



AMERICAN BENEFITS COUNCIL

May 22, 2009

The Honorable Max Baucus
Chairman
Senate Finance Committee
Washington, DC 20510

The Honorable Charles Grassley
Ranking Member
Senate Finance Committee
Washington, DC 20510

Re: Comments on Senate Finance Committee Policy Options for Expanding Health Care Coverage

Dear Senators Baucus and Grassley:

Thank you for your leadership on the vitally important goal of achieving comprehensive health reform and for the opportunity to comment on the Committee's recent option paper on expanding health care coverage. I am writing on behalf of the American Benefits Council, a trade association representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to retirement and health plans covering more than 100 million Americans.

For our members, the best reform options are those that preserve and strengthen the voluntary role employers play as the largest source of health coverage for most Americans. By keeping employers engaged as sponsors of health coverage, we also keep the innovation and expertise employers bring to the table in the collective effort to achieve broad-based, practical health system reform.

One of the many strengths of our voluntary employer-based system is that group purchasing lowers health care costs because employers, especially larger employers, are able to effectively pool the risks of employees. In addition, employers are demanding purchasers of health care services. They are increasingly focused on leveraging their health care dollars with those who can demonstrate proven value and improved health care status for employees and their families. Because employers have a strong interest in the health and productivity of their workforce, they work hard to identify solutions that improve productivity, reduce chronic illness, and lower disability costs. These investments in the health of their workforce not only provide broad access to primary

care and specialty services, they increasingly have engaged employees in innovative health coaching and healthy lifestyle programs, cost and quality transparency initiatives, pharmaceutical management programs, and value-based health plan designs.

Typically, employers do not consider pre-existing health conditions when offering health coverage to their employees and do not adjust premiums, or limit coverage based on individual health status. Further, with the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), individuals cannot be denied health coverage due to their health status as they move from job to job. Employees typically report high levels of satisfaction with the health coverage they obtain through their employer and increasingly understand its value as the high cost of health coverage would make it much more difficult to obtain on their own.

It is also important to keep in mind that nearly all employers with 200 or more employees provide health care coverage today. In fact, data from a 2008 Kaiser Family Foundation survey shows that 99 percent of employers with 200 or more employees offered health benefits to their workers, and that this percentage has never been lower than 98 percent at any time over the last ten years. By comparison, the same survey shows that 62 percent of firms with fewer than 200 employees offered health coverage. Clearly, these numbers demonstrate that an overwhelming majority of larger employers already provide health benefits for their employees. They also underscore that the solutions to expanding coverage among smaller employers will critically depend on the ability to make this highly valued benefit more affordable and sustainable for all.

Personal Responsibility for Obtaining Coverage

We support a requirement for all individuals to obtain and maintain health coverage in a reformed health care system. Making health care coverage an individual obligation would be a significant shift in current policy, but this shift is a necessary one. As a nation, we need to ensure that all Americans have health coverage, not only because it is the right thing to do, but because the costs of uncompensated care are shifted to employers, insurers, consumers and the government and result in a hidden tax on health coverage. This hidden tax also results in more employers – especially small employers – unable to offer health coverage, more individuals unable to pay their share of insurance premiums and more restrictions on eligibility and payments by government health insurance programs, resulting in further cost shifts to other payers.

Expanding health coverage to all Americans will have other benefits, too. For example, not all those who are uninsured are high risk or high cost. According to recent census figures, nearly 20 million of those who are uninsured are estimated to be young adults between ages 18 and 34. Covering these large numbers of uninsured young adults should not only improve the overall risk pools for covered individuals, but importantly,

means that more young adults are likely to have their health conditions detected and treated at earlier stages before they become more costly and complicated to address.

We also concur with the general approach in the Committee's option paper which is to include incentives for obtaining and maintaining coverage, by permitting the limited application of pre-existing exclusion periods and higher premiums for late enrollees, in an effort to minimize the use of back end tax penalties for failure to obtain required coverage. We also agree that standards for obtaining an exemption to tax penalties will be needed to avoid situations where the individual coverage requirement could impose unusual hardship.

