Statement for Roundtable Discussion
on
Health Care Coverage

Submitted by

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for the
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I. Introduction

Chairman Baucus, Ranking Member Grassley, and members of the committee, I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We thank the committee for holding this roundtable discussion on the topic of health care coverage, and we appreciate this opportunity to outline our proposals for addressing this priority. We also applaud President Obama for laying out a bold framework for comprehensive health care reform. We believe that legislation needs to be enacted and signed into law this year, and we are committed to playing a productive role in this debate.

In December 2008, AHIP announced a comprehensive proposal for moving the nation toward a restructured health care system that achieves universal coverage, reduces the growth of health care costs, and improves the quality of medical care. In March 2009, we announced our support for additional steps with respect to rating reforms, addressing the needs of small businesses, achieving cost containment, and reforming delivery and payment structures. Recognizing that the issues of coverage, affordability, and quality are interconnected, we believe they must be addressed simultaneously with market reforms that build upon the strengths of the current system and recognize that both the private sector and public programs have a role to play in meeting these challenges.

AHIP's proposals are the culmination of three years of policy work by our Board of Directors, which has focused on developing workable solutions to the health care challenges facing the nation. They also respond to the concerns and incorporate the ideas that were raised by the American people during a nationwide listening tour we conducted last year as part of AHIP's "Campaign for an American Solution." This listening tour included roundtable discussions involving Americans from all walks of life, including people with and without insurance, small business owners and their employees, union leaders and members, elected officials, and community leaders.

The statement we are submitting for this forum responds to issues on which the committee is seeking input and, additionally, discusses a series of comprehensive proposals we have developed in an effort to ensure that no one falls through the cracks of the U.S. health care system. These policy changes, if implemented in coordination with strategies to contain costs

and enhance value, will help build a high quality, affordable health care system for all Americans.

II. The Responsibilities of Individuals, Employers, Government, and Health Insurance Plans

Developments in the states demonstrate why it is important for individual market reforms to be pursued in conjunction with universal coverage. A report by Milliman, Inc. found that the enactment of guarantee issue and rating restrictions in the absence of an individual coverage requirement allows people to defer seeking coverage until they have health problems – a situation which unfairly penalizes those who are currently insured and raises premiums because the costs of caring for the uninsured are shifted by providers to people who have coverage. According to the Milliman report, states that implemented these guarantee issue and rating restriction laws without adopting a policy that requires all individuals to participate in the system, experienced a rise in insurance premiums, a reduction of individual insurance enrollment, and no significant decrease in the number of uninsured.

The approach we are proposing recognizes that it is necessary to bring everyone into the system to make guarantee-issue coverage work. It also emphasizes that all stakeholders have a role to play in helping the nation transition to a high quality, affordable, patient-centered health care system.

Because we believe health insurance plans have a responsibility to advance meaningful reforms, our members have demonstrated strong leadership in proposing specific policy solutions that directly address the challenges of coverage, quality, and affordability. Our proposals include a strong focus on issues within our sector – including insurance market reforms – that need to be addressed by any comprehensive strategy for health care reform.

Additional responsibilities lie with the federal government, which needs to maintain a strong health care safety net for persons who are financially vulnerable and provide assistance to make coverage affordable for working families. The government also has a responsibility to improve regulatory structures to strengthen consumer protections and promote innovation and competition, while ensuring that regulations are clear, consistent, and equitable across the states.

Employers have long played an important role in offering a range of health insurance options to their employees. Under the reforms we are proposing, we envision a system in which employers will continue to view employee health benefits as a valuable tool for attracting and retaining a skilled workforce.

Finally, within the context of a modernized health care system that offers affordable coverage options, we believe consumers have a personal responsibility to obtain health coverage. An April 2009 survey by Hart Research, conducted on behalf of AHIP, found that 72 percent of respondents would support a requirement for all Americans to have health insurance coverage, provided that two conditions are met: (1) the government provides tax credits or other financial assistance to make coverage affordable; and (2) health insurance plans are prohibited from denying coverage or charging higher premiums for persons with pre-existing conditions.

