



# National Association of Health Underwriters

*America's Benefits Specialists*

## ***Healthy Access—NAHU's Views on Affordable and Responsible Health Reform***

The National Association of Health Underwriters believes that health reform changes must begin by addressing the true underlying problem with our existing system: the cost of medical care. The reality is that consumers pay for all health care costs in one of three ways: through taxes, health insurance premiums or out-of-pocket expenditures. If the cost of health care becomes too great, the method of payment no longer matters – the country and its people will be bankrupt and/or unable to access care.

Constraining skyrocketing medical costs is the most critical – and vexing – aspect of health care reform. It is the key driver in rising health insurance premiums and it is putting the cost of health care coverage beyond the reach of many Americans. There is no one magic answer to health care cost containment and there are many reasons health care costs are skyrocketing. Addressing this massive societal problem requires a multitude of comprehensive actions both by individual citizens and their government. NAHU feels we need to focus on responsible reforms that will guarantee access to coverage, lower costs, improve quality, and create greater efficiency in our private delivery system.

NAHU applauds government leaders and others who have put forward comprehensive reform proposals, and we agree that reform to our current system is imperative. As Congress and the Obama Administration consider comprehensive health reform legislation, we offer the following ideas for your consideration.

As Americans and insurance professionals, NAHU members believe the United States already has the best health care system in the world, meeting the needs of most Americans. We should build on the strengths of the current system and guarantee access to coverage for all Americans.

As the individuals on the front lines marketing health insurance products to families and businesses large and small, NAHU members occupy a unique place in the health care coverage system. We see firsthand what's working and what's not. We educate consumers on their health care coverage choices, help them select the most appropriate plans for their specific needs, and serve as their advocate if problems arise. We are acutely aware of the need for more affordable private health insurance options, and we are absolutely committed to reforming our health care delivery system through a private-market solution.

## **Market Reforms**

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

One inconsistency among state individual and small-group health insurance markets is 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.

Another idea under widespread consideration is to allow the use of 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 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 wellness factors, smoking status and geography.

Specifically allowing for wellness factors to be allowed as rating characteristics when determining group and individual market premium rates is a critical market reform.. Since we know that up to 50 percent of health status is determined by personal behavior choices,<sup>1</sup> in order to have effective cost containment, we need to be able to reward healthy behaviors. The rating requirements for employer groups should include not only incentives for individuals meeting wellness factors like smoker status, body mass index and participation in disease-management programs, but also an overall ability for carriers to give incentives to small businesses that offer wellness programs to employees. The rating factors in both markets should be broad to allow for adjustments and innovations in wellness programs over time.

Reform of the consideration of pre-existing conditions is also important. A pre-existing condition clause applies to coverage already in force and limits the amount of time a particular condition may be excluded from coverage. Pre-existing condition clauses are

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<sup>1</sup> Mercer Management Journal 18. “The Case for Consumerism in Health Care”  
[http://www.oliverwyman.com/ow/pdf\\_files/MMJ18\\_Case\\_Consumerism\\_Healthcare.pdf](http://www.oliverwyman.com/ow/pdf_files/MMJ18_Case_Consumerism_Healthcare.pdf)

used to prevent the adverse selection caused by people failing to obtain coverage until they know they need the benefit.

When considering reform to the use of these clauses, though, is important to remember that pre-existing condition clauses are rarely a problem for those with employer-sponsored coverage because the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established uniform rules in this area for the group market. Carriers can look back at a new group member's medical history for no more than the six months prior to when the individual joined the group and may exclude coverage for certain conditions for up to 12 months. However, the law rewards those who have consistently maintained health insurance coverage. As long as a new group member has no more than a 63-day break in coverage, the group health plan must give the individual credit for his prior coverage. This credit for prior coverage, as well as the controlled entry and exit into group plans, means that pre-existing condition clauses rarely need to be exercised in the group market. They only come into play to prevent true adverse selection, and their timeframe is limited and relatively consistent across the states.

In the individual market there are no consistent rules. 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 be much simpler for consumers to understand. Also, insurers should be required to give pre-existing condition credit for prior coverage in the individual market just as they do for the group market.

Another market reform idea that must be addressed is the guaranteed issuance of coverage. From a pure access perspective, it would seem that one of the simplest ways to get individual-market buyers covered would be to require that all individual health insurance policies be issued on a guaranteed basis without regard to pre-existing medical history, as is already required in the small-group insurance market. However, in addition to being accessible to all Americans, coverage also must be affordable. If such a purchase mandate is passed, enforcement will take time to become effective. Without near-universal participation, a guaranteed-issue requirement in the individual market would have the perverse effect of encouraging individuals to forgo buying coverage until they are sick or require sudden and significant medical care.

