Written Statement for the Record by
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Subcommittee on Health, Employer, Labor, and Pensions Subcommittee

Ways to Reduce the Cost of Health Insurance for
Employers, Employees, and Their Families
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Mr. Chairman, Members of the Committee:

Thank you for inviting Families USA to testify today at this very important hearing about health care reform. We are excited that Congress is moving forward with health care reform this year, and happy to help you think through the implications for employer-based health insurance.

We have two core goals for health care reform: that everyone who currently has satisfactory health care coverage can keep that coverage, and that those who do not currently have health care coverage can get it. We believe that the most effective and efficient way to achieve both of those goals is to build upon the existing health care system. The employer-based health insurance sector is of great importance, covering well over half of all non-elderly insured Americans. In health reform, we must do the following:

- strengthen employer-based health coverage by improving regulation of the market,
- subsidize coverage for those workers with low and moderate incomes to enable them to obtain and keep health coverage, and
- expand the Medicaid program to fill in the gaps for low-income people whose needs are not met by the employer-based system.

Strengthen Employer-Based Coverage

Employer-based coverage provides important protections: It is guaranteed—that is, people will not be denied coverage based on their health; insurers are limited in their ability to exclude coverage of pre-existing conditions; and employees within a group cannot be charged higher

premiums based on their age, health status, or gender. Further, large employers are generally able to negotiate for good, comprehensive coverage for their employees. These protections are not provided in the individual insurance market in many states, much to the detriment of consumers, and they are essential protections to build upon in health care reform.

However, there are also weaknesses in the protections described above. Even limited pre-existing condition exclusions create inequities and contribute to the phenomenon of "underinsurance." And although employees performing similar jobs in a company cannot be charged different health insurance premiums, the business as a whole may pay higher premiums based on its employees' health or other characteristics. The variability of insurance offered by employers means that some employees get good coverage at work while others get coverage that leaves them exposed to high out-of-pocket costs or provides limited benefits, or they get no coverage at all. And finally, in the current health care system, even if people have very minimal incomes, many are not eligible for public coverage or any help paying their premiums.

I'd like to spend a few minutes talking about each of these problems and then talk more specifically about protections people with low incomes will need in a reformed market.

Improvements Needed in Employer-Based Coverage

Prohibit pre-existing condition exclusions

Under the Health Insurance Portability and Accountability Act (HIPAA), people have *some* protections against pre-existing condition exclusions when they receive coverage through their employers:

- They cannot be subject to a pre-existing condition exclusion if they have had 12 months of continuous coverage;
- Only conditions which have been treated or diagnosed by a medical professional in the last 6 months count as pre-existing conditions; and
- Insurers cannot decline to offer group coverage due to the health of an employee.

(In Medicaid and CHIP, people are not subjected to pre-existing condition exclusions at all.)

However, HIPAA does allow insurers to exclude coverage for a pre-existing condition for up to one year for employees who previously had less than 12 months of continuous coverage. (The exclusionary period is reduced by the amount of time that they had previous continuous coverage.) These exclusions cause employees to postpone or forgo treatment for serious illnesses such as cancer.[1]

Pre-existing condition limitations are intended to serve a policy goal of encouraging people to keep insurance, but this does not make much sense in the group market. Mostly, the people who go without coverage are those who do not have help paying premiums from their employer and who cannot afford to maintain coverage on their own. People who try to purchase coverage on their own in the individual market often face extremely high premiums, especially if they are older or in less than perfect health, and many are denied coverage altogether. And many adults, no matter how poor, do not qualify for Medicaid.

In passing the American Recovery and Reinvestment Act (ARRA),[2] Congress recognized the unfairness of counting a time that someone cannot afford coverage as a "break" that subjects people to pre-existing condition exclusions. Congress directed that any gaps in coverage between the time a person was laid off and when the new COBRA subsidy became available cannot be counted as a break in coverage and therefore the person cannot be subjected to new pre-existing condition exclusions. At the very least, this principle of not counting unavoidable gaps in coverage should be extended to a reformed market. Families USA recommends that ERISA be amended to entirely prohibit pre-existing condition exclusions in employer-based plans. The Pre-existing Condition Patient Protection Act of 2009 would do this.

