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STATEMENT

Before the

UNITED STATES HOUSE OF REPRESENTATIVES
HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH HEARING

On

HOUSE COMMITTEES' DRAFT HEALTH REFORM LEGISLATION

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INTRODUCTION

The Blue Cross and Blue Shield Association (BCBSA) commends Chairman Pallone's and Ranking Member Deal's leadership in holding this important House Energy and Commerce Subcommittee on Health hearing on healthcare reform. We are very pleased Congress and the Administration have made healthcare reform a national priority, and we share the commitment to enacting healthcare reform legislation this year that expands coverage to all Americans, reins in costs, and improves the quality and safety of care delivered to patients.

BCBSA strongly believes everyone in our country should have high quality, affordable coverage. It is unacceptable that 46 million people are uninsured, and we appreciate the opportunity to work with Congress, the Administration and all stakeholders to ensure everyone has coverage.

BCSBA represents the 39 independent, community-based Blue Cross and Blue Shield companies that collectively provide health insurance coverage to more than 100 million individuals – one in three Americans. With over 80 years of experience, Blue Cross and Blue Shield Plans offer coverage to individuals, small employers, and large employers in every zip code in our country. We also partner with the government in Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federal Employees Program. As such, the Blue System has a unique perspective on how to improve our health care system. Our statement today focuses on:

I. BCBSA's recommendations to rein in costs, improve quality and extend coverage to all; and
II. BCBSA's initial comments on the House Committees' draft health reform legislation.

I. BCBSA Recommendations to Rein in Costs, Improve Quality and Cover All

We believe that the most effective way to expand coverage is to build on the employer-based system – which already provides coverage to more than 160 million people today. To attain the goal of having everyone covered, we must also address the underlying problems of our current delivery system.

Our proposal, *The Pathway to Covering America*, seeks to expand coverage, rein in costs, and improve quality through five recommended steps. The first four recommendations focus on attacking costs and improving quality and the fifth seeks to expand coverage.

1. **Encourage research on what works.** Researchers and policymakers agree there is insufficient information on what medical treatments work best, resulting in more costs for sub-optimal care.

   BCBSA urges Congress to create a new independent institute to support research comparing the effectiveness of new and existing procedures, drugs, devices and biologics. We believe the institute should prioritize clinical trials and other research necessary to respond to the needs of frontline-providers and patients who want to know which treatments work best. We are pleased the House draft bill would create a permanent comparative effectiveness entity. We believe this proposal could be strengthened by making it an independent entity to insulate it from political pressures.

2. **Change incentives to promote better care.** The incentives in our system must be changed to advance the best possible care, not just more services with little or no care coordination. We believe Congress should:

   - *Move Medicare away from a system based on fee-for-service* to one that pays based on quality, coordinated and outcome-driven care. Medicare should work with the private sector

to expand pay for quality programs and pilot test new payment models such as accountable care organizations and patient centered medical homes (PCMH).

- *Improve access to generic drugs by giving* FDA authority to approve scientifically feasible and safe generic versions of biological products.

- *Strengthen the delivery system* by expanding the primary care workforce through increased Medicare payments, graduate medical education changes, and additional educational loans and grants, including loan forgiveness for primary care providers who work in medically underserved areas.

Many of these recommendations, which we support, are included in the draft bill.

3. **Empower consumers and providers with information and tools** needed to make more informed decisions. Blue Plans across the U.S. are leading efforts to promote widespread adoption of electronic medical records, e-prescribing, personal health records, and consumer decision-support tools. Many Plans are giving providers and consumers access to comprehensive information on a patient's health and medical history through payer-based electronic health records that enable providers to better coordinate care. BCBSA urges Congress to continue to advance adoption of health information technology with an electronic health record in every doctor's office based on uniform, interoperable standards.

4. **Promote health and wellness.** Today's increased healthcare spending is partly due to unhealthy lifestyles by many Americans. Chronic illness also is a growing problem, with the cost of treating chronic illness estimated to account for 75 percent of healthcare spending.

   BCBSA applauds the Committee for emphasizing prevention, wellness, and coordinated care for those with chronic conditions. Specifically, BCBSA recommends:

   - Removing barriers that hinder employers from encouraging healthy employee lifestyles (e.g., requiring employers to give non-smoker discounts to smokers who enroll in, but do not successfully complete, cessation programs).
   - Supporting school programs that encourage healthy lifestyles and improve the nutritional quality of school meals.
   - Requiring Medicaid cover smoking cessation programs and incorporate wellness and disease prevention incentives.