If we are going to have a guaranteed-issue requirement, it is very important that some type of financial backstop or risk adjuster be used to ensure that the result of market reform is not the exorbitant premiums 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. Such a mechanism is imperative for the individual market, but would also benefit the small-employer group market as well. Furthermore, we believe that such while risk-adjustment mechanisms should operate under federal guidelines,

their administration and design should be state-based to allow for flexibility and for states to take advantage of existing risk-adjustment structures.

As we look at premium stability and the demonstrated importance of an adequate risk-adjustment mechanism, one good model to look at for both the individual and small-employer market 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. Although New York is a guaranteed-issue state for all markets, it still uses this mechanism to spread the risk of higher-risk participants. If we compare the rates for similar coverage in neighboring New Jersey, which is also a guaranteed-issue state but has no financial backstop, it becomes clear that, although premiums are higher in New York than in non-guaranteed-issue states due to community rating laws, the financial backstop provided by the reinsurance mechanism has improved affordability there.

### **Health Insurance Exchange**

In 2006, Massachusetts policymakers enacted a far-reaching health reform plan, creating what is known as the Massachusetts health insurance “connector,” along with other reforms designed to improve health insurance coverage affordability and accessibility. Now many policymakers are exploring whether the connector concept, which is also sometimes referred to as an exchange, portal or one-stop-shop, is an effective means of reducing the number of uninsured Americans.

NAHU has thoroughly evaluated the policy ideas behind exchange proposals and we recognize that some believe the concept has promise. But NAHU believes that Congress and the Administration need to carefully weigh the pros and cons of any connector or exchange proposal concerning access to health insurance.

An important point to remember is that the Massachusetts connector is a form of purchasing pool. While purchasing pools may provide more health plan options for individuals to choose from, history shows that they do not reduce health insurance costs. 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.

Most purchasing pools to date have not been risk-bearing (acting as an insurer) but are aggregators of plans. In a purchasing pool, 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. That’s why pools have historically not been very successful in lowering cost, although they do provide choices for individual employees in small-group plans.

Depending how an exchange is structured, there may be legal issues that need to be resolved as well. Under the Massachusetts connector model, all policies are individual policies, regardless of whether they are sold to individuals independently or they are purchased through a small employer. Thus, they could cause individuals who currently have traditional group coverage to lose existing federal consumer protections that were established by HIPAA and only apply to traditional small-group policies. There are also potential conflicts with the Employee Retirement Income Security Act of 1974 (ERISA) and the Consolidated Budget Reconciliation Act of 1985 (COBRA). Like HIPAA, these laws serve essential functions to protect consumers, and NAHU does not want to see these protections diminished.

Despite all of our concerns about a traditional health insurance exchange, NAHU does recognize the need for greater opportunities to enroll individuals in health insurance coverage. In particular, the issue of individuals who are eligible for programs like Medicaid and CHIP but are not actually enrolling needs to be addressed. There is also the perception that uninsured individuals need a centralized place to access coverage options, connect with qualified professionals and make choices based on their individual needs and budgets. Finally, the employer-sponsored health insurance system provides tax advantages, but it's not always an available option for everyone.

If a connector or exchange is part of greater health reform, it is critical that such an entity be structured in such a way that it does not damage or eliminate the traditional private insurance marketplace. If pools totally replace other private-market options, there may be no other vehicle for coverage if the pool fails.

One of the most key structural decisions that will need to be made is if an exchange will be a "portal" or a bricks-and-mortar institution and regulatory body that also sells private coverage and/or offers a public program option. The portal approach may be the best way to provide consumers with easier access to coverage options without disrupting the existing private insurance market. In addition, rather than a national exchange, we would prefer to see national rules implemented at the state level. This would allow states to do what is most appropriate for their citizens.

State-based portals or exchanges could present coverage options and quality information in a standardized format. Furthermore, we believe all portals or exchanges should include an option to contact a certified, state-licensed agent/broker for assistance. This function could be structured similarly to the internet-based home sales portal operated by the National Association of Realtors, [www.realtor.com](http://www.realtor.com), which connects potential homebuyers with the state-licensed property listing agent. Realtor.com is an excellent example of the portal approach to access to a service: Private companies compete and list homes for sale in one place, in a standardized format. But Realtor.com does not regulate the types of properties that can be listed, nor does it regulate the prices that sellers charge consumers. The real estate market is also a good example of how multiple, competing portals can be used to serve consumers. While Realtor.com is a nationwide service, it does not preclude individual and regional realty companies like Weichert and Coldwell Banker from operating their own portals to assist homebuyers.

If an exchange is included in national reform, another issue that needs to be addressed is how the rules governing the exchange(s) will mesh with existing and varying state coverage rules and consumer protections. Plan rating rules and other requirements should mirror state laws outside the exchange, 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. Under no circumstances should rating laws be less restrictive inside the connector, and rating laws more restrictive than the outside market will cause selection against the connector. Also, in terms of rating requirements, Congress and the Administration should keep in mind that current state rating law differences reveal that more restrictive age bands result in higher costs and lower participation over time.