Employer "Pay or Play" Requirement

As the Committee considers coverage solutions as part of health reform, we believe that strategies that focus on making health coverage more affordable for employers of all sizes is the best way to ensure both the continuation of the extremely high levels of participation by larger employers and increase the level of participation by smaller employers. Indeed, one reason we believe that a "pay or play" approach would be an inappropriate coverage solution is that the myriad requirements that would inevitably be imposed on those who might prefer to sponsor health coverage would ultimately, if unintentionally, result in a net reduction in employer-sponsored coverage by leading some companies to simply "pay" rather than "play". This would lower the level of active employer engagement and their important role as innovative and demanding purchasers of health care services.

We also believe that a federal minimum benefit standard is needed only for the purpose of determining whether individuals have enrolled in qualified health coverage and have met their individual coverage obligation. Once this standard is defined, employers will have strong incentives to ensure that their plans meet or exceed the minimum coverage standard applied to individuals. To not do so would leave their employees without adequate levels of coverage and subject to year-end penalties. Individuals who enroll in these employer plans will therefore satisfy their individual coverage obligation and should be allowed to do so by enrolling in an employer plan that is at least actuarially equivalent to the minimum benefit standard for the individual coverage requirement. Also, since we believe that most employer-sponsored coverage is likely to meet or exceed the actuarial value of any minimum standard established for individual coverage obligation purposes, we recommend that employers be permitted to self-certify that their plans would constitute qualified coverage for their employees in order to avoid a more costly and unnecessarily burdensome determination process.

Finally, we recommend that there be a safe harbor for qualified high deductible health care coverage. By doing so, individuals who enroll in a high deductible plan that meets existing federal standards to be offered in combination with a health savings account

(HSA) would be assured of meeting their individual coverage obligation. This also helps ensure that high deductible plans are not required to become more costly solely for the purpose of meeting an minimum coverage requirement.

Employee Opt-Out from Employer Plans

The Committee's option paper also includes a proposal to permit employees to opt-out of employer coverage and obtain coverage in the individual insurance market through one of the new health insurance exchanges. Employers would be required to contribute their "normal" premium contribution to the health insurance exchange for employees who opt-out of their plans. These employer contributions would be used to help finance the income-based tax credits available to lower-income individuals who elect to receive coverage through the insurance exchanges. Lower-wage employees who remain in an employer plan would not be eligible for the income-based premium subsidies.

We believe that a better approach would build on the premium support program in the Children's Health Insurance Program (CHIP) where premium subsidies available to lower income individuals may be for the employee share of the premium for employer-sponsored coverage. Under the CHIP program, employers may opt to receive these subsidy payments directly on behalf of eligible individuals or the payments may go the individuals to use for the payment of their premium share for the employer plan. In either case, the program recognizes that in many cases it will be less costly for the government to subsidize the qualified employees' costs for available employer-sponsored coverage, allow premium subsidy dollars to go further for those without access to employer-sponsored coverage, and minimize disruption to employer plans.

We also believe that if an opt-out provision is included as part of health reform legislation, that it should not apply where employers are providing meaningful health insurance coverage (e.g., a typical group health plan that meets the "creditable coverage" definition under the Health Insurance Portability and Accountability Act of 1996), nor should employers be required to pay their "normal" premium contribution to the insurance exchange for coverage that an individual is not obtaining through their employer plan. This approach would be particularly problematic for self-insured employers who could be required to contribute significantly more to the exchange than what some of these employees may have actually cost the employer if they had remained in their plan. This would occur whenever younger, healthier employees opt-out of the employer plan and obtain coverage through the insurance exchange. In effect, employers would be required to both "play and pay" for those employees who opt-out of their employer-sponsored plan and obtain coverage elsewhere.

Temporary Medicare Buy-In

The Committee's paper also presents an option to permit individuals who are 55 to 64 years old, and who do not have employer-sponsored coverage or are not covered under Medicaid, to voluntarily enroll in Medicare until such time as coverage is broadly available through the newly-established health insurance exchanges. Individuals who elect to enroll in Medicare would be required to pay the full cost of the coverage, plus a 5 percent administrative fee. In addition, these premium amounts could later be adjusted higher or lower depending on the actual claims experience of those in this age group who opted for Medicare coverage. The Medicare buy-in opportunity would be effective January 1, 2011 and would presumably end within two years after the health insurance exchanges and insurance market reforms are implemented. Individuals who elected Medicare coverage during this period would be permitted to retain it indefinitely.

