

America's Health  
Insurance Plans

Karen Ignagni  
President &  
Chief Executive Officer



July 16, 2009

The Honorable George Miller  
Chairman  
House Education and Labor Committee  
2181 Rayburn Building  
Washington, D.C. 20515

The Honorable Charles Rangel  
Chairman  
House Ways and Means Committee  
2354 Rayburn Building  
Washington, D.C. 20515

The Honorable Henry Waxman  
Chairman  
House Energy and Commerce Committee  
2125 Rayburn Building  
Washington, D.C. 20515

Dear Mr. Chairmen:

On behalf of America's Health Insurance Plans (AHIP), I am writing to reaffirm our strong support for comprehensive health care reform, and to express our view that key provisions of the Tri-Committee Bill will cause millions of patients to lose their current coverage, dismantle the employer based health care system, put at risk hospitals nationwide and exacerbate the nation's long-term fiscal crisis.

We are strongly committed to providing leadership in advancing bipartisan health care reform. AHIP's Board of Directors has endorsed comprehensive proposals for significant restructuring of the health care system to ensure that no one falls through the cracks, while also promoting quality improvements and providing greater value for the dollars our nation spends on health care. Our plan builds upon the strengths of the current system, calling for major insurance market reforms that would provide peace of mind to all Americans, regardless of their health status or medical history. Our broad-strategy for health reform directly addresses the goals of achieving universal coverage, reducing the future growth rate of health care costs, and improving quality of care. We are concerned, however, that the House bill includes a number of proposals that would undermine these goals.

601 Pennsylvania Avenue, NW  
South Building  
Suite Five Hundred  
Washington, DC 20004  
202.778.3200



### **Government-Run Health Insurance Plan**

We strongly oppose the creation of a new government-run health insurance plan. A government-run plan that reimburses providers based on Medicare reimbursement rates would erode the employer-based system, significantly increase costs for those who remain in private coverage, and add additional liabilities to the federal budget. Alternatively, strong market rules and consumer protections will ensure that nobody falls through the cracks and will do so without disrupting the coverage of tens of millions of Americans who like and want to keep their current health plans.

A government-run plan would exacerbate the cost-shifting that already occurs, from public programs to private payers, as a result of the inadequate reimbursement rates that Medicare and Medicaid pay to hospitals and physicians. According to a recent Milliman study, an average family of four already pays a hidden tax of more than \$1,500 annually on their premiums because Medicare and Medicaid significantly underpay hospitals and physicians, compared to their actual costs of delivering medical care. To offset these inadequate payments, providers pass on higher costs to individuals, families and employers in the private sector.

If Congress establishes a new government-run health plan, the insured population would migrate, because of lower payment rates, from employer coverage to the new government-run plan and providers would have a declining base to shift costs to in the remaining commercial market. Eventually, this dynamic would accelerate with rising costs in the private market because of the exacerbating cost shift, causing further declines in private coverage and leaving significant costs to be covered by the federal budget.

The economic realities surrounding this issue are directly related to the ability of a government-run plan to set reimbursement rates below the actual cost of delivering care and below the rates paid by private plans. The consequence of much lower reimbursement rates is lower premiums in the government-run program, attracting those with private coverage to the government-run option. Ultimately, with the loss of cross-subsidization by the private sector, we estimate that public programs would face hundreds of billions of dollars in additional costs that are not accompanied by a commensurate revenue offset.



Finally, a government-run plan would undermine efforts to transition to a high quality health care delivery system. Recognizing that the traditional Medicare program has made very little progress in developing innovative care management programs, we are concerned that creating a government-run plan for the broader population would result in tens of millions of Americans being enrolled in a new coverage option that lacks a meaningful commitment to care coordination, disease management, health promotion, and other pro-active initiatives that have been successfully implemented by private sector health plans. Moreover, the skills and capabilities needed to advance delivery system reforms would be lost as programs developed by private sector plans would be eliminated by the large-scale movement from private coverage to public coverage.

### **Health Insurance Exchange**

We believe that every state should have a system through which individuals and families can evaluate coverage options offered by all health plans, and receive assistance in understanding their choices. We are concerned, however, that the regulatory structure for the proposed Health Insurance Exchange would replicate functions now being carried out by state insurance commissioners, creating an overly complex regulatory environment without providing an equally meaningful improvement in access. To address this concern, we believe the responsibilities of the Exchange should be redefined to promote a more workable regulatory structure. Moreover, to promote health plan choices that compete based on quality and price and to improve choices for individuals and employers, we encourage you to revise the bill to allow health plan choices to be offered to individuals outside of the Exchange and to ensure that premium assistance is available to all qualifying individuals and families, not just to those who pursue coverage that is offered through the Exchange.

