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Statement of

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Hearing on
The Tri-Committee Draft Proposal for Health Care Reform

Committee on Energy and Commerce

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Good afternoon, Mr. Chairman and Members of the Committee.

I am Karen Pollitz, a Research Professor at the Georgetown University Health Policy Institute, where I study the regulation of private health insurance.

I commend the Members of the three House Committees, including this one, for the Tri-Committee Draft Proposal for Health Care Reform. Your hard work, wisdom, and practicality are evident in this proposal. It contains the key elements necessary for effective health care reform that will achieve universal coverage and introduce cost discipline into the health care system. I congratulate you on this effort, and as a citizen, I thank you for it. This time, you will get the job done.

In my remarks today, I will comment on some of the central health care reform provisions contained primarily in the first five titles of the draft legislation and offer several suggestions that I hope you will find helpful and constructive as you work toward enactment later this year.

For health care reform to provide all Americans with secure coverage, changes must be adopted and enforced to ensure that health insurance is always available, affordable, and adequate. Key elements of the Tri-Committee proposal will address these critical needs.

Individual responsibility

The legislation requires all Americans to have health insurance coverage. More importantly, it makes other changes to our coverage system to enable people to comply with this requirement.

Essential benefit standard

A most basic component of health care reform is to define what constitutes health insurance. Far too many policies that provide inadequate coverage are on the market today, and as a result, almost as many Americans are under-insured as uninsured. Recent studies find that 57 million Americans are burdened with medical debt, and 75 percent of them have health insurance.[1] Medical bills continue to be a leading contributor to personal bankruptcy and most medical bankruptcies also occur among people who are insured.[2] This spring, *Consumer Reports* magazine reported on a host of health insurance products that nonetheless left policyholders on their own to pay tens of thousands of dollars (or more) in medical bills.[3] Studies show the under-insured, similar to the uninsured, have difficulty accessing timely and quality health care.[4]

A fundamental purpose of health care reform must be to put an end to medical debt and medical bankruptcy and to ensure that health coverage is, indeed, a ticket to health care. The Tri-Committee draft proposal sets national standards for an essential health benefits package that includes hospital care, inpatient and outpatient medical care, prescription drugs, mental health and substance abuse treatment, rehab services, preventive care services, and maternity care. Enhanced benefits for children are also covered. Cost

sharing for covered services provided in-network cannot exceed $5,000 per year for an individual, $10,000 for a family. The annual limit on cost sharing is a comprehensive limit that applies to all forms of cost sharing, similar to that required for tax preferred HSA-eligible health plans today.

All qualified health benefit plans will be required to cover the essential benefits package. Three levels of plan options can be offered. The Basic Plan level must set cost sharing to achieve an actuarial value of 70 percent of the essential benefits package. Enhanced and Premium Plan options must have actuarial values of 85 and 95 percent, respectively, of the essential benefits package.

A Health Benefits Advisory Committee chaired by the Surgeon General will fill in other important details on plan features, such as the annual deductible(s) and update the benefit package over time.

Recommendation – The essential benefit package must include a maximum out-of-pocket limit whether people receive care in or out of network. Though the bill provides for the establishment of network adequacy standards, patients nonetheless need protection against unlimited cost sharing when they must seek care out of network. The sickest patients are most likely to need care from sub-specialists who may not participate in their plan network. And any patient who is hospitalized may inadvertently receive costly care from non-network doctors whom they do not choose (for example, anesthesiologists, radiologists, pathologists, emergency physicians.)

In addition, an often mentioned benchmark standard for coverage adequacy is the Standard Option plan offered by Blue Cross Blue Shield under the Federal Employees Health Benefits Program (FEHBP) - coverage that most federal employees and many Members of Congress have today. The essential benefits package outlined in the draft proposal appears to provide less coverage than this FEHBP standard. If that is the case, additional resources should be added to the bill to raise the minimum benefit standard. Over the next decade, our economy will generate more than $187 trillion in gross domestic product and we will spend a projected $33 trillion on medical care. Investment in health care reform that guarantees an adequate level of protection for individuals and families is worthwhile.

Whatever benefit standard is ultimately adopted, the Health Benefits Advisory Committee should be required to regularly report on medical bills that individuals and families incur in order to monitor and strengthen coverage adequacy.

