state individual health insurance markets are very fragile and price-sensitive. Also, there currently is no controlled means of entry and exit into the individual health insurance market independent of health status, like there is with employer-group coverage. Without near-universal participation, a guaranteed-issue requirement in this market would have the perverse effect of encouraging individuals to forgo buying coverage until they are sick or require sudden and significant medical care. This, in turn, would undermine the core principle of insurance: spreading risk amongst a large population. The result would be exorbitant premiums like we currently see in states that already require guaranteed issue of individual policies but do not require universal coverage or have a financial backstop in place.

Great care needs to be taken when implementing market reforms on a national level to not inadvertently cause costly damage to the existing private-market system. 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.

Recommendations to Achieve Near-Universal Coverage

To bring everyone into the health coverage system, NAHU believes that Congress would be wise to look at our existing system for holes and examine what the states have done to successfully fill those coverage gaps. A few simple reform measures would go a long way toward extending health insurance coverage to millions of Americans. State small-group health insurance markets and consumers ultimately benefited from the passage of federal Health Insurance Portability and Accountability Act of 1996 (HIPAA); a similar measure that preserves state regulation and consumer protections for individual-market consumers but would also make coverage options more consistent and affordable is warranted.

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. In either case, NAHU believes that the following policy recommendations would have a profoundly positive impact on individual health insurance market access and affordability nationwide.

Recommendation 1: Require Guaranteed Access to Individual Coverage with Qualified State-level Financial Backstops for Catastrophic Risks to Keep Coverage Affordable

Federal access protections in HIPAA ensure that small-group health insurance customers and individuals leaving group health insurance coverage under specified circumstances must have at least one guaranteed-purchasing option. But these federal protections do not apply to everyone. People purchasing coverage in the traditional private individual health insurance market who are not transitioning from an employer's plan do not have federal guaranteed-issue rights. That means right now, in a number of states, there are people with serious medical conditions who cannot buy health insurance at any price.

Furthermore, in many of the 45 states[3] that have independently established at least one mandatory guaranteed-purchasing option for individual-market consumers with serious health problems, there are still access problems due to design flaws. For example, some states have required that all people be guaranteed access to all coverage on an immediate basis, without regard to health status. Unfortunately, merely requiring guaranteed issuance of individual coverage has led to adverse selection and, consequently, very high premium rates that create a barrier to entry for most consumers. On the other hand, in some states that allow for the consideration of health status, there can be a great deal of inconsistency in what types of risks are deemed to be uninsurable by individual carriers. Also, states with a high-risk health insurance pool often have funding difficulties that can result in high premiums and pool instability, both of which can be a barrier to entry.

While the mechanism for access to health care coverage may vary from state to state, access should not be denied to any American. The federal government should immediately require that all states have at least one guaranteed-purchasing option for all individual health insurance market consumers. But, beyond that, the federal government should also stipulate that a guaranteed-issue mandate, a designated carrier of last resort or a high-risk health insurance or reinsurance pool alone may not be a sufficient means of providing guaranteed access.

The best solution is a partnership between the private individual market and the mechanism for guaranteed access. A state's high-risk pool or reinsurance mechanism could serve as a backstop to insulate the traditional market against catastrophic claims costs. The federal government should establish broad guidelines for qualified state-level financial backstops (i.e., capped rates for high-risk individuals) to allow for state innovation but also ensure consistency of access and affordability.

Several states have been able to successfully combine a guaranteed-issue approach with universal underwriting criteria for all carriers and either a traditional high-risk pool or a reinsurance mechanism. When establishing state guaranteed-access requirements coupled with a financial backstop, four states in particular should be looked at as potential models:

Idaho

One of the most interesting arrangements is from Idaho. It is a hybrid arrangement—the only one of its kind—known as an individual high-risk reinsurance pool. Although the idea of reinsurance isn't new, Idaho is using it in a manner that is different than what has been done before. In Idaho, if a person's health status (based on a uniform medical questionnaire that all carriers use) meets a certain threshold, the carrier can cede a large part of the financial risk for the individual to the reinsurance pool. Individuals who are insured in this manner are still issued a policy through the insurer they applied for coverage with, but must select one of four standard options. The coverage is still comprehensive, but the more limited benefit choices make administration of the reinsurance mechanism simpler. The carrier pays a premium to the pool in exchange for the pool taking on the risk of the individual's high claims. The individual consumer pays premiums to the insurer and has coverage issued by that insurer, not the pool itself. So the reinsurance mechanism is largely invisible to the consumer, although the premium is somewhat higher than the consumer would have otherwise paid. This program is funded through several mechanisms. First, the state's premium tax, paid by all insurers in the state, is the primary funding source and this is considered a stable funding source since it is not a state appropriation. In addition, when a carrier cedes risk to the pool, it pays a premium to the pool. Finally, the pool has the ability to assess insurance carriers for funding but, so far, it hasn't needed to do so. The Idaho pool is one of the few state programs that has more than enough funds to operate on a consistent basis.