Greater stability will also be realized by not mixing market types (i.e., not combining individuals purchasing coverage independently with small businesses or other group coverage). State laws differ significantly between the group and individual markets and, actuarially, these segments are quite different. Combining them would cause adverse selection to the pool. And although including the self-employed in a connector is an attractive idea, it should be done cautiously as it can cause the same problems as combining individual and small-employer markets. If both small groups and the self-employed are eligible for participation, extra restrictions should be made on the self-employed to control entry into the pool and to ensure the existence of a business.

One function of the Massachusetts connector is to administer the state's subsidized coverage program, Commonwealth Care. However, in Massachusetts, subsidies are also available outside of the connector through the state's premium assistance program, the Insurance Partnership. If a national exchange is utilized as a means of subsidy administration, such subsidies should be broad-based and available to eligible individuals and businesses both inside and outside the connector. If subsidies are available only inside the connector, "crowd out" from existing private plan coverage will be dramatic and could destabilize the market. Subsidies only available in the pool can also result in higher-than-expected costs for those in the pool and an apparent larger number of uninsured than actually exist.

### **The Role of Agents and Brokers**

As Congress and the Administration consider meaningful proposals for national health reform, one key test of public approval for any sustainable and equitable plan will be ensuring continued access to the services of independent—and state-licensed—agents, brokers and consultants who serve as American consumers' counselors and advocates.

In fact, a recent survey of 1,000 American consumers found an overwhelming preference for personalized service and human interaction from their insurance providers, and that three-quarters of consumers are very satisfied with the service provided by their agents and remain committed to working with them in the future. More than half (53 %) of consumers cite personalized service as what they like best about the services offered by

their insurance agent, and quality of service topped the list of the key factors in choosing an insurance provider.

In addition, the nonpartisan Center for Studying Health System Change concluded in a study that insurance brokers play an important role in helping small employers find affordable health coverage for their workers and dependents:

*“ ... an examination of the role of brokers in 12 nationally representative communities ... indicated that brokers provide valuable services to small firms, such as obtaining prices for coverage, explaining benefits to employees and problem solving for employers. In some markets, brokers also helped educate employers and employees about state policy initiatives to expand coverage. In contrast to the notion that brokers merely make insurance more costly, these findings suggest brokers can provide important benefits to small employers, plans and policy makers.”*

Insurance agents, brokers and consultants are highly regulated service professionals. States have developed many requirements for this profession, including strict licensing and continuing-education laws to protect consumers and ensure that they receive the highest level of advice from insurance professionals.

NAHU believes that this already stringent process can be enhanced by creation of a public/private partnership among the federal government, the states and not-for-profit insurance agent and carrier professional associations, such as the National Association of Health Underwriters. NAHU would assume responsibility for training insurance agents in all coverage options both public and private through the creation of a certification/designation program—the Certified Health Care Access Advisor. The CHCAA training program would include both national and state-specific components, and NAHU would make available to the public a searchable database of insurance advisors who have agreed to help this population of people find coverage. Trained advisors would help increase access and overall coverage rates by helping individuals determine what options were available and best suited to their individual needs.

Development of this educational program is already underway and will save millions of administrative and public outreach dollars, allowing the savings to be used in a better direction—toward providing lower-income individuals with the subsidies they need to purchase health care coverage.

It’s also important to note that insurance brokers are, most often, small business people active in their communities and contributors to a robust local economy. Their entrepreneurial spirit and acumen enhances the community while adding important entry-level and advanced-level jobs in their communities.

### **Individual Mandate**

NAHU 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. 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.<sup>2</sup> 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 well need to be phased in over time, starting with perhaps select populations like children age 25 and under, ultimately it must apply to all populations equally.
- An individual mandate must be accompanied by a national qualified guaranteed-access mechanism with a financial backstop or a method of risk-adjustment so that all individuals have cost-effective private health coverage options available to them. This is especially critical during the transition period, where 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.

### **Minimum Creditable Coverage Standards and the Essential Benefit Package**

NAHU believes that the key to the success of an individual mandate is making it enforceable, which necessitates establishing a reasonable standard for minimum creditable coverage. We believe the standard for minimum creditable coverage 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 weed out limited-benefit packages and would allow states to be of immediate assistance

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<sup>2</sup> Insurance Research Council. "IRC Estimates that more than 14 Percent of Drivers are Uninsured." <http://www.ircweb.org/news/20060628.pdf>

in helping with enforcement because this is a standard that is already embedded in law for all states.

One item that has been proposed is extending the definition for HIPAA creditable coverage by eliminating annual limits on benefits. This could be a problem for things like chiropractic care or other services that are appropriately limited. 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 also have concerns 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. While we don't 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.