5. **Foster public-private coverage solutions to address the uninsured.** Whether someone is uninsured because they have difficulty affording coverage within their family budget or are a low-wage worker in a small firm – we need to make sure people get the health coverage they need. Recognizing that the uninsured is a diverse group, BCBSA recommends tailored solutions to help the three key segments:

   Those squeezed out by cost: Approximately 56 percent of the uninsured may have difficulty affording coverage because they are ineligible for government assistance, but earn less than 300 percent of the federal poverty level. BCBSA recommends:

   - *Providing four new types of tax assistance*: Congress should enact: (1) a tax credit for small employers; (2) a refundable tax credit for those whose health premiums represent a large share of their income; (3) a refundable tax credit to help those between jobs; and (4) tax deductibility for those without access to employer coverage.

- *Expanding the government safety net:* Medicaid should be extended to cover everyone under the federal poverty level.

Those missing out on public coverage: Twenty-five percent of the uninsured (12 million) are eligible for Medicaid or SCHIP under current rules, but are not enrolled.

- BCBSA strongly supported reauthorization of the Children's Health Insurance Program, including the additional funding for outreach and enrollment for those who are eligible but not enrolled and the new "Express Lane" expedited eligibility process for states. Ensuring expanded enrollment in CHIP is a critical undertaking. Blue Plans, which serve one-third of CHIP enrollees today, look forward to working with states and the federal government to expand coverage to the estimated 4.1 million additional children who will obtain coverage under the reauthorized program.

- We also supported the inclusion of a new state option for subsidizing employer premiums. Premium assistance is a "win-win" approach to expansion because it leverages employer coverage and employer contributions, and expands access to family coverage for lower-income employees who may not otherwise be able to afford their share of the premium.

Those opting out of coverage: Twenty percent of the uninsured may be able to afford insurance, but may: (1) not value it because they are young or healthy; (2) be unaware of coverage options and their tax deductibility (for the self-employed); or (3) overestimate the cost of coverage. BCBSA recommends:

- *Educating Americans about the importance of being insured*: The public and private sectors should partner on a broad-based educational campaign on the value of insurance.

- *Ensuring all individuals obtain coverage:* create a new health coverage responsibility program as described below.

6. Personal Responsibility for Obtaining Health Coverage

To achieve universal coverage, BCBSA supports a new health coverage responsibility program for all Americans to obtain and maintain health coverage, with subsidies to help those likely to have difficulty affording insurance. This health coverage responsibility program is essential to assuring everyone has coverage and keeping premiums affordable. Along with this new program, BCBSA supports insurance reforms in the individual market with subsidies to make coverage affordable.

It is important to note that subsidies alone are not an adequate substitute for an effective health coverage responsibility program. RAND's Compare Model predicts that even with full subsidies for persons with incomes up to 200 percent of federal poverty level and partial subsidies up to 400 percent of federal poverty level, only 12.4 million individuals would be newly insured. In contrast, combining these subsidies with an effective health coverage responsibility program would increase the newly insured to 33.5 million.

7. Insurance Market Reforms to Assure Everyone has Access to Affordable Insurance

An effective, health coverage responsibility program that includes federal subsidies for those that need help purchasing coverage is essential for insurance market reforms to work. With these components in place, BCBSA supports a new requirement for all insurers to accept everyone in the individual market regardless of their health status ("guarantee issue").

Guaranteed issue can only work if everyone – young and healthy as well as higher risk individuals – purchases coverage.

BCBSA also supports new rating rules in the individual market, including:

- *Prohibitions on Health Status Adjustments.* Insurers should not be allowed to vary premiums based on health status once everyone is covered. Experience shows that bans on health-status rating in voluntary markets lead to significant increases in premiums for many people, especially young and healthy individuals. As healthier people drop coverage because of increased premiums, subsidies for sicker enrollees are lost and the remaining enrollment is left with much higher premiums.