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[3] The states without a guaranteed-access mechanism are Arizona, Delaware, Georgia, Nevada and Hawaii. Furthermore, Florida's high-risk pool has been closed to new applicants since 1992, so it effectively also has no access mechanism for new medically uninsurable individuals.

Utah

In Utah, health insurance carriers in the individual market must offer coverage to everyone who applies, but if an individual's medical costs are deemed to potentially exceed a set threshold ascertained through a medical questionnaire, the carrier can refer the person instead to the state high-risk pool. Of importance here is that every insurance carrier uses the same medical questionnaire, so the pool gets only the most serious health risks and the regular market keeps other applicants. The current downside of the Utah arrangement is that the excess funding for the pool comes from the state so, while the benefits are extremely comprehensive, state budget limitations have resulted in the need for an annual cap on benefits that is troublesome. But the mechanism is interesting and could be replicated and otherwise works well, if the funding issue could be resolved to something more stable.

Washington

The Washington state high-risk pool and guaranteed-issue requirements work similarly to those in Utah although, in addition to the consistent underwriting requirements, carriers are limited to a set percentage of individual business that can be referred to the pool. Since Washington's pool isn't state-funded, it does not have an annual benefit maximum. It's another example of a partnership with the private market and a public guaranteed-access mechanism that works and could be replicated elsewhere.

New York

Another twist on the reinsurance concept is New York with its *Healthy New York* program. Small employers, sole proprietors and uninsured working individuals, regardless of health status, who meet set eligibility criteria and participation rules can purchase a limited range of comprehensive coverage options offered through private carriers and backstopped with a state-level reinsurance pool for extraordinary claims. This is a different kind of reinsurance than in Idaho, since it works on a retrospective basis, but it is a great example of why a backstop can increase affordability. Although New York is a guaranteed-issue state, it still uses this mechanism to spread the risk of higher risk participants. If we compare the rates for similar coverage in New Jersey, also a guaranteed-issue state but with no financial backstop, it becomes clear that, although premiums are higher than in non-guarantee issue states, the financial backstop provided by the reinsurance mechanism has improved affordability there.

Recommendation 2: Give Pre-existing Condition Credit for Prior Individual Market Coverage to Ensure True Heath Insurance Portability

The issue of pre-existing conditions and individual market coverage portability has been repeatedly identified as a problem. And it's not just a problem for people who have a serious medical condition when they apply for coverage. People who have obtained individual coverage when healthy and then acquired medical conditions over time can be limited in their ability to switch coverage plans due to pre-existing conditions and medical underwriting requirements.

HIPAA does provide individual-market consumers some protections, but they don't go far enough. Current law requires that all health insurance policies be guaranteed renewable unless there is non-payment of premium, the insured has committed fraud or intentional misrepresentation, or the insured has not complied with the terms of the health insurance contract. In addition, most states require that individual health insurance policies be renewed at class average rates and prohibit the practice of re-underwriting (making people fill out a new health questionnaire at renewal), provided that the policyholder sticks with the same product.

The flaw in HIPAA is that it does not protect individuals who want to change carriers or health insurance products within the individual market. This is not only a problem for the individuals who want to make a change, but it also stifles individual market carrier which in turn has a significant impact on price.

To solve this problem, states should be required to adopt a qualified access program so that no individual will be denied a private health insurance option because of a pre-existing condition, as described in Recommendation 1. In addition, individual market health insurance carriers should be required to give individual health insurance market consumers credit for prior individual coverage when changing insurance plans, if there is no greater than a 63-day break in coverage, just as is required in the group market by HIPAA. This means that existing individual-market consumers who wanted to switch health insurance products and/or health insurance carriers would be given credit against any pre-existing condition look-back or exclusionary periods equal to the amount of prior coverage they have. Furthermore, NAHU believes that the 63-day coverage window provisions should be amended to specify credit should be granted as long as the individual applies for coverage within 63 days, to protect individuals in cases where coverage cannot be issued immediately upon application.