Finally, the draft proposal continues to permit the sale of certain so-called "excepted benefits" in traditional health insurance markets. These include cancer policies and other dread disease and limited benefit policies. Consumers are vulnerable to abusive marketing practices when it comes to these policies and state regulators have long warned they are a poor value.[5] At a minimum, such policies should contain warning labels that they do not constitute qualified health benefit plans and that coverage is duplicative of that provided under qualified health benefit plans.

Subsidies and Medicaid expansion

Today most uninsured people have low incomes and lack coverage chiefly because they cannot afford it. The Tri-Committee proposal addresses affordability in two ways.

First, it expands Medicaid coverage to all Americans with family incomes up to 133-1/3 percent of the federal poverty level (FPL). This is an important departure from the current Medicaid program, which only provides coverage for certain categories of individuals – children and their parents, and other adults only if they are elderly or disabled. In addition, current Medicaid income eligibility standards for adults vary significantly by state but often are set at levels far below the FPL.

To make this expansion affordable for states, the draft legislation provides that the federal government will pay the full cost of covering new expansion populations – childless adults and other adults for whom current income eligibility levels are below 133-1/3 percent FPL. Further, to ensure individual choice, Medicaid-eligible individuals will have the choice between enrolling in Medicaid or seeking other subsidized private health insurance coverage

Second, the discussion draft provides for sliding scale financial assistance for individuals and families to purchase private health insurance. Premium subsidies would be offered on a sliding scale for people with income up to 400 percent of FPL. Subsidies at this level will be absolutely necessary, and, as discussed below, may well need strengthening.

Importantly, the discussion draft also provides subsidies for cost sharing under private health insurance. This is also critically important. Deductibles, co-pays, and coinsurance are additional payments required of insured individuals at the point when they seek health care. Decades of research shows that cost sharing deters the use of care, including medically necessary care, particularly by people with limited income. Further, research shows that when out-of-pocket spending for medical bills (not including premiums) exceeds just 2.5 percent of family income, patients become burdened by medical debt, face barriers to accessing care, and have problems paying other bills.[6] Cost sharing subsidies are necessary to ensure that people can afford to access covered benefits.

Recommendation – Depending on what premiums are charged for qualified health benefit plans, subsidies capped at 400 percent of FPL may prove to be insufficient to ensure affordable health care for all Americans. At last count, ten percent of the uninsured, or some 5 million Americans, had incomes at or above 400 percent FPL. This is due to the fact that our measure of poverty level income is very low, while the cost of good health coverage is relatively expensive. For example, an income of 400% of FPL for a family of three is $73,240. For that family to enroll in the FEHBP Blue Cross Blue Shield Standard Option plan would cost $13,446, or 18 percent of gross family income.

The Massachusetts health care reform experience is instructive. In that state, subsidies are limited to residents with incomes to 300 percent of FPL, and as a result, the state waives the individual mandate on grounds of affordability for approximately 2 percent of residents.[7] Because people with incomes above the subsidy levels provided in this bill

may find quality health insurance coverage costs more than they can afford, you should consider improvements to the premium subsidy schedule.

The Committee might consider instead a rule that no individual or family will have to pay more than 10 percent of income on health insurance premiums (with lower limits set for low-income individuals, as the Tri-Committee draft does.) Cutting subsidies off entirely at an arbitrary income level can leave families vulnerable.

As shown in Figures 1 and 2, if the intent of the Committees is to assure that no families or individuals will have to pay more than 10 percent of income for health insurance premiums, and if the FEHBP Blue Cross plan is used as a benchmark premium, then people will need help beyond that provided for in the draft proposal. The cost of good coverage is will be sizeable compared to what many working families earn. (See Figure 3) A subsidy system that caps people's liability for premiums at no more than 10 percent of income would be more protective and subsidies would taper off gradually, avoiding a cliff. Some assistance would reach people at higher income levels, though help provided to higher earners would be modest.