III. The Role of Public Programs

Improving the public safety net is an important priority that must be addressed in the health care reform debate. We strongly supported the funding that is committed to this priority by H.R. 2, the "Children's Health Insurance Program Reauthorization Act of 2009" (CHIPRA). We also support extending Medicaid eligibility to all individuals with incomes at or below 100 percent of the Federal Poverty Level. In addition, adequate support should be provided to community health centers, recognizing the critical role they play in providing access to services for vulnerable populations and to ensure they can continue this role in the future.

To achieve comprehensive health care reform, AHIP has proposed a plan that provides universal coverage, cost containment, and quality improvement. Our plan focuses on fundamentally overhauling regulation in the marketplace, improving information and transparency for consumers, taking bold steps to ensure that coverage is affordable, and clearing obstacles to the next generation of quality improvement innovations. As discussed below, this strategy would achieve universal coverage *without* jeopardizing quality improvement initiatives that are working in the system today, *without* exacerbating cost shifting already occurring, and *without* undermining employer-based coverage.

In addition to recognizing that a new public plan is not necessary to achieve successful health care reform, we believe it is important for policymakers to consider the unintended consequences that could result from establishing a public plan to compete against existing private health insurance plans under a reformed health care system. To illustrate our concerns about how we move toward an integrated, high quality, health care delivery system under a public plan option, the committee should consider the success of the private market in offering innovative care management programs, and the difficulty associated with achieving similar results in a new government plan.

Medicare has not effectively coordinated care, addressed chronic illness, or encouraged high performance. The private market has a well-established infrastructure in place that is moving rapidly to collaborate with providers on new models that promote value and enhance quality. As noted in the recently released AHIP publication, *Innovations in Recognizing and Rewarding Quality*, plans are implementing strategies that reward physicians and hospitals for achieving national benchmarks, demonstrating outstanding performance, and making measureable improvements over time.

IV. Ensuring Portability and Continuity of Coverage for Consumers in the Individual Market

We are proposing to combine guarantee-issue coverage with an enforceable individual health insurance requirement and premium assistance to make coverage affordable, while eliminating preexisting condition exclusions and eliminating rating based on health status in the individual market.

We envision a rating system based on the following demographic factors: geography, age, and product type. The product type factor addresses the issue that the actuarial value of benefits differs across products reflecting, for example, differences in co-pays and deductibles and differences in provider reimbursement rates (i.e., the cost differences that would exist if the same person were to enroll in one plan versus another). We also encourage Congress to provide flexibility for plans to offer premium discounts to individuals who make healthy choices, such as not smoking, participating in wellness programs, and adhering to treatment programs for chronic conditions.

Another key element of our proposal calls for premium assistance to ensure that coverage is affordable for lower-income individuals and working families. We are proposing refundable, advanceable tax credits that would be available on a sliding scale basis for those earning less than 400 percent of the Federal Poverty Level. Additional steps are needed to promote tax equity for individuals purchasing health insurance on their own.

V. Helping Small Business Provide Health Care Coverage More Affordably

Small business owners find themselves in an increasingly difficult marketplace for health insurance because of constantly rising health care costs and the limited ability of most small businesses to bear risks, contribute a substantial share of costs, or support administrative

functions. A policy statement approved by AHIP's Board of Directors in March 2009 outlines solutions, some of which also apply to individuals, for helping small businesses:

- **Essential Benefits Plan:** We propose the creation of new health plan options that are affordable for small employers and their employees, as well as individuals. These "essential benefits plans" would be available nationwide and would include coverage for primary care, preventive care, chronic care, acute episodic care, and emergency room and hospital services. Alternatively, "essential benefits plans" should include coverage that is at least actuarially equivalent to the minimum federal standards for a high-deductible health plan sold in connection with a health savings account, along with the opportunity to include enhancements such as wellness programs, preventive care, and disease management. Allowing benefit packages to vary based on actuarial equivalence is crucial to ensure that any package can evolve based upon new innovations in benefit design and the latest clinical evidence. To maintain affordability, the essential benefits plan should not be subject to varying and conflicting state benefit mandates (and that do not apply to the generally larger employers that enter into self-funded health care coverage arrangements).