However, to protect against adverse selection, a provision would also need to be included to address situations where individual-market consumers were substantially changing their level of coverage and/or benefits. In these cases, while credit for prior coverage would be applicable, carriers would still be able to assess for insurable risk when determining initial premium rates.

Recommendation 3: Standardize State-Level Requirements Regarding the Consideration of Pre-existing Conditions

Right now, state exclusionary and look back periods for pre-existing conditions in the individual market range from none at all to five years. NAHU believes greater standardization could easily be achieved in a similar way as was done relative to the small-group market in HIPAA when a federal maximum look-back window of six months and a 12-month exclusionary period was established for the states. Having a pre-existing conditions rule that is consistent in both the individual and group model would also be much simpler for consumers to understand.

In the absence of a fully implemented and enforceable individual purchase mandate, plans and high-risk options must be able to look back at a new applicant's medical history and impose reasonable waiting periods in order to mitigate adverse selection. Until implementation is complete, greater standardization of limitations is necessary and warranted.

Recommendation 4: Improve Federal Group-to-Individual Coverage Portability Protections So that People Can Transition Directly from Employer Coverage to Individual without Hurdles

HIPAA attempts to provide individuals who are leaving group health insurance coverage with portability protections to make it easier for them to purchase coverage in the individual market. Unfortunately, the protections are confusing and many consumers unintentionally invalidate their HIPAA guaranteed-issue rights without realizing it and then risk being denied coverage when they apply for individual coverage.

Under current law, individuals who are leaving group coverage must exhaust either COBRA continuation coverage or any state-mandated continuation of coverage option if COBRA is not applicable before they have any group-to-individual rights under HIPAA. Once the consumer exhausts these options if available, then he or she can purchase certain types of individual coverage on a guaranteed-issue basis, provided that there is no more than a 63-day break in coverage. Each state was required under HIPAA to develop a mechanism for

providing this coverage. The two most common state elections are to either allow HIPAA-eligible people to purchase coverage through a state high-risk health insurance pool, or to require all individual market carriers to guarantee-issue HIPAA-eligible consumers at least two products, which are often priced higher than traditional individual coverage.

Most people who leave group coverage are unaware of all of the stipulations required to receive federal portability-of-coverage protections. Faced with high COBRA or state-continuation premiums, many individuals decline such coverage either initially or after a few months. Then, depending on their health status or a family member's, they may experience extreme difficulty obtaining individual market coverage. To solve this problem, the HIPAA requirement to exhaust state continuation coverage or COBRA before federal guarantees are available should be rescinded, and individuals leaving group coverage should be able to exercise their federal group-to-individual portability rights immediately, provided that there is no more than a 63-day break in coverage.

Recommendation 5: Stabilize Individual Market Rates by Requiring More Standardization as to How Individual Market Carriers Determine Pricing

Another inconsistency among state individual health insurance markets is the way that premium rates are determined at the time of application. In a few states they are determined merely by geographic location (pure community rating) and in several others rating factors are determined by the state but are limited in nature (i.e., age, gender, industry, wellness, etc.), which is known as modified community rating. However, even with states with modified community rating, the rating factors and how they may be applied vary significantly by state. It is NAHU's view that state individual health insurance markets would benefit from greater standardization as to how premium rates are determined.

The first step to greater standardization would be for states to adopt a uniform application for applying for individual insurance coverage. A clear and understandable uniform application would assure full disclosure of accurate and consistent information when individuals apply for coverage. It would also be easier for consumers when applying for coverage with several different insurance carriers at one time.

In the vast majority of states, no specific rating structure is required in the individual market, and carriers can assess for insurable risk at the time of application and discount or increase rates based on health status with few limitations. Full, accurate and complete risk assessment has proven to be the most effective rating mechanism because it has been demonstrated to lower overall premium cost. However, the unlimited rating structure used in most state individual markets is in contrast to most state small-group health insurance markets and can create anti-selection issues between the two markets. Most state small-group carriers are also allowed to assess for insurable risk but have limitations on the amount of premium adjustments based on health status. In addition to these initial limitations, most state small-group laws require that premium increases are limited on renewal. This means that the amount each small group's premium can go up annually is based on the overall health experience of the carrier's entire small-group pool and is limited by the state to usually 10-15 percent plus an additional amount for inflation.

The federal government could require that states meet a minimum standard of rate stabilization by imposing maximum rate variations for initial applicants, as well as a cap on renewal premium increases, as most states do for their small-group market. Another option would be to allow a modified community rate. However, 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 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 wellness factors, smoking status, gender and geography. Since we know that up to 50 percent of health status is determined by personal

behavior choices[4], in order to have effective cost containment, we need to be able to reward healthy behavioral choices.