- *Continuation of Age Adjustments.* It is extremely important to continue to allow insurers to vary premiums based on age (5:1) – even with a health coverage responsibility program. Age adjustments are essential to enable younger individuals – who may earn less than older people – to buy coverage and comply with the health coverage responsibility program. Younger people often do not value health insurance because they tend to use fewer medical services. If the premiums are set too high, there is likely to be a backlash among younger people.

- *Continuation of Wellness and Geography Adjustments.* Insurers should be encouraged to adjust premiums based on wellness factors (such as non-smoking) and geography. Wellness adjustments provide important incentives for consumers to engage in healthy behaviors and help prevent chronic illnesses. In addition, given the significant variation in healthcare costs across different regions in the country, premium adjustments to account for geography are critical.

These reforms must be appropriately phased-in, taking into account state variations and actuarial modeling, to avoid disruptions and major premium hikes to consumers currently in the market.

States should continue to be the primary regulators of insurance to best protect consumers. Federal rules should set minimum standards upon which states can build, and all insurers offering coverage in a state should be required to abide by the same rules. States have a long, successful history of regulating health insurance and protecting consumers – a role that could not be replicated effectively at the federal level. Further, we recommend exploring broadly-funded state reinsurance programs with federal funding for persons with high medical costs to ensure that individual market premiums are affordable for everyone.

Health coverage responsibility and adequate subsidies are essential to ensuring that guaranteed issue and community rating reforms work. In the 1990s, several states experimented with guaranteed issue and community rating reforms in voluntary markets. These states experienced an adverse selection spiral, where younger and healthier individuals opted out of the insurance market, causing higher premiums for those remaining in the insurance market – who often tended to be older and less healthy. States saw dramatic premium increases, drastic reductions in the number of individuals buying coverage, and fewer insurance products being available to consumers.

8. Making it Easier to Shop for Coverage by Creating State Exchanges

Today, individuals and small employers often find it difficult to shop for health insurance from multiple health plans. BCBSA supports efforts to make it easier to shop, compare, and enroll in health plans through creation of state-based exchanges.

This model would provide a central point in each state where individuals and small employers could learn about coverage options and apply for subsidies. These state exchanges would enable:

- Comparison of all insurance options in a state based on key factors including benefits, price, quality metrics, and provider networks. Each state would develop easy-to-understand comparison templates to promote transparency and informed decision-making.

- Real-time price quotes from multiple insurers. Each state would develop standard applications that individuals and small businesses could use to apply to several insurers simultaneously to obtain estimated premium quotes instead of completing multiple applications and waiting for each insurer to follow up.

- Calculation of any tax benefits and subsidies available or determination of eligibility for public programs. Enrollees could enter basic financial information, learn about the estimated final cost of coverage, and learn if they are eligible for any public programs such as Medicaid.

- Simplified enrollment in plan of choice. Individuals and small businesses could easily enroll in coverage online or apply for subsidies directly through interfacing with the agency verifying eligibility.

II. BCBSA's Initial Comments on the House Committees' Draft Bill

BCBSA strongly supports passing comprehensive healthcare reform. The recommendations we have laid out today would accomplish the objectives of reform by building on the employer-based system to rein in costs, improve quality and extend coverage to all.

The House Committees' draft bill addresses many of the critical steps required to transform our health care system. BCBSA largely supports the broad framework put forth. Specifically, we are very supportive of:

- Individual responsibility requirement to assure universal coverage with subsidies to make coverage affordable.
- Insurance reforms to assure everyone can obtain coverage and eliminate preexisting condition exclusions and health status-based rating.
- Delivery system reforms in Medicare to transform the program from paying for volume to paying for outcomes.
- Focus on prevention and wellness to keep people healthy and to better manage patients with chronic illnesses.

We have strong concerns that specific provisions will have serious, unintended consequences that undermine the goals the Committees are seeking to achieve.

Why a New Government Plan is Unnecessary and Would Cause Significant Problems

We are deeply concerned with the provisions in the House bill to create a new government-run health insurance plan that would be offered through the national health insurance exchange. A government plan that pays based on Medicare rates, as proposed, for any period of time is unnecessary and would run counter to the goals of reform. It would have devastating consequences because it would:

1. *Cause many people to lose the private coverage they enjoy today*

   Employer-based coverage would be significantly eroded by a government health plan. An independent analysis by the Lewin Group estimates that tens of millions of people would be shifted to a new government plan, if Medicare rates (or some variation) are used.