We agree that better coverage solutions are needed for those without employer-sponsored coverage, regardless of age. The Committee's proposed option for those age 55 to 64 to permit a temporary Medicare buy-in highlights the urgent need for responsible and workable insurance market reforms so that anyone will be able to obtain affordable, meaningful health coverage. Rather than provide a stop-gap opportunity to enroll in Medicare, we believe that the priority should be to achieve market reforms as quickly as possible so that Americans of all ages will be able to obtain the health coverage they need through competitive private plan options.

Public Health Insurance Plan Option

Several different approaches to offering a public health insurance plan option are included in the Committee's option paper. These range from permitting a "Medicare-like" plan to compete with private health plan options in the reformed health insurance market, to having a third party administrator (TPA) organize networks of health providers and negotiate payment rates for public plan options that would compete with private health plans, or permitting states to allow individuals to enroll in state-based health insurance plans, including plans for state-employees. The Committee's option paper also recognizes that another approach would be to have no public health insurance plan option and instead rely on private plan options in "a reformed and well regulated private market".

We believe the better alternative is to focus on the conditions needed to achieve a reformed and well regulated private market, which will be challenging enough without attempting to introduce public plan options that risk destabilizing the insurance market at the time when it will be undergoing significant change and meeting demanding new standards. Moreover, just as a public plan option was a topic of significant debate during the consideration of the Medicare prescription drug benefit, the evidence clearly

shows that private health plans are now widely available in all parts of the country providing the Medicare Part D drug benefit; and that Medicare beneficiaries report high levels of satisfaction with the coverage they receive under these plans. Well structured health insurance reform should achieve the same result and we believe that vibrant competition among private health plan options in the reformed market should be given every opportunity to succeed.

Employer Wellness Credits

A new tax credit to encourage employer wellness programs is also included in the Committee's option paper. Under the proposal, a tax credit would be allowed for 50 percent of employer costs for qualified wellness programs. The credit would be limited to a maximum of \$200 for the first 200 employees and \$100 for all additional employees and would be available for a maximum of five years. Qualified wellness programs would be those that are available to all employees, and meet standards for health awareness, employee engagement, behavioral change and a supportive environment as well as be consistent with other evidence-based research and best practices. Another option under consideration would be to limit the availability of the tax credit only to smaller employers with fewer than 50 employees and increase the amount of the credit to \$400 per employee.

We support incentives to encourage the development of innovative and effective employer wellness programs and recommend that any tax credits for these purposes be available to employers of all sizes since many of the most innovative efforts in this area are being pursued by large employers. We also recommend that expedited and streamlined procedures be considered for obtaining a certification as a qualified wellness program, both to minimize any administrative burdens of obtaining the certification and to increase certainty about the availability of the tax credit when planning a qualified program. One possible way to expedite the certification process might be to allow a self-assessment (subject to audit) based on guidance that describes activities in each category that would be required in a qualified program.

Medicaid Enrollment and Retention Improvements

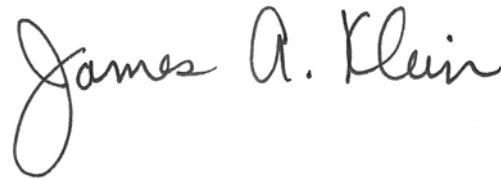
The Committee's options paper includes several possible initiatives to strengthen Medicaid enrollment and retention. These are intended to remove barriers to enrollment in Medicaid and to help streamline the eligibility determination process. States that meet these standards would qualify for federal bonus payments to encourage their adoption.

We support efforts to encourage states to strengthen their outreach programs to enroll and retain those who are already eligible for coverage under Medicaid. Indeed, as part

of health care reform where all individuals will have a responsibility to obtain coverage and where the goal is to achieve the broadest possible level of coverage, it will be essential for states to increase their efforts to reach and enroll eligible individuals for these safety-net health insurance programs. We recommend that in addition to financial incentives for enhanced enrollment and retention activities, that timelines be established for implementing the new outreach efforts and that activities that have proven to have been successful where they have already been adopted in selected states be considered as core activities for federal Medicaid matching funds.

Thank you again for the opportunity to comment on the Committee's options paper on expanding health care coverage. We look forward to continuing to work with the Senate Finance Committee on the urgent national priority of achieving comprehensive health care reform.

Sincerely,

A handwritten signature in black ink that reads "James A. Klein". The signature is written in a cursive style with a large, looping initial "J".

James A. Klein
President