Working from the standard for minimum creditable coverage, a standard for an essential benefits package can be developed that would apply to subsidy eligible individuals. This standard would include cost-sharing limits that could be based on a percentage of income. This would still allow for significant choice in product offerings and allow individuals and families to select the coverage most appropriate for their needs.

If used in an essential benefits package, account based plans like HRAs and HSAs could meet the cost-sharing requirements by a combination of the underlying health insurance plan and funds deposited into or available through the account.

### **Subsidies, Public Assistance Programs and Premium Assistance**

Another essential element to the success of an individual health insurance coverage mandate is providing adequate help to those whom cannot afford to purchase private health insurance coverage or need some degree of assistance towards the cost of private coverage premiums.

One of the means discussed most often to provide consistent coverage assistance to all of the lowest-income Americans equally is an expansion of the federal Medicaid program. NAHU believes that any expansion of this program should be limited to the truly needy—no more than 100 percent of the Federal Poverty Level. 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. Requiring the subsidization of such employer-sponsored coverage will lower costs by taking advantage of any premium dollars employers are willing to contribute toward their eligible employee dependent premiums—money that is now often “left on the table.” Furthermore, the risk associated with coverage would be borne by the private market plan rather than the public program, and licensed health insurance producers, who are already helping millions of business owners purchase health insurance coverage for their employees nationally, could provide outreach and enrollment assistance at virtually no cost to the government.

NAHU also supports targeted premium-assistance programs and/or refundable and advanceable tax credits for low-income individuals and small businesses purchasing private coverage, and we feel that the federal government should help 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.

Finally, some changes need to be made in our tax system simply to provide equity for individual market consumers with their counterparts in employer-sponsored plans. For example, removing the 7.5 percent of adjusted gross limit of medical expenses on tax filers' itemized deduction Schedule A form and allowing the deduction of individual insurance premiums as a medical expense in itemized deductions would help many people who are part-time workers or who work for employers that don't offer health insurance coverage. And to put self-employed individuals who are sole proprietors or who have Sub-S corporations on a level playing field with businesses organized as "C" corporations, their current deduction from gross income should be changed to a full deductible business expense on Schedule C.

### **Government-Run Public Plan**

Regarding a government-run public plan option, there are many stakeholders in the health care reform debate that have articulated the belief that such a plan is necessary in the marketplace and should be offered as an alternative to traditional private-market, employer-sponsored and individual health insurance coverage. NAHU feels that, when crafting comprehensive health reform legislation, Congress and the Administration need to avoid creating a public health plan option to be offered as an alternative to, or in competition with, private-market health plan offerings.

There are a number of reasons to question the creation of a new bureaucratic and untested government-run regime in health insurance markets. One of the primary reasons is that a much more direct, efficient and compatible solution would be widely accepted reforms to the private insurance marketplace (such as a requirement for universal insurance participation coupled with guaranteed-issue rights, and the removal of health status and pre-existing conditions as rating factors in pricing health insurance policies).

There are also significant questions as to whether the government can better achieve desired coverage, cost-containment and quality goals in a neutral, non-politicized, level-playing-field manner compared to a reformed private health insurance market. Although many proponents of a government-run public plan claim there should be an unambiguous level playing field with private insurance, there are many complex issues involved in such a model: Would states be able to tax the premiums of a public plan as they tax private insurance premiums? Would a public plan have to comply with state laws, as private insurers do? Would the government plan be held to the same solvency and actuarial standards to which commercial insurance carriers must adhere?

Given the experiences of Medicare and Medicaid, there are very legitimate concerns that Congress would give a public plan the power to dictate prices and indemnify the government-run plan for unexpected costs. This could guarantee, at least temporarily, that the government-run plan would offer insurance at below-market costs. Should this occur, the government-run plan would take over the market for health insurance, leaving room for only the government-run plan and making health care decisions dictated from Washington.

Expansion of government-run programs could also further exacerbate the cost-shift that already drives up average health care spending by \$1,788 (or 10.7 percent) annually per family.<sup>3</sup> Cost-shifting is hidden tax on private payers that occurs when government payment rates are too low and providers shift costs to the privately insured to make up the difference.

Existing public plans also provide less coverage and restrict provider access more than the average employer-sponsored plan. The Congressional Budget Office (CBO) estimated that the benefit package for Medicare is 15 percent below the average employer-sponsored plan. Under Medicaid, specialists are often inaccessible without long waits. Under a new government-run plan, Americans will find it more and more difficult to make appointments with physicians and other health care providers. This is because lower payments will make it increasingly unaffordable for providers to see patients—particularly the increasing number of patients with public coverage.

Moreover, public programs like Medicare lag behind the private insurance industry in terms of containing cost and improving quality. Medicare just recently started refusing to pay medical care providers for “never events,” when a patient suffers a knowable and catastrophic mistake such as having the wrong limb removed. The private insurance market has been doing this for years.