- **Tax Credits or Other Incentives to Assist Small Business:** We support the establishment of tax code incentives or other types of assistance that encourage both small business owners to offer coverage to their employees and employees to take up coverage. We recognize the special challenges, both administrative and financial, that small businesses face in offering contributions toward their employees' coverage. Providing assistance can encourage these contributions and help enable employees to take up coverage which improves predictability and stability in the small group market.

- **Improving Coordination of Private and Public Programs Strengthens Small Group Coverage:** Premium or other assistance offered to low-income individuals and working families can be applied to and work with employer-sponsored coverage. This is important whether the assistance is provided through Medicaid, the Children's Health Insurance Program (CHIP), or other expanded programs designed to help individuals and families obtain coverage. Improved coordination allows workers to take up coverage offered by small businesses by leveraging both public and private sources of assistance, and benefits the firms' employees as a whole by increasing rates of participation in the small group plan.

- **Micro-firms:** "Micro-firms" (those with fewer than 10 employees) face special challenges in offering coverage. Statistics show that only about one-third of these firms offer coverage. This reflects the administrative, financial, and logistical challenges many micro-firms face in setting up and establishing plans and offering and contributing to their employees' coverage. To help these firms meet these challenges, enhanced tools could be developed that would

allow those micro-firms that have found it impractical to offer coverage, to contribute to coverage purchased on a pre-tax basis by individual employees. As part of comprehensive health care reform, employees could then use these contributions to help purchase coverage in a reshaped health care system that combines an individual requirement to obtain coverage with reforms in the individual market.

- **One-stop information source:** All small firms will benefit from collaborative efforts between health plans and the public sector (e.g., insurance commissioners) to ensure that small employers and individuals have one-stop access to clear, organized information that allows them to compare coverage options. This "one-stop shop" also could allow individuals to confirm eligibility for tax credits or other assistance and even provide a mechanism to aggregate premium contributions from multiple sources. By providing a mechanism to combine even modest contributions from multiple sources (public and private), this new one-stop shop could be especially helpful to employees who may hold multiple jobs.

VI. Strengthening the Large Group Market

We support building upon the existing employer-based system, which currently covers 177 million Americans according to the U.S. Census Bureau. It is a key part of our economic fabric. Although the employer-based system faces challenges, more than 90 percent of employers report that offering high-quality coverage is important to their ability to recruit and retain valuable workers and enhance employee morale. Thus, as a first priority, the nation's reform agenda should be committed to a policy that "first does no harm" to that system and limits strategies that would reduce employer coverage. Focus should be placed on retaining a national structure for the large group market that continues to promote uniformity and ensures the smooth functioning of the employer-based system.

At the same time, the nation's economic uncertainties and job losses underscore the need for new strategies to assist individuals who become unemployed or are transitioning from job to job. While a Congressional Budget Office (CBO) study found that nearly 50 percent of the uninsured go without coverage for four months or less, additional protections are still needed. We propose ensuring that tax credits are available to individuals on an advanceable basis to help them through job transitions along with access during these times to more affordable coverage options consistent with our proposal for a basic benefits plan.

VII. Structural Changes Needed for a Reformed System to Function Better

Employers and individuals may find the current system difficult to navigate with a lack of simple, streamlined information about multiple coverage and care options and related assistance programs. To address this concern, we are proposing modifications to introduce greater simplicity to the system through technology and regulatory reform. These proposed efforts will benefit all participants in the health care system and, at the same time, help a reformed health care system function better.

In our December 2008 Board statement, we emphasized that any health care reform proposal should include recommendations to streamline administrative processes across the health care system. Success will require advances in automating routine administrative procedures, expanding the use of decision support tools in clinical settings, and implementing interoperable electronic health records. Using technology to help streamline administrative processes will improve care delivery, enhance the provider and patient experience, and speed claims submission and payment. Done right, streamlining can also help reduce costs system-wide, leading to improved affordability.