Prohibit premium variation based on health status and gender

In 40 states and the District of Columbia, small group insurers can charge employers higher premiums if the employees as a group seem to be in poorer health than average. In most of those states, insurers can also raise premiums in future years based on a business's medical claims.[3]

This means that though employers are not supposed to discriminate in their hiring practices, they will pay more if they hire people who already have health conditions or who develop health problems. Similarly, gender rating in many states puts businesses with higher concentrations of female employees at a disadvantage.

Some states have addressed these problems through laws requiring community rating or adjusted community rating: Insurers must charge all small employers equally, no matter the health status (and in some states, the gender) of their employees. This effectively spreads the risk of the highest cost enrollees equally among all employers buying a particular health insurance policy. Families USA recommends that Congress further improve employer-based coverage by banning health status and gender rating nationally.

Spread costs and responsibility for health care equitably across employers

States confront several problems when they try to reform the employer-based health care system to better spread risk and ensure coverage. First, if they try to redistribute the cost of high claims across the population through risk pools or reinsurance systems, they can only readily assess insurers that they regulate to pay those claims—they cannot easily assess large, self-insured employers. High-cost claims should be spread to larger employers as well, and across policies offering different benefit designs. Second, if states try to subsidize coverage for people who do not have access to employer-sponsored care, they can easily create disincentives for employers who do provide coverage, yet state attempts to hold employers responsible for health care payments quickly confront ERISA challenges.

An employer-based system can only work if all employers either provide health benefits for their workers themselves or pay into a public system that provides care. Without this provision, employers and employees face great inequities: Through their premiums, those paying for coverage are also paying for the uncompensated care of workers in another business that did not provide coverage. Of course, employers could be exempted from a pay or play responsibility based on their size, revenues, and expenses if they did not have the funds to contribute. Massachusetts and Vermont currently require very small employer assessments to help pay for

their health care systems. San Francisco requires a more significant contribution to the city's program for the uninsured by employers who do not elect to provide coverage themselves. San Francisco's system has withstood legal challenges thus far, but Congress could help to clarify a framework within which other states and localities can act.

Families USA recommends that Congress develop large national pools, including both large and small employers, to share the risk of high-cost claims. Further, Families USA recommends that Congress either establish an equitable system for employer contributions to health care nationally, or clarify that ERISA allows states to assess employers for public health care and to give tax credits to those that already cover their own workers. Some small employers will need federal subsidies in order to provide coverage for their workers.

Require adequate benefits

Some employers and some subsidized coverage programs have sought to control costs by purchasing minimal coverage. This is penny wise and pound foolish. Unable to afford the care that is not covered, consumers delay seeking care until they are much sicker. When they do finally seek care, they pay what they can—and go into debt doing so. The share they cannot pay—the uncompensated care—is shifted to other payers; we all pay a portion of these costs in our health insurance premiums.[4]

- **Limit cost-sharing and the sale of high deductible plans**

When employers offer high-deductible health plans, the policies require families to spend an average of nearly $4,000 out of pocket before coverage begins. Half of working families with HSA-qualified high deductible plans are offered no other insurance options by their employers, and nearly half of employers offering these plans leave families on their own to pay the high deductibles out of pocket.[5] An analysis of Census data showed that only one in 10 families with incomes up to about $52,800 annually (about 300 percent of poverty for a family of three in 2008) could afford to pay the average deductible with their savings,[6] so if they have serious illnesses, these families will be left with medical debt. Employers should offer their employees a reasonably priced, low-deductible coverage option. When high-deductible plans are offered,

there is a danger that healthier employees will gravitate to them and less-healthy employees will choose low-deductible plans; this "adverse selection" will drive up the premiums of low-deductible plans, which will encourage more people to opt for high-deductible plans, and so on. If health reform includes an exchange with a variety of cost-sharing options, the option with the lowest cost-sharing should not be priced higher due to the risks of those who select it. Instead, Families USA recommends development of a price structure for all product lines within an exchange that treats everyone in the exchange as being part of the same risk pool. The coverage option with the lowest cost-sharing should be priced as low as possible, and low-income people should receive meaningful subsidies to pay its premiums.