Figure 1. Comparison of Single Premium for FEHBP BCBS Standard Option to Various Income Levels, 2009

% FPL	Annual Income	BCBS FEHBP Annual Premium	Premium / Income	Sliding Scale Income Cap on Premium Liability	Individual Pays	Amount Help Needed	(%) Help Needed
100%	$10,830	$5,872	54%	0	0	$5,872	100%
200%	$21,660	$5,872	27%	2%	$433	$5,439	93%
300%	$32,490	$5,872	18%	6%	$1,949	$3,923	67%
400%	$43,320	$5,872	14%	8%	$3,466	$2,406	41%
500%	$54,150	$5,872	11%	10%	$5,415	$ 457	8%
600%	$64,980	$5,872	9%	10%	$5,872	0	0
1,600%	$174,000	$5,872	3%	10%	$5,872	0	0

Figure 2. Comparison of Family Premium for FEHBP BCBS Standard Option to Various Income Levels, 2009

% FPL	Annual Income	BCBS FEHBP Annual Premium	Premium / Income	Sliding Scale Income Cap on Premium Liability	Family Pays	Amount Help Needed	(%) Help Needed
100%	$18,310	$13,446	73%	0	0	$13,446	100%
200%	$36,620	$13,446	37%	2%	$732	$12,714	95%
300%	$54,930	$13,446	24%	6%	$3,296	$10,150	75%
400%	$73,240	$13,446	18%	8%	$5,860	$7,586	56%
500%	$91,550	$13,446	15%	10%	$9,155	$4,291	32%
600%	$109,860	$13,446	12%	10%	$10,986	$2,460	18%
700%	$128,170	$13,446	11%	10%	$12,817	$629	5%
735%	$134,460	$13,446	10%	10%	$13,446	0	0
950%	$174,000	$13,446	8%	10%	$13,446	0	0

Figure 3. What do people earn?

Individual			Family of 3		
% FPL	Annual Income	Example occupations*	% FPL	Annual Income	Example occupations*
100%	$10,830		100%	$18,310	
150%	$16,245	Fast food worker	150%	$27,465	Dishwasher + part time laundry worker
200%	$21,660	Home health aide	200%	$36,620	Cafeteria attendant + shampooer
250%	$27,075	School bus driver	250%	$45,775	Restaurant cook + stock clerk
300%	$32,490	Travel agent	300%	$54,930	Receptionist + secretary
400%	$43,320	Social worker	400%	$73,240	Police officer + child care worker
500%	$54,150	High school teacher	500%	$91,550	Legal secretary + electrician
600%	$64,980	Nurse (RN)	600%	$109,860	Real estate agent + librarian
1,600%	$174,000	U.S. Congressman	950%	$174,000	Administrative law judge + aerospace engineer

* Source: Bureau of Labor Statistics

Private health insurance market reforms

The Tri-Committee proposal prohibits the use of common insurance industry practices today that have the effect of discriminating against people based on health status. Under reform, health insurance would have to be offered on a guaranteed issue basis. No longer could individuals or employer groups be denied coverage based on health status or health history, although insurers would be allowed to surcharge premiums by as much as 100 percent based on age – a strong proxy for health status. The discussion draft also provides for guaranteed renewability of coverage – a requirement of current law – with clarification that the rescission of health insurance is also prohibited. In other words, insurers will be explicitly prohibited from a common practice today of taking back coverage from individuals and employer groups after claims are made. The draft legislation also prohibits the imposition of pre-existing condition exclusion periods and prohibits insurers from varying premiums based on health status. These market rules will promote the spreading of risk, instead of today's industry practices of segregating risk. And they are essential in a world where people are required to have health insurance.

Other new market rules will ensure that coverage works well and efficiently for consumers. Standards for network adequacy and the timely payment of claims are provided for under the bill. In addition, insurers will be required to meet minimum loss ratios of 85 percent, so that no more than 15 percent of premium dollars can be spent on marketing, administrative costs, and profits.

Recommendation – Consideration should be given to tighter limits on age adjustments to premiums, or for elimination of such adjustments altogether. Particularly if premium subsidies are capped at 400 percent FPL, affordability problems may be substantial for members of the "Baby Boom" generation. Premiums for coverage sold today in Massachusetts, where age rating of 2:1 is also permitted, illustrate the affordability problem for people as we age. See Figure 4.

Figure 4. Monthly age-rated premiums (2:1), family of 3, Massachusetts

Plan-type	Age 24	Age 64
Bronze	$626 - $1,020	$1,144 - $1,759
Silver	$834 - $1,466	$1,648 - $2,483
Gold	$1,091 - $1,878	$2,183 - $3,172

Finally, for market reforms to be meaningful, Congress must authorize and appropriate resources for oversight and enforcement, both at the federal and state level. The Tri-Committee proposal wisely requires extensive data disclosure by health plans so that regulators can monitor compliance with market rules. But regulators will need expert staff to review and analyze data, as well as to conduct compliance audits and respond to consumer problems and complaints.