A government-run plan like Medicare does not have to comply with varying state insurance regulations nor does it have to underwrite applications because Medicare is open to all seniors at the same cost. Reforming the insurance market could significantly reduce administrative costs for private plans.

Private insurers must build provider networks. These networks can include high-value providers and exclude low-quality providers. Except for certain circumstances, including criminal acts, Medicare is forbidden from excluding poor quality providers. It lets in everyone who signs up. So one question to ask is: Will a public plan have Medicare’s indifference to quality -- or invest in the cost of a network?

Private insurers must also negotiate rates. Medicare just fixes prices using a statutory and regulatory scheme. And anyone who imagines a public plan would be less costly than

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<sup>3</sup> Milliman, *Hospital and Physician Cost Shift: Payment Comparison of Medicare, Medicaid and Commercial Payers*, December 2008. <http://www.ahip.org/content/default.aspx?docid=25216>

private plans must keep the following issue front and center: In the many procedure categories where Medicare's statutory price does not cover full provider costs, shortfalls are shifted to private payers who end up subsidizing the public program. So will a public plan negotiate rates or simply use fiat as a means of gaining subsidies from private insurance?

Private insurers must combat fraud -- or go out of business. Indeed, these payers have every incentive to invest in antifraud personnel and strategies down to the point where return and investment are equal. But anyone who thinks that a public plan could serve as a "yardstick" for the private sector needs to consider Medicare's dismal record with regard to fraud, waste and other abuse.

Private administrative costs cover important services like disease-management programs and research to determine which interventions actually work. It is ironic that the same advocates who frequently cite the need for the government to spend billions in taxpayer dollars to improve health outcomes are the same who decry the high administrative costs in health care plans. As Ezekiel Emanuel, an adviser to President Obama on health care (and brother of White House Chief of Staff Rahm Emanuel), wrote, "The idea that we could wring billions of dollars in savings [from cutting administrative costs] is seductive, but it wouldn't really accomplish that much. For one thing, some administrative costs are not only necessary but beneficial. Following heart-attack or cancer patients to see which interventions work best is an administrative cost, but it's also invaluable if you want to improve care."<sup>4</sup>

The creation of a government-run public insurance plan would make the government the gatekeeper – the controller of prices and the provider of coverage. Health care decisions would increasingly be made in Washington and be subject to political pressures that take into account neither patient needs nor economic realities. The cost of the program would be such that the effort to pay for it would become the central concern of American politics – crowding out other government priorities. As is seen around the world, health care is a central part in ballooning welfare states.

There are really only two ways to keep costs under control: by building a real marketplace in which cost-conscious consumers make choices in a more efficient delivery system or by imposing arbitrary limits, determined by the government, on care. Reforms to the private insurance markets are widely recognized as necessary. But the creation of a government-run public plan would likely displace tens of millions of happily insured Americans and exacerbate the worst elements of the current system: gross inefficiency, high costs and bureaucracy.

### **Employer Mandate**

Although NAHU is a strong proponent of employer-sponsored coverage, we believe that the employer-based system must continue to be voluntary. A mandate to force employers

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<sup>4</sup> Ezekial Emanuel and Shannon Brownlee, *Washington Post* Op-Ed, "5 Myths on Our Sick Health Care System," November 23, 2008.

to provide health insurance to their employees, while well-intentioned, could actually hurt American workers and health insurance coverage. It would decrease job and economic growth, and do little to reach the current uninsured population. A mandate would have a negative impact on wages and job creation, and discourage production – often in firms with the most vulnerable employees and employers. Recent NFIB research data shows an employer mandate would cause the economy to lose more than 1.6 million jobs. Overall, mandates are bad for any size employer but this research shows small firms would be most adversely affected by the mandate and account for approximately 66 percent of all jobs lost.<sup>5</sup>

Additionally, employer proposals often come with an opportunity for employers to “opt out” of providing coverage themselves and instead pay into a government-sponsored plan or fund that would provide coverage in lieu of the employer’s plan. Such programs would compete unfairly with the private market and cause employers that continue to provide coverage to experience higher costs due to cost-shifting. In a similar vein, proposals that allow employees to opt out of their employer-sponsored plans in favor of some type of pooled purchasing arrangement would jeopardize the ability of employers to continue to offer their plans by decreasing pooling efficiencies, increasing employer administrative cost for tracking plan selection, and jeopardizing the employer’s ability to meet plan-participation requirements.

There are also obvious problems and questions that would arise were the government to force the employer system on populations that do not naturally belong to it. How do we deal with part-time workers, workers who change jobs frequently, low-wage workers and workers in small firms? These are the workers whose job-based coverage has been eroding the most. It does not make sense to force part-time workers, multiple job holders or workers in small, unstable businesses to obtain coverage through their jobs. Often, they and their employers will have gone their separate ways before the coverage even becomes effective. In such cases, an employer mandate may be ineffective and, inadvertently, may also become a hidden payroll tax on low-wage workers in small businesses. For individuals in these situations, a more level playing field with tax subsidies in the individual market (in tandem with ESI) merits serious consideration, and would assist with health insurance portability.