   This analysis assumes employers would shift to the new government plan because of the lower Medicare payment rates (which results in lower premiums). This would lead to significantly higher costs in the remaining private market because of exacerbated cost-shifting. A recent Milliman study shows the annual cost of employer health insurance is already $1,788 higher per family because of Medicare and Medicaid underpayments. As private premiums skyrocket, private insurance would become unaffordable for most – making the government plan the only affordable option.

2. *Underpay healthcare providers, creating major problems with access to care*

   The House draft bill would underpay health care providers by paying doctors and other healthcare professionals' current Medicare rates plus five percent and hospitals Medicare rates for individuals enrolled in the government plan. Medicare currently pays hospitals and physicians 30 and 20 percent less than private insurers for the same services, respectively. At a time when demand for healthcare will increase as up to 46 million uninsured Americans are brought into the system, these reduced payments are likely to cause major access problems in the healthcare system, such as long waits for services.

   A 2008 MedPAC study found that 29 percent of Medicare beneficiaries surveyed reported having problems finding a physician to take new patients. In addition, the Texas Medical Association in 2008 reported that only 38 percent of primary care physicians in the state will accept new Medicare patients.

3. Undermine much needed delivery system reforms

   It would also jeopardize much needed delivery system reforms critical to controlling costs. We agree Medicare needs to be reformed to reward high quality care and good outcomes rather than just paying for services. We commend the Committees for proposing delivery system reforms to help modernize Medicare. However, history has shown the government can be slow to innovate and implement changes due to the complex legislative and regulatory processes as well as political pressures. For example, the government has not been successful in selectively contracting with the best providers.

   The private sector, on the other hand, is free to innovate, and is having excellent results. BCBSA is significantly improving care outcomes and lowering costs through our national program of nearly 800 Blue Distinction Centers across the country. Readmission rates at our Cardiac Care centers are much lower than at other hospitals (26 percent lower for bypass surgery and 37 percent lower for outpatient angioplasty, based on 30-day cardiac-related readmission rates).

The House draft bill implies that the government plan would operate on a "level playing field" because it would be required to meet the same standards as other private health plans participating in the exchange. While the new government plan would meet some of the same standards as private plans, there are many clear advantages for the government plan in the draft bill. For example:

- Individuals in the government plan could sue only for their denied services in federal court, as under Medicare, while private plans could be sued in state courts for punitive, compensatory, or other damages. This alone is a huge advantage.
- Employers who have ERISA group health plans who choose to purchase private coverage through the Exchange would for the first time be subject to state liability. However, if they purchase the government plan, they would essentially be limited to Medicare remedies – which are similar to current ERISA remedies.
- Private health plans would have to meet 50 different state benefit mandates totaling over 1800 separate benefit and provider requirements, while the government plan would be exempt from these requirements.
- The government plan would be exempt from state premium taxes and other assessments, as well as federal taxes, while private plans would continue to pay taxes and assessments.
- The government plan would enjoy significant funding advantages, including an unspecified amount of start-up funding. While it has to maintain a contingency reserve, the government plan would be exempt from state solvency regulations that are likely to be far more stringent and expensive.

Clearly, the government plan enjoys major costs and regulatory advantages that will tilt the market in its favor and would ultimately lead to the government plan taking over the exchange marketplace.

BCBSA urges the Committees to reject inclusion of a new government plan and instead focus on the new major roles the federal government should undertake with reform:

- Expanding Medicaid to cover all people in poverty and enrolling all those who are eligible.
- Reforming Medicare to pay for quality and assuring Medicare's long-term solvency.
- Establishing new rules for insurers to assure access for everyone regardless of health status.
- Providing subsides to help those who may have difficulty affording coverage.

Other Comments

We are continuing to review the draft bill and intend to submit detailed comments to improve the legislation. However, we want to raise the following key concerns that will have unintended consequences on expanding coverage and ensuring affordability for consumers.