Resources at the federal level are particularly lacking and must be increased. At a hearing last summer of the House Committee on Oversight and Government Reform, a representative of the Bush Administration testified that the Centers for Medicare and Medicaid Services (CMS), which is responsible for oversight of HIPAA private health insurance protections, then dedicated only four part-time staff to HIPAA health insurance issues. Further, despite press reports alleging abusive rescission practices, the agency did not investigate or even make inquiries as to whether federal law guaranteed renewability protections were being adequately enforced.[8]

Additional resources will also be needed at the U.S. Department of Labor (DOL). After the enactment of HIPAA, a witness for DOL testified the Department had resources to review each employer-sponsored health plan under its jurisdiction once every 300 years.[9]

At the state level, limited regulatory resources are also an issue. In addition to health coverage, state commissioners oversee all other lines of insurance. In several states the Insurance Commissioner also regulates banking, commerce, securities, or real estate. In four states, the Insurance Commissioner is also the fire marshal. State insurance departments collectively experienced an 11 percent staffing reduction in 2007 while the premium volume they oversaw increased 12 percent.[10] State regulators necessarily focus primarily on licensing and solvency. Dedicated staff to oversee health insurance – and in particular, insurer compliance with HIPAA rules – are limited. Enforcement of consumer protections is often triggered by complaints.

In order for new promised consumer protections to be real, strong oversight and enforcement will be essential. Your colleague, Congresswoman Rosa DeLauro, has wisely introduced legislation (HR 2427) to strengthen oversight and enforcement capacity at the federal and state level.

Establishment of a national health insurance Exchange

The Tri-Committee proposal also provides for the establishment of a national health insurance Exchange. An Exchange is a more organized health insurance market than

what individuals, employers, and insurers are used to today. For purchasers in the Exchange, there will be subsidies to make premiums affordable. There will also be considerable new sources and types of assistance – for example, the provision of comparative information about plan choices, as well as assistance with enrollment, appeals, determination of eligibility for subsidies, and so on. Many of these services will be provided by a new Health Insurance Ombudsman, created solely to help consumers navigate the coverage system and make choices that are best for them.

For sellers of health insurance, the Exchange will accept bids and negotiate with insurers over the premiums they charge. The Exchange will also exercise much closer oversight of health insurance. Insurers will be required to report data on their products and practices in order to make more transparent the black box that is private health insurance today. These data will be used to establish risk adjustments to premiums and to monitor compliance with market rules and consumer protections.

Initially, the Exchange will serve those consumers who are most in need of these added protections – individuals and the smallest employers (with fewer than 20 employees) who lack market clout and the resources to hire human resources experts of their own. Authority to permit other employers to participate in the Exchange is delegated to a Commissioner starting in the fourth year of implementation.

The Commissioner is also authorized to require that certain consumer protections – such as network adequacy protections, transparency standards, and external appeals – apply to all qualified health benefit plans, including those outside the Exchange. However, the Commissioner might not require parallel protections. Further, the legislation does not require that insurers offer the same plan options at the same prices both inside and outside the Exchange.

Recommendation – In order to protect against risk selection, it is important for requirements to be identical for all qualified health benefit plans, no matter where they are sold, in or outside of the Exchange. Insurers who sell coverage to employers inside the Exchange should be required to offer identical policies outside of the Exchange and for the same price. If insurers can vary the plan options and prices they offer in different markets, they will be more able to steer risk, and small employers will be vulnerable to distorted prices when somebody in their group gets sick. The legislation should clarify that sanctions for violation of market rules will be the same for insurers who sell coverage outside of the Exchange. In addition, the Tri-Committee plan includes special sanctions for employers if they are caught steering plan participants into the Exchange when they get sick. Similar "anti-dumping" sanctions should be applied to insurers who operate outside of the Exchange.

<u>A public plan option</u>

Within the health insurance Exchange, consumers will have a choice of private health insurance plans and carriers, as well as a public plan option. This key provision in the draft reform bill will promote both choice and cost containment. Under the Tri-

Committee proposal, the public plan option must meet the requirements of other qualified health benefit plans offered by private insurers.

A recent national poll indicates Americans are strongly behind the establishment of a public plan option to compete with private health insurers.[11] By introducing this option into the marketplace, a public plan option can address failures of competitive health insurance markets today.