Recommendation 6: Increase Consumer Protections Regarding Individual Market Coverage Rescissions

Under very rare circumstances, individual health insurance carriers rescind an insurance policy based on a submission of fraudulent information on an application or an intentional omission of required information. Surveys of individual health insurance plans indicate this happens to far less than one percent of individual market consumers annually[5], but all individuals buying individual coverage deserve assurances that they will not be subject to unfair policy rescissions or pre-existing condition determinations.

All states should be required to develop an independent medical review process to resolve disputes concerning policy rescissions and/or pre-existing condition determinations. In addition, health plans should be required to limit rescissions to only material omissions and misrepresentations on the uniform insurance application. Health plans should be responsible for reviewing all applications received for clarity and completeness at the time of application and not after the policy is issued. If a carrier does not conduct a review of listed medical conditions on the application upon submission, it should not be allowed to use any subsequently obtained health information as a standard for a rescission, unless fraud or deceit has occurred. Health plan consumers should be clearly informed of their rights relative to rescissions and pre-existing condition determinations. Consumers also should be informed of their obligation to provide complete and accurate responses on health plan applications and to provide additional information at the time of application upon request of the health plan.

Recommendation 7: Making it Easier for Employers to Help People Purchase Individual Coverage

One of the biggest complaints about the individual market is that coverage is too difficult to purchase independently, and one of the greatest advantages of employer-group coverage is its ease of enrollment and payment. Many employers would like to offer their employees traditional health insurance coverage but simply can't afford to do so under current economic conditions. Also, some employers have an employee base that is difficult to cover under a traditional group scenario. As an alternative, employers should be allowed to work with licensed insurance agents and brokers to help employees purchase and pay for individual coverage by setting up a Section 125 plan, deducting premiums from wages, aggregating premiums and sending them to the insurer, and possibly providing a defined contribution. This would be a particularly appropriate coverage option for certain types of businesses that are rarely able to offer benefits to all employees (for example, restaurants and some small retail establishments) and for employees who may not be eligible for an employer's group plan, such as part-time or contract workers. This could help to draw many uninsured individuals into the private health coverage system. In addition, it could expand the size of the individual market, making it less fragile and, therefore, less costly.

However, current federal law requires that all individual health insurance policies sold in a group setting are subject to ERISA and all of the HIPAA consumer protections relative to <u>group</u> health insurance plans, including the group guaranteed-issue and pre-existing requirements and all nondiscrimination provisions. Under current market conditions, practically no individual-market policies can meet all of the HIPAA small-group protections since they are not designed for a product that is marketed to individual consumers. In addition, the sale of list-billed policies, which are individual policies where the employer agrees to payroll-withhold individual health

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[4] Mercer Management Journal 18. "The Case for Consumerism in Health Care" http://www.oliverwyman.com/ow/pdf_files/MMJ18_Case_Consumerism_Healthcare.pdf

[5] America's Health Insurance Plans. Comprehensive Health Insurance Policy Rescissions in the Individual Health Insurance Market Reported by AHIP Member Companies, 2007 Survey

insurance premiums on behalf of its employees and send the premium payments to the insurance carrier but does not contribute to the cost of the premium, is specifically prohibited by some states.

Congress should overturn state bans of the sale of list-billed policies and clarify that individual health insurance policies purchased by employees are not the same as group health insurance policies and are not subject to the group insurance requirements specified in HIPAA or ERISA but rather the newly reformed rules for the individual market. In particular, the federal requirements regarding individual policies sold on a list-bill basis need to be clarified, since even minimal involvement on the part of the employer could trigger group health plan requirements.

Congress should also establish that all individual health insurance policies sold under a list-billed arrangement are subject to all insurance regulations governing the issuance of traditional individual insurance policies in the state in which the policy was sold. This would include rating requirements, issuing requirements and the requirement that such products only be sold by licensed health insurance producers, among other consumer protections.

Recommendation 8: Provide Federal Financial Assistance to Keep Individual Health Insurance Coverage Affordable

The most critical problem that we see in state individual health insurance markets is affordability, particularly for those individuals who have medical conditions. The high cost of coverage for these people often doubles as an access barrier.