In addition, to maintain employer-provided coverage, we believe the Health Insurance Exchange should focus on serving individuals and micro-groups. Opening the Exchange to larger groups would unravel existing risk pools and undermine the current system of employer-sponsored coverage. Such a proposal would incentivize large employers with younger and healthier workers to self-fund, while those larger employers with older and less healthy workers would join the insurance pool – significantly driving up premiums for individuals and small employers.



### **Regulatory Structure**

We also are concerned that the bill proposes an overlapping and potentially conflicting regulatory structure for employers and health insurers. In general, the bill would divide responsibility for oversight, rulemaking, and enforcement between six governmental entities: (1) a new independent federal agency, the Health Choices Administration and a Health Choices Commissioner appointed by the President; (2) a newly created Health Insurance Ombudsman; (3) the Department of Health and Human Services; (4) the Department of Labor; (5) the Department of the Treasury; and (6) state insurance regulators.

We believe the federal government should establish consistent rules that are applied across the country and enforced by the states. We encourage the committee to establish consistent rules and clear lines of regulatory responsibility, instead of establishing new structures that create confusion and duplicative state and federal roles.

We also suggest that in establishing new rules for the insurance market, consideration should be given to clarifying what types of coverage will be covered by the new rules. We believe the bill should clarify that the market reforms aimed at major medical coverage do not apply to products that currently are considered to be “excepted benefits” under HIPAA.

### **Health Choices Commissioner**

We have concerns that the proposed legislation delegates open-ended authority to the new Health Choices Commissioner, and we would recommend that the legislation provide clear and consistent standards that could be implemented inside and outside the Exchange. Under the House bill, the Health Choices Commissioner would be given broad authority over employer and union sponsored group health plans, group and individual health insurers, the public health insurance option, Federal Employees Health Benefits plans, and state and local government employee plans, as well as supervision of the Health Insurance Exchange and state-based exchanges.

### **Age-Based Rating**

We are concerned that the House bill fails to sufficiently balance the importance of making premiums affordable for all purchasers with the goal of building a universal system. By strictly limiting premium variation based on age to a ratio of 2:1, the bill would force young people to heavily subsidize the naturally higher health care costs of older individuals. To illustrate this problem, it is essential to consider the impact of moving from a 5:1 ratio to a 2:1 ratio. According to the



Census Bureau, people in the 18-34 age category currently are twice as likely to be uninsured as those in the 45-64 age category. If Congress establishes a 2:1 ratio for age-based rating, young people will be paying premiums that are significantly higher than their actual health care costs. Therefore, establishing a rule that disproportionately increases costs for young individuals, the fastest growing segment of the uninsured, would undermine the committee's goal of achieving universal coverage. To avoid this outcome, we urge the committee to consider expanding the ratio for age-based rating and to consider special subsidies for those over 55.

### **Synchronization of Reforms**

It is critical to ensure that the timing of the individual coverage requirement is synchronized with market reforms and the availability of financial assistance to low- and moderate-income families and individuals to bring everyone into the system and ensure that persons who currently have health insurance coverage are not adversely impacted by higher costs. If this objective is not met, individuals and families who are covered in the individual market may experience unintended consequences similar to those experienced in several states where insurance market reforms were enacted in the absence of universal coverage in the 1990s.

In September 2007, Milliman Inc. conducted a report that examined eight states – Kentucky, Maine, Massachusetts, New Hampshire, New Jersey, New York, Vermont, and Washington – that enacted various forms of community rating and guarantee issue laws in the 1990s. The Milliman report found that some people in these states responded to these reforms by deferring coverage until they experienced health problems – resulting in higher premiums for those with insurance, reduced enrollment in the individual health insurance market, and no significant decrease in the number of uninsured. As a result, several states that initially implemented community rating and guarantee issue laws have since repealed or modified their laws with the intent of stabilizing the insurance marketplace and providing consumers more choice and access to coverage. These findings are worth carefully considering. The clear lesson is that any reforms that give healthy people incentives to delay purchasing coverage will lead to unintended consequences for the broader population and diminish access to high quality, affordable health insurance.



### **Flexibility in Benefit Packages**

Our members have been leaders in proposing ideas not only to assure health care coverage to all Americans, but to drive a transformation of our health care system to better determine what procedures and technologies are safe and most effective, and to improve clinical quality through better dissemination and transparency of information on safety, effectiveness, and performance. Based on this experience, we are concerned that the bill's approach to establishing benefit packages would seem to turn back the clock. Instead of delegating to an advisory committee the task of establishing benefit packages, we believe the House bill should establish categories of coverage and reasonable actuarial value ranges to promote innovation and flexibility, while allowing the availability of an affordable range of benefit offerings.