Employers that can afford to sponsor health insurance typically provide generous benefits – and most large employers do. Employers that cannot currently afford to offer health insurance benefits will not be able to do so simply because they are mandated to do so – small employers, seasonal employers and businesses that operate on very small profit margins will still be unable to afford to provide benefits. The Massachusetts employer mandate failed to have a meaningful effect on the uninsured, and actually exempted most of the businesses that did not offer insurance – but it was disruptive to existing plans. In

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<sup>5</sup> Chow, Michael and Bruce Phillips, “Small Business Effects of a National Employer Healthcare Mandate, NFIB,” January 2009. available at [http://www.nfib.com/Portals/0/PDF/AllUsers/NFIBStudy\\_HealthcareMandate.pdf](http://www.nfib.com/Portals/0/PDF/AllUsers/NFIBStudy_HealthcareMandate.pdf)

fact, reliance on that employer mandate has in part contributed to serious funding problems in the Massachusetts plan, because more employers “played” with insurance offerings rather than “paid” the penalty to the state (an occurrence the Massachusetts budgeting experts got wrong).

### **Wellness Incentives and Other Means of Cost Containment**

Unhealthy behavior and lifestyle choices are two key factors in the increased cost of health care. As such, wellness and preventive care promotion and incentives in national reform legislation is imperative. NAHU believes that any comprehensive health reform proposal should require federal and state governments to incorporate wellness, prevention and disease-management programs into medical programs for employees and government-subsidized health coverage programs such as Medicaid, Medicare, CHIP and the Veterans Health system. In addition to requiring the creation of such wellness programs if they do not already exist, we feel that national legislation should contain premium and cost-sharing incentives for program beneficiaries to spur participation.

Furthermore, any federal market reform provisions should allow for wellness factors to be allowed as rating characteristics when determining private group and individual market premium rates. This includes for employer groups not only the existence of a wellness program, but also factors that help determine wellness like smoker status, BMI, participation in disease-management programs, etc. These rating factors should be broad to allow for adjustments and innovations in wellness programs over time.

NAHU also supports codification of the current HIPAA bona fide wellness plan rules for employer-sponsored health insurance plans with the following changes:

- Allow state insurance commissioners or HHS or DOL to waive the 20% limit on the value of wellness plan incentives on a case-by-case basis to allow employers to design innovative plans to accomplish wellness plan goals. An alternative would be to raise the cap to 50 percent. Either option will fully allow employers to vary premium rates/copayments/coinsurance charged and provide other rewards to employees based on employees participating in wellness programs, obtaining routine preventive care and meeting personal wellness participation goals. Currently, the value of all incentives may be no more than 20% of each individual’s total annual premium.
- Establish a safe harbor for those employers promoting wellness and health activities among their employees from non-intentional discrimination charges.
- Address the Equal Employment Opportunity Commission rules that currently prohibit mandated health risk assessment due to their interpretation of Americans with Disability Act.

Beyond wellness incentives, we believe that as part of comprehensive national reform incentives for doctors and medical facilities to improve system inefficiencies and eliminate errors through pay for performance, best-practice guidelines and support for evidence-based medicine should also be created. Specifically, we are very supportive of the concept of moving payments to Medicare providers to more of a pay-for-performance model through value-based purchasing. In addition, we believe that providing financial

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incentives to more efficient providers and those that practice care management is a good idea. Additional quality reporting in Medicare, greater transparency regarding physician financial interests in the referral process, and promoting more coordinated care to prevent hospital readmissions will also help greatly.

NAHU also feels that national reform must include an effort to increase the number of primary care providers and those practicing in rural areas. We need to address the serious provider shortage issues that many Americans face, both within Medicare and in our delivery system generally. The lack of provider access is a critical barrier to care. Reducing waste, fraud and abuse in our public programs and medical assistance plans is another cost-containment step that NAHU feels it is critical for the federal government to take.

Regarding health information technology, NAHU supports efforts to extend health IT financial incentives to a broader range of providers. 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. However, we feel that it is imperative that interoperable technology is 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.

NAHU believes that obtaining and making widely accessible objective information on best medical practices and protocols through comparative effectiveness research is imperative to improving the quality of health care and the affordability of insurance coverage. It can help better inform and educate providers and patients and produce better health outcomes. Continued federal funding for such unbiased research is an important priority. However, in determining a national framework for comparative effectiveness research and priorities, how comparative effectiveness research data may be used to make payment decisions in the private sector and in government programs is an important issue. NAHU feels that it is imperative that it be specified that the outcomes of such research are only to be used as an informational tool between doctors and patients. In no way should such research data be used by the government or other entities in making coverage determinations.