As part of this effort, we have committed to developing a multi-payer online portal to give providers a uniform method to communicate with health plans and afford them access to current information on eligibility and benefits. This will ease the administrative challenges that physicians and other providers face, and will help them and their patients better understand coverage and predict out-of-pocket costs. We also are working with providers on a standard data aggregation approach with the goal of giving providers and consumers useful performance information. Administrative streamlining should be viewed through the eyes of consumers, with the goal of making the health care system easier to navigate and more consumer friendly. A key part of this effort is our focus on the reform of market rules to enhance access for consumers and provide them with clear, useable information on coverage and care options.

Another important priority is to rethink regulatory structures to make them work better and provide for a more consistent approach in areas such as external review, benefit plan filings, and market conduct exams. In a reformed market, policymakers should be driven by striking a balance between the traditional roles of the federal government and the states, and the objectives of achieving clearer and "smarter" regulation that promotes competition and avoids duplication of existing functions. Greater consistency in regulation and focusing on what works best will enhance consumer protections across states and help improve quality, increase transparency, and increase efficiency leading to reduced administrative costs.

VIII. Confronting the Cost-Shifting Surtax and Moving Toward a System That Pays for Value Rather than Volume

As part of any national health care reform initiative, Congress must address the fact that reducing outlays in one area inevitably means shifting costs elsewhere. Underpayment of physicians and hospitals by public programs shifts tens of billions in annual costs to those with private insurance. A December 2008 study by Milliman, Inc. projects that this cost shifting essentially imposes a surtax of $88.8 billion annually on privately insured patients, increasing their hospital and physician costs by 15 percent. This study concluded that annual health care spending for an average family of four is $1,788 higher than it would be if all payers paid equivalent rates to hospitals and physicians. The transfer of these costs to those with private coverage cannot be sustained and is critical to addressing concerns over affordability.

The impact of cost-shifting is dramatically illustrated by the tables below, which use real data showing that hospitals in California recorded significant losses in 2007 by serving Medicare and Medicaid beneficiaries. These losses are offset, however, by higher costs charged to commercial payers. This cost shifting translates into higher premiums for working families and employers.

Hospital Net Income Figures in California (millions)						
Year	***Medicare and Medicaid***		***Commercial***		***Total***	
	DSH	Non-DSH	DSH	Non-DSH	DSH	Non-DSH
2001	256	(1051)	137	1621	(825)	853

Hospital Payments to Non-DSH Hospitals Relative to Costs in California (percentages)			
Year	***Commercial***	***Medicare***	***Medicaid***
2001	117	98	67
2007	142	85	56

Non-DSH Hospital Margins in California (billions)			
Year	***Commercial***	***Medicare***	***Medicaid***
2001	2.0	(0.2)	(0.9)
2007	6.2	(2.4)	(1.9)

In addition, the U.S. currently spends approximately $50 billion each year to provide health services to those without coverage, leading to high levels of uncompensated care. This too results in cost-shifting to those with coverage in the form of higher premiums and other related costs. According to a 2005 Families USA study, the cost-shift due to uncompensated care adds $922 annually to family premiums. When these costs associated with uncompensated care are combined with the cost shifting that results from the underfunding of Medicare and Medicaid, the impact for families with private coverage is an overall surtax of $2,710 annually due to cost-shifting.

Ultimately, the success of health reform and getting all Americans covered will depend upon implementation of strategies that enhance value by improving quality and reducing costs, in conjunction with key insurance market reforms. Only by realigning incentives that drive improved outcomes will the system be placed on a long-term sustainable path. As noted earlier, a recent AHIP publication, entitled "Innovations in Recognizing and Rewarding Quality," highlights key private sector initiatives that have been implemented throughout the country to move the system toward a value-based structure. This publication demonstrates that innovative care coordination programs that enhance outcomes and reform payment incentives are in place in a private market with appropriate infrastructure, which is often lacking in public programs, to reform the health care system.

IX. Conclusion

AHIP appreciates this opportunity to outline our suggestions for extending health care coverage to all Americans as part of a comprehensive health care reform package. Our complete set of policy proposals – including innovative strategies to contain costs and improve quality – are outlined in a series of Board statements we have released since December 2008. We are strongly committed to working with committee members and other stakeholders to develop solutions for ensuring that all Americans have access to high quality, affordable health care coverage.