For example, health insurance plans have developed tools to support employer-based prevention initiatives. Recognizing that these tools have had positive results in reducing smoking and improving participation in wellness and chronic care management, we urge the committee to consider making the legislation more flexible to allow employers and their employees to continue to benefit from these tools. By promoting benefit designs that encourage prevention and chronic care management, we can take important steps to improve health outcomes and provide greater value for the dollars we spend on health care.

We recognize and appreciate that the bill takes into account the financial burden of state benefit mandates, which are not always based on clinical evidence or outcomes.

### **Medical Loss Ratios**

Additional concerns are raised by a provision of the bill that would establish medical loss ratio requirements that fail to measure the value provided by a particular health plan. This requirement has the potential to undermine the bill's objective of advancing administrative simplification and other initiatives to improve quality and contain costs. It also would adversely affect private sector initiatives to standardize and automate key health plan functions to simplify administrative processes for patients and clinicians.

Because funds spent on administrative simplification are not categorized as patient care expenses for purposes of calculating medical loss ratios, this provision could limit the ability of health insurance plans to devote funds to improving the system for patients and providers and, ultimately, to improving the quality of care that patients receive. Similar challenges would result for



initiatives addressing health information technology, disease management, health disparities and culturally and linguistically appropriate services, and other activities that provide value to consumers. Because the loss of these initiatives would be counterproductive for patients, we oppose the proposed medical loss ratio requirement, but we do support the disclosure of administrative costs applied broadly across all participants in the health care system.

### **Medicare Advantage Funding**

We strongly oppose the Medicare Advantage funding cuts proposed by the House bill, and we are deeply concerned about the harmful impact such reductions would have on health care choices and benefits for the 10 million Medicare beneficiaries who rely on Medicare Advantage plans to meet their health care needs. The proposed cuts would cause major disruptions for millions of Medicare beneficiaries, eliminating health plan choices for many and leading to reduced benefits and higher out-of-pocket costs for others. Another serious concern is that if Congress enacts this legislation, many beneficiaries will lose the care coordination and other innovative strategies that Medicare Advantage plans have implemented to help keep beneficiaries healthy, detect diseases at an early stage, and coordinate care across the full range of health care settings and services.

The proposed cuts would have a particularly deleterious effect in rural and other areas, such as the upper northwest, Minnesota, Michigan, Ohio, and upstate New York, with low fee-for-service costs. To ensure that a minimum level of payment would be maintained in every county, Congress – with the support of both Democrats and Republicans – established payment floors that caused health plan payments to be higher than Medicare FFS spending in certain geographic areas. The impact of these payment floors, first enacted in 1997 and then revised in 2000, continues to be seen today in the benchmarks that form the basis for bidding under the current Medicare Advantage payment system. The areas in which the floors have had the greatest impact are largely responsible for the MedPAC findings of differences in Medicare Advantage payments and FFS expenditures.

The additional value that Medicare Advantage plans provide is especially valuable to low-income beneficiaries. Analyses of CMS data demonstrate that Medicare Advantage plans are an extremely popular option for beneficiaries with incomes between \$10,000 and \$20,000. Almost half (48%) of all Medicare Advantage enrollees in 2006 had incomes in this category.

July 16, 2009

Page 8



Previous analysis indicates the impact the House bill would have on Medicare beneficiaries. The Congressional Budget Office's analysis of the 2007 CHAMP Act, which included similar provisions, found that Medicare Advantage enrollment would decline by approximately 3 million beneficiaries within five years – almost one-third of the beneficiaries currently receiving care through Medicare Advantage plans. Recognizing that Medicare Advantage plans offer a coordinated and quality-focused approach to patient care, we urge you to reject funding cuts that would undermine the availability of these important health plan choices.

### **Delivery System Reforms**

Finally, we want to emphasize that comprehensive health reform will succeed only if it includes bold steps to modernize the delivery system to promote safer, more effective care. Health insurance plans are committed to working with other stakeholders – public and private – to explore innovative payment models that promote comprehensive evidence-based care, and optimize the patient experience and patients' overall health status. We have offered a wide range of proposals for linking provider payments to quality, promoting the use of patient-centered medical homes, setting standards and expectations for the safety and quality of diagnostics, bundling payments for better management of chronic conditions, and refocusing our health care system to keep people healthy, intervene early, and provide coordinated care for chronic conditions. We stand ready to work with Congress to address these priorities as the legislative process moves forward.

Thank you for considering our perspectives on these critically important issues. Our members remain strongly committed to advancing solutions for ensuring that all Americans have access to high quality, affordable health care coverage. We stand ready to work with you to achieve this important objective.

Sincerely,

A handwritten signature in cursive script that reads "Karen Ignagni".

Karen Ignagni