Finally, we believe that delivery system reforms are important not just in Medicare but in the private sector as well. Pay-for-performance incentives, increased provider quality and cost transparency, and incentives for doctors and medical facilities to improve system inefficiencies and eliminate errors through best-practice guidelines and support for evidence-based medicine are cost-saving policy ideas that should be extended to the private-market delivery system as well as to providers who serve publicly funded programs.

### **Financing Issues in Health Reform**

Many of the Healthy Access recommendations, particularly those concerning controlling our nation's rising health care costs, will actually save both state and federal health care dollars. Bending the growth curve of health delivery costs and creating and synthesizing

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greater efficiencies in the delivery of medical care is the most important step toward making insurance coverage more affordable and our health system sustainable in the long term. Associated with this critical goal are many related issues as to what are the most appropriate financing tools for health insurance coverage and health delivery, and what financial incentives best align the interests of patients, providers, employers and other stakeholders.

While NAHU agrees with many that a more suitable balance of our current health care spending through systemic delivery reforms (such as value-based purchasing models) is a top priority, some comprehensive reform elements will be investments that may require additional upfront costs.

### **Lifestyle Tax Revenues**

In order to help realign our health system's focus to more prevention and wellness promotion, NAHU believes that federal policy can encourage or discourage behavior affecting health and health costs. With the CDC estimating that 75 cents of every health dollar spent in the U.S. goes to treating patients with one or more chronic conditions (e.g., heart disease, asthma, cancer and diabetes), NAHU believes it is wholly appropriate to consider health-related excise taxes in financing health reform that can help deliver revenue and simultaneously discourage unhealthy lifestyles that are contributing to obesity and are a major component in fueling growing health care costs.

To promote health and reduce health care costs, health-reform legislation should include strong, specific prevention measures. States have been very active in: pursuing high-leverage, diet-related means of preventing chronic diseases; treating serious diseases in a more economical, yet still effective, manner; and levying taxes that would both promote health and generate revenues that could help fund expanded health care coverage. Some of these options include:

- Increased taxes on alcoholic beverages
- Increased taxes on tobacco products
- Excise tax on highly sweetened soft drinks
- Greater strictures to discourage partially hydrogenated oil – and artificial trans fat – from being used in our food products

CBO estimates that a federal excise tax of three cents per 12 ounces of “sugar-sweetened” beverages alone would generate \$24 billion over five years and \$50 billion over 10 years. And this merely represents the revenue-generation side of the ledger today; into the future we should realize reduced health care spending associated with discouraging consumption of these products.

NAHU recognizes that these proposed excise taxes are regressive, in that they would most affect low- and moderate-income households. NAHU further recognizes that potential targets of these added levies will have their own powerful interest groups strongly opposing such lifestyle taxes. We are talking, however, of options for financing

national health care reform that includes universal coverage. The net effect on this part of the population would be a substantial gain in well-being. Low- and moderate-income households that reduced their consumption of unhealthy products as a result of changes in tax policy also would benefit from improved health outcomes.

### **Changes to the Employer Exclusion: Raising Issues and Complications That Outweigh Revenue?**

The federal government supports employer-sponsored coverage through the Tax Code by recognizing health insurance premiums paid by employers on behalf of their workers as a business cost, which are generally deductible by the employer for tax purposes. These same premium payments by employers are currently not taxable to employees as a part of their compensation. NAHU believes the preservation of this current federal employer deduction and employee exclusion is critical to the success of any health reform effort.

The current employer-based model for health care has been, and continues to be, very successful in delivering comprehensive health coverage to a majority of American families. In 2007, 61 percent of non-elderly Americans were covered by employer-based health insurance.<sup>6</sup> It is the most convenient, stable and efficient means of spreading risk for insurance coverage in our country. Employer-sponsored health insurance coverage has many advantages, including the controlled entry into the program, federally guaranteed consumer protections like portability rights, the ease of group purchasing and enrollment, and the economies of scale of group purchasing power. In addition, it is a means for employers to provide equitable contributions for their employees.

There has been discussion as to whether the employee exclusion should be modified. Some have suggested that the value of the current employee exclusion should be limited or otherwise “capped” by limiting the amount of the exclusion to some specific amount – thereby taxing employer-paid coverage in excess of such amount – or by allowing the availability of the employee exclusion only to persons with incomes below a certain threshold.

NAHU believes it would be misguided to limit or otherwise undermine the exclusion. Equating to less than 10 percent of our annual health expenditures, the current exclusion is simple, straightforward and unambiguous. It is not subject to the political whims or budgetary picture of the day. It makes possible essential coverage for a significant majority of American families. Raising taxes on those who participate in health plans raises a host of issues relating to the design, sustainability and public approval for such a change in policy.