There are clear broad-scale solutions that NAHU supports relative to coverage affordability. The most important of these is acting on the true underlying problem with our existing system: the cost of medical care. Health care delivery costs are the key driver of rising health insurance premiums, and they are putting the cost of health insurance coverage beyond the reach of many Americans.[6] Addressing the cost of care and its impact on the cost of coverage is critical in every market.

However, there are other affordability reforms that could be crafted that would specifically help individual market health insurance purchasers.

Tax Equity – Enhanced Deductibility of Premiums

The most important step toward making individual coverage more affordable would be extending tax equity to individuals and families purchasing health insurance coverage on their own and equal tax treatment for the self-employed. NAHU believes federal tax laws should be updated to provide the same federal tax deductions to individuals and the self-employed that corporations have for providing health insurance coverage for their employees, although not at the expense of the existing employer exclusion. Specifically, NAHU feels Congress should take action to:

- Remove the 7.5 percent of adjusted gross limit of medical expenses on tax filers' itemized deduction Schedule A form.
- Allow the deduction of individual insurance premiums as a medical expense in itemized deductions.
- Equalize the self-employed health insurance deduction to the level corporations deduct by changing it from a deduction to adjusted gross income to a full deductible business expense on Schedule C.
- Clarify in statute that employers implementing list-billing arrangements for their employees may also establish Section 125 premium-only plans for their workers. This would enable employees to

[6] PricewaterhouseCoopers. "The Factors Fueling Rising Health Care Costs, 2008." http://www.americanhealthsolution.org/assets/Uploads/risinghealthcarecostsfactors2008.pdf

pay for their individual policies on a tax-favored basis. If an individual participated in a Section 125 plan for a list-billed policy, those premiums would not be eligible for deduction as a medical expense under Schedule A.

Subsidies

NAHU also supports targeted premium-assistance programs for low-income individuals purchasing private coverage, and we feel that the federal government should finance such programs. A subsidy program could be national in scope or each state could be required to create one that suits the unique needs of its citizens in partnership with the federal government. Several states have already created successful subsidy programs and their existing structures could be used as a model framework for a national reform. I have included a chart at the end of this statement that itemizes some of the state subsidy programs that provide us with some good models on creative ways to help both employers and their employees with the cost of health insurance coverage. Two states in particular should be looked to as models:

Oregon

The Oregon Family Health Insurance Assistance Program (FHIAP)[7] is one state program that could serve as a model. FHIAP is an innovative state coverage initiative that subsidizes both employer-sponsored coverage and individual insurance coverage. Eligible families making over 150% FPL who do not receive cash assistance must participate if employer coverage is available, and others can participate on a voluntary basis. Licensed health insurance professionals help both employers and individuals with enrollment and participation. The program subsidizes coverage on a sliding scale according to income. Subsidies range from 50% to 95% of the premium. Individuals and families use FHIAP subsidies to pay for insurance at work or to buy individual health plans if insurance is not available through an employer. FHIAP members pay part of the premium. They also pay other costs of private health insurance such as co-payments and deductibles. Once approved for FHIAP, members are eligible to remain in the program for 12 months. Three to four months before the member's eligibility ends, FHIAP sends a new application and members may re-apply. FHIAP provides direct premium assistance through the insurer for people who use its benefits to purchase individual coverage. For those with employer coverage, FHIAP reimburses employees for the cost of their premium within four days of receipt of a valid paystub denoting the employee contribution. This program has been around for a number of years and struggles each year with funding, but many have benefited from it and it is a streamlined approach with little administrative cost.

Oklahoma

Oklahoma’s Employer/Employee Partnership for Insurance Coverage (OEPIC or Insure Oklahoma)[8] is another very successful state subsidy program that works with both employer-sponsored and individual health insurance coverage for self-employed people, certain unemployed individuals, and working individuals who do not have access to small-group health coverage. In 2008, 9,923 employees and dependents were directly subsidized by Insure Oklahoma, which is a 234% increase from the previous year.[9] Licensed insurance agents and brokers help identify applicable participants and enroll people and employers in the plan. Through the program, the employer pays only 25% of the premium of the low-wage worker, the employee pays up to 15% of the premium and the state pays the remainder. The program's passage was supported by insurers, small employers, agents and brokers and providers. It is funded by a state tobacco tax and federal funds based on a Medicaid Health

[7] http://www.oregon.gov/OPHP/FHIAP/
[8] http://www.oepic.ok.gov/
[9] Blue Cross Blue Shield Association. “Insure Oklahoma: Overview and Impact.” http://www.bcbs.com/issues/uninsured/background/insure-oklahoma-overview.html

Insurance Flexibility and Accountability waiver. Twenty insurers participate, offering dozens of qualified products that meet simple specified coverage standards.