1. **State-based exchanges should be used to simplify purchasing, facilitate competition**

   A state-based approach would be a better alternative to a new national exchange because it would: (1) build on states' expertise as the regulators of today's health insurance market; (2) provide a less costly, less complex, and faster alternative to creating a new federal bureaucracy; and (3) avoid the problem of dual regulation. States have spent years crafting insurance rules and consumer protections and are in the best position to regulate this market. We have several recommendations for the exchange:

   - *Build on existing state infrastructure, rather than creating new entities:* The draft bill establishes a new federal entity to assume many regulatory functions that are currently being performed by the states, including: certifying benefit plans, enforcing consumer protections, handling grievances, investigating complaints, risk pooling, and other functions assumed by the new Commissioner. States already have thousands of staff assigned to these functions. Creating a new federal agency to perform these functions would result in unnecessary, ineffective, and costly dual regulation.

- *Focus the exchange on the goal of simplifying the purchase of insurance and promoting competition.* The draft bill would have the exchange take on a wide range of functions, including selecting the plans available to consumers. This would limit choices for consumers and constrain competition.

  As previously mentioned, we agree that a state exchange is needed to help individuals and small employers shop for coverage. However, the core functions should be limited to those necessary to help consumers and small employers make informed decisions on their coverage, easily enroll in the health plan of their choice, and apply for subsidies.

- *Allow people to purchase coverage outside the exchange with subsidies available to all eligibles.* The draft would make the exchange the sole source for obtaining coverage and subsidies in the individual market. This could cause people to drop their current health plan to obtain subsidies, causing significant disruption in the marketplace. BCBSA recommends that subsidies be available both inside and outside the exchange to minimize disruption for consumers.

- *Keep the employer market intact.* The draft bill would break up small employers within the exchange by permitting employee choice of plan. This would transform the group market into a higher cost individual marketplace that would have higher administrative costs and be prone to adverse selection. There are 4.8 million small employers (under 50) today with 32 million employees. Employee choice would result in increased costs as administrative functions would now have to be performed for each individual employee that receives coverage through the exchange.

In addition, employee choice would result in significant adverse selection problems – choice is likely to be limited to "tight network" coverage as richer, PPO-like benefit packages are driven from the exchange. BCBSA recommends that small employers remain intact and select coverage through the exchange on behalf of their employees. Keeping groups intact is likely to result in lower out-of-pocket costs for employees as their employers will likely provide higher contributions. If Congress wishes to provide employees greater choice, a better alternative would be to allow health plans to offer a choice of plans within their own pool.

2. Assure appropriate pooling to minimize disruption

The House Committees' draft bill appears to require insurers to apply rating rules to large employers and create a single insurance pool for all fully insured lines of business (individual, small group, and large group). These requirements would increase premiums in the small group and individual markets. Large employers with less healthy workers are likely to opt into plans provided by the exchange, while healthier employers likely would self-fund their coverage. This would increase premiums for individuals and smaller employers who may be forced to drop coverage as a result. In addition, these requirements would decrease incentives to adopt wellness initiatives. If forced into a community-rated pool, large employers will know that their premiums will be the same, regardless of whether employees take advantage of wellness programs. Therefore, large employers would be less likely to invest in wellness programs.

3. Incentives are needed to ensure younger people purchase coverage

The draft legislation would limit use of adjustments for age to a range of 2:1. BCBSA strongly urges the Committee to allow greater variation in age adjustments of 5:1 to ensure that young people comply with the personal responsibility requirement. Premium discounts for younger individuals – who earn less and often use fewer services than older people -- are key to getting

them to buy coverage – and thereby provide the cross-subsidies essential to pay for the care of older individuals. Premium affordability issues for older individuals should be addressed by assuring sufficient income-based subsidies are available to them.

4. Medicare Advantage

The House draft bill would reduce Medicare Advantage payments to the level of FFS claims costs over a three year period, while providing bonus payments to plans based on quality. While BCBSA supports the goal of providing quality bonuses, we have significant concerns regarding the level of cuts to Medicare Advantage. Cuts of this magnitude would cause millions of Medicare Advantage enrollees to lose their coverage and lead to significant reductions in benefits or increases in premiums for millions more. We want to work with the Committee to ensure that Medicare Advantage meets the goal of enhancing value for both beneficiaries and the government, while assuring that changes do not threaten access to coverage for the 11 million people who rely on Medicare Advantage.

Conclusion

BCBSA appreciates the opportunity to testify on how to reform our health care system. We look forward to working with this Committee to enact comprehensive health care reform legislation.