The theory behind a “cap” on the amount of the exclusion and/or the absence of any meaningful indexing is that such a change could help contain health costs. CBO estimates

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<sup>6</sup> Kaiser Family Foundation, *The Uninsured: A Primer, Key Facts About Americans Without Health Insurance* (2007), available at [www.kff.org/uninsured/upload/7451-03.pdf](http://www.kff.org/uninsured/upload/7451-03.pdf).

that capping the exclusion would increase the number of uninsured by millions because many firms would drop coverage and it would put out of financial reach for many their convenient, popular and comprehensive employer-based coverage.<sup>7</sup> NAHU questions the wisdom of pursuing broad health reform through diminished health care coverage based on such an untested theory.

By definition, revamping the tax exclusion would mean the government would be determining at some level what the “appropriate” amount of health care is. The American Benefits Council and the Employee Benefit Research Institute among others have put forth compelling analyses on how it would be very difficult, if not impossible, to design a limit to the current employee exclusion that did not result in tax inequities and/or require a burdensome and costly set of valuation rules for employers and workers.<sup>8</sup> Notably, this was tried once before with the enactment of Internal Revenue Code Section 89 and it was famously unsuccessful. Despite best intentions, the statutory and regulatory regime established by Congress and the Treasury Department for purposes of valuing employer-provided health coverage proved completely unworkable.

NAHU also has grave concerns about proposals to modify the structure of account-based health coverage options like health savings accounts (HSAs), flexible spending arrangements (FSAs) and health reimbursement arrangements (HRAs). We oppose any change to the tax treatment of any of these consumer friendly benefit products. Modifying the tax advantages associated with any or all of these coverage options would not raise much in terms of federal revenues, but it would discourage employers from utilizing these important means of making health care more accessible and affordable for their employees.

Each of these tax-favored options are different and serve a valuable role in the benefits spectrum, with millions of Americans benefitting from each of them. Each also encourages employers to offer coverage, since they allow the employer to provide comprehensive coverage in an underlying health plan in combination with additional funding for benefits under one of the account based plans. HRAs, for example, allow employers of all sizes to take on some risk for their employees’ health care costs in a safe and predictable way. Without the ability to use an HRA, these same employees would be faced with significantly greater potential cost-sharing. FSAs have for years provided a cost-effective way for employees to cover out of pocket expenses. They are a classic example of employers partnering with their employees to share the risk of these expenses. And HSAs have provided coverage options for literally millions of people who

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<sup>7</sup> Congressional Budget Office, “Budget Options, Volume I: Health Care,” Pub. No. 3185, December, 2008, pp. 24-28, available at <http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf>

<sup>8</sup> See EBRI Issue Brief #325, “Capping the Tax Exclusion for Employer-Based Health Coverage: Implications for Employers and Workers,” January, 2009, available at [http://www.ebri.org/pdf/briefspdf/EBRI\\_IB\\_1-2009\\_TaxCap1.pdf](http://www.ebri.org/pdf/briefspdf/EBRI_IB_1-2009_TaxCap1.pdf); also see Statement of James A. Klein, American Benefits Council, before the U.S. Senate Committee on Finance, Roundtable Discussion on Financing Comprehensive Health Reform, May 12, 2009, available at <http://finance.senate.gov/James%20A%20%20Klein.pdf>

previously were uninsured and have empowered consumers of all ages, incomes, and states of health to become better informed about their health care. These innovative plans are not the place to implement cost reductions.

NAHU recognizes that an enormous amount of resources will be required for comprehensive health reform to be effective, but we do not believe it should be financed in any way by limiting American's existing health coverage choices. We know that an investment in change is required to see positive reform results, and that there will likely be many actions necessary to raise the revenues needed to make sure that all Americans have access to affordable and high-quality health care coverage. The membership of NAHU is committed to financing health reform in a responsible way that improves the health of American citizens and does not limit people's options for coverage.

### **Conclusion**

The NAHU membership urges Congress and the Obama Administration to carefully consider these ideas to improve individual health insurance coverage options for consumers nationwide. Our private health insurance market is innovative, flexible and efficient, and, most important, up to the task of responding to well-structured reforms.

Furthermore, America's licensed and professional benefit specialists stand ready to work with you in the coming months on the challenges and opportunities that lie ahead. We also welcome serving as continued resources in crafting meaningful comprehensive health reform that guarantees access and choice, lowers costs, improves health care quality and puts the needs of the American people first.

### **About NAHU**

The National Association of Health Underwriters (NAHU) is the leading professional trade association for health insurance agents, brokers and consultants, representing more than 100,000 benefit specialists nationally. Our members service the health insurance policies of millions of Americans and work on a daily basis to help individuals and employers purchase health insurance coverage.

The members of NAHU believe all Americans deserve a health care system that delivers world-class medical care and financial security. Americans deserve a system that is responsible, accessible and affordable. This system should boost the health of our people and our country's economy. Americans also deserve a system that is realistic.