Federal Financial Support for Qualified Access Mechanisms

Finally, we support even more targeted means of providing federal affordability assistance to individual market consumers, particularly to individuals with serious medical conditions. Since in any insurance pool of risk a small number of insureds incur the majority of claims, NAHU's access solutions alone, by guaranteeing that the highest-risk individuals are covered in a financially separate private-market pool will help lower costs for all consumers. But even more could be done to help lower costs.

Funding for high-risk health programs is a continual problem in some states. When a pool consists of only sick people, there is no spreading of risks, so premiums charged to policyholders are never enough to cover expenses and additional funding mechanisms must be created. A variety of funding sources are currently being used, including using state premium taxes, direct state appropriations, assessments to carriers that operate in the state, hospital taxes, or a mixture of several sources. Current limited federal grant funds for high-risk pools have enabled a number of state high-risk pools to lower premiums and even start low-income subsidy programs. NAHU believes this funding should not only continue, but it should also be increased and expanded to the new qualified access mechanisms outlined in Recommendation 1.

The issue of affordability is key. A state should be required to demonstrate that the funding source for whatever high-risk option it elects will be both broadly distributed over as much of the marketplace as possible and stable over time. CMS could develop broad criteria, and this program could be administered easily with the career employees already dedicated to the current high-risk pool grants. It would be important when establishing criteria not to hinder state innovation relative to funding sources as this is a key factor of ensuring affordability. Furthermore, due to the high-needs population being served, premiums alone cannot be considered a stable funding source.

Funding could be conditional upon a state's ability to meet federally established broad criteria regarding the framework of a qualified program. This may be the biggest bargain for federal dollars that exists. A small amount of funding will go a long way. The current $75 million grant funding for high-risk pools has helped many pools establish low-income subsidies, disease-management programs and other important benefits for pool participants. New funding would be used to help subsidize premiums for the high-risk beneficiaries because, regardless of the backstop option the state creates, premiums alone in a state high-risk option will never be enough to satisfy claims, and premiums for participants in these programs must be at reasonable levels to ensure adequate participation. Funding could also be used as an additional backstop to state high-risk options that meet specified requirements for those rare individuals whose medical expenses are so great they would exceed high-risk pool lifetime caps.

Recommendation 9: Getting Everyone Covered

NAHU believes that implementing recommendations 1 through 8 will bring our country much closer to all Americans having health coverage. But an additional way to achieve the standard of near-complete coverage that is necessary for stand-alone guaranteed issuance of coverage as well as controlled entry and exit into the individual insurance market is through the implementation of an enforceable and effective individual mandate.

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.[10] Also, 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 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 as described in Recommendation 1 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.

Recommendation 10: Allow State Implementation with a Federal Fallback Enforcement Mechanism

States should be given a finite timeframe of several years to achieve these reforms through legislative or regulatory means. If a state cannot adopt the necessary reforms in the timeframe allotted, federal enforcement through CMS should be the fallback, similar to the way CMS serves as the federal fallback enforcement authority for HIPAA's small-group market requirements.

Conclusion

NAHU members work on a daily basis to help individuals and employers of all sizes purchase health insurance coverage. We also help clients use their coverage effectively and make sure they get the right coverage at the most affordable price.

All of this experience gives our membership a unique perspective on the health insurance marketplace. Our members are intimately familiar with the needs and challenges of health insurance consumers, and they have a clear understanding of the economic realities of the health insurance business, including both consumer and employer behavioral responses to public policy changes. We have had the chance to observe the health insurance market reform experiments that have been tried by the states and private enterprise, and we have based these individual-market health reform policy recommendations on what we believe would be the most beneficial changes for individual health insurance consumers.

The NAHU membership urges Congress to carefully consider these ideas to improve individual health insurance coverage options for consumers nationwide. Our private health insurance plans are innovative, flexible and efficient, and our marketplace is up to the task of responding to well-structured reforms. We look

[10] Insurance Research Council. "IRC Estimates That More Than 14 Percent of Drivers Are Uninsured." http://www.ircweb.org/news/20060628.pdf

forward to working with federal and state policymakers to fill the gaps in our nation's coverage system and to make private individual health insurance coverage more affordable and accessible for all Americans.

We appreciate this opportunity to participate in today's hearing and look forward to the discussion with the Committee and other panelists.

Addendum: Chart on State-Level Private Health Insurance Subsidy Programs for Low-Income Individuals