First, it offers consumers an alternative to private health plans that, for years, have competed on the basis of discriminating against people when they are sick. At a hearing of the House Energy and Commerce Committee just last week, patients testified about having their health insurance policies rescinded soon after making claims for serious health conditions. One woman who is currently battling breast cancer testified that her coverage was revoked for failure to disclose a visit to a dermatologist for acne. At this hearing, when asked whether they would cease the practice of rescission except in cases of fraud, executives of leading private health insurance companies testified that they would not.[12] Experiences like these make some consumers distrust private insurers.[13] If consumers are required to buy health insurance, having a public coverage option that does not have to compete on the basis of profits will give many peace of mind.

Second, a public plan option will promote cost containment. Research shows that health insurance markets today do not compete to hold down costs. Rather, insurers and providers negotiate to pass cost increases through to policyholders while maintaining and even growing corporate profits.[14] Under the Tri-Committee proposal, the public plan option will initially be allowed to base its payments to doctors, hospitals, and most other providers on the fee schedules used by Medicare, albeit at a higher level than Medicare pays today. The public plan will negotiate new payment rates for prescription drugs with pharmaceutical companies. And it will be able to offer bonus payments for providers that participate in both Medicare and the public plan. The public plan option is further tasked with development of innovative payment methodologies that hold down cost and promote quality. This will help move the market in the direction of competition based on the efficient delivery of health care services.

Shared responsibility

Finally, the Tri-Committee draft proposal provides for a continued role by employers in the provision of health benefits. Most insured Americans today get health coverage at work and a stated goal of health care reform is to let people keep current coverage if they are satisfied with it. A requirement for employers to provide health benefits ("play") or contribute toward the cost of other public subsidies for coverage ("pay") is consistent with this goal and will help keep employer resources in the financing system.

Conclusion

Mr. Chairman, the Tri-Committee draft proposal for health care reform is an impressive accomplishment, worthy of the challenges we face to make health coverage available, affordable, and adequate for all Americans. Your proposal defines a minimum health

benefits standard, requires it for all Americans, and institutes reforms to ensure affordable coverage in reformed and better organized markets with added, important consumer protections. You also make available a new public plan option that will add to consumer choice and prompt insurance companies to compete on the basis of quality and cost efficiency, not risk selection.

No doubt, others will recommend modifications as I have today. The legislative process was intended to consider all points of view and then act in the best interests of the public you represent. I could not be more pleased to see this legislative process at work. I thank you for your courage and commitment to health care reform that secures good, affordable health coverage for all Americans, and will be happy to provide you any additional information or assistance that I can.

Notes

[1] Peter Cunningham, "Tradeoffs Getting Tougher: Problems Paying Medical Bills Increase for US Families, 2003-2007," Center for Studying Health System Change, Tracking Report No. 21, September 2008.

[2] David Himmelstein, et.al., "Medical Bankruptcy in the United States, 2007: Results of a National Study," *The American Journal of Medicine,* June 8, 2009.

[3] "Hazardous health plans: Coverage gaps can leave you in big trouble," *Consumer Reports*, May 2009.

[4] Cathy Schoen, et al., "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," The Commonwealth Fund, June 10, 2008

[5] See, for example, http://www.ncdoi.com/consumer/consumer_publications/health%

[6] Peter Cunningham, "Living on the Edge: Health Care Expenses Strain Family Budgets," Center for Studying Health System Change Tracking Research Brief No. 10, December 2008.

[7] Health Care Reform Facts and Figures, Commonwealth Connector, June 2009.

[8] Testimony of Abby Block, Hearing on Business Practices in the Individual Health Insurance Market: Termination of Coverage, Committee on Oversight and Government Reform, U.S. House of Representatives, July 17, 2008.

[9] Testimony of Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration, Senate Labor and Human Resources Committee, October 1, 1997.

[10] National Association of Insurance Commissioners, *2007Insurance Department Resources Report,* 2008.

[11] Kevin Sack and Marjorie Connelly, "In Poll, Wide Support for Government-Run Health" *New York Times,* June 21, 2009.

[12] Lisa Girion, "Health insurers refuse to limit rescission of coverage," *Los Angeles Times,* June 17, 2009.

[13] Gallup poll, June 17, 2009, available at http://www.gallup.com/poll/120890/Healthcare-Americans-Trust-Physicians-Politicians.aspx

[14] James Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs,* November/December 2004.