- **Retain important benefit mandates and raise benefit caps**

Over the years, states have mandated that the plans they regulate provide certain benefits. Generally, these mandates were to fill holes that insurers typically left in coverage. For example, states have mandated that plans cover well-child care, colorectal screening, and diabetes supplies when some plans previously failed to cover these important services. Mandates do not now regulate the amount of hospital, doctor, and drug coverage the plans must provide. Some people have advocated for exemptions from benefit mandates as a way to save money. However, this leaves people without needed health care and creates hidden costs that still exist in the health care system. States that have analyzed the cost of various benefit mandates have found that most mandates enacted in their states raised premiums by less than 1 percent.[7] Further, when looking at the total cost of state mandates, one state found that the net cost impact of all 26 of its mandates was only 3-4 percent.[8] These findings suggest that the elimination of mandates from insurance plans would reap little in the way of premium reductions. Federal law currently sets few benefit mandates: It requires employer-based health plans to cover newborn care, certain care for women with cancer, and to provide mental health parity. If federal and state relationships change with respect to health insurance regulation, Congress or an independent body should look carefully at benefits mandates enacted by states to set a floor on coverage.

Further, annual and lifetime caps create barriers to care. In 2007, 22 percent of workers had caps from $1 million to $2 million,[9] and some workers had caps as outrageously low as $250,000[10]—

a cap that would preclude coverage for typical cancer treatment. Few people ever hit their lifetime caps but for those who do, the consequences are disastrous.[11] Caps mean, for example, that cancer patients stop getting treatment. Premature infants on ventilators and toddlers receiving heart transplants are among those who may exhaust a $1 million cap, and the infusions that allow hemophiliacs to live normal lives can easily eat through a $2 million cap. While these treatments are too expensive for any one person to afford, since so few people need them, the cost is miniscule when spread across a population. Families USA recommends passage of legislation such as the Health Insurance Coverage Protection Act (S. 442/H.R. 1085) to increase the lifetime caps to $10 million in employer-based coverage for employers with 20 or more employees.

- **Provide for oversight of the health insurance market**

Some states have done a better job than others of overseeing health insurance company behavior by requiring prior approval of health insurance rates and by setting standards about how much health insurers must spend on medical expenses (as opposed to administration and profit). In addition, they have looked at factors such as excessive compensation and whether a nonprofit insurer was investing in services that benefit the larger community when determining whether the insurer met its obligations in the marketplace. Standards such as minimum medical loss ratios and strong oversight are essential to controlling costs. New York, New Jersey, and Maine are examples of states that provided premium refunds to employers and individuals when plans failed to spend at least 75 percent of premium dollars on medical care. Colorado, Maryland, and Pennsylvania are examples of states where nonprofit insurers are now using surpluses that they had built over the years to make substantial contributions to community health needs. Families USA recommends setting federal and state responsibilities and standards for oversight of the health insurance marketplace.

Provide Adequate Subsidies for Moderate-Income Individuals

A regulated private health insurance market is an absolutely essential part of health care reform, but these reforms are not enough to help those with moderate incomes afford coverage. Moderate

income individuals whose employers do not offer health coverage, or whose employer-based coverage is too expensive, need more than just a better-regulated insurance market; they also need subsidies that put private coverage within financial reach. These subsidies should be larger for those with the lowest incomes, who are the least able to afford coverage. Further, these subsidies should be accompanied by appropriate limits on out-of-pocket costs for low-income individuals. Research points out the serious barriers that unaffordable out-of-pocket costs erect between moderate income individuals and needed health care.[12] If subsidies are insufficient for these individuals, they will continue to be left out of the nation's health care system.

Subsidies must be built on a regulated market as described above: Premiums should not vary based on health or gender; coverage must be available regardless of pre-existing conditions; benefits must be adequate and cost-sharing limited; and the federal government, together with states, should oversee the system to be sure that public dollars actually go to health care and that companies do not make unreasonable profits.

Expand and Improve Medicaid for Low-Income Individuals

Moderate-income individuals will benefit greatly from subsidized coverage available in a reformed private insurance market. But for the lowest-income Americans, the most appropriate coverage vehicle is undoubtedly the Medicaid program. Health reform must also address expanding and improving Medicaid to ensure that all Americans can have affordable, quality health coverage. Medicaid is specifically designed to meet the unique needs of low-income people with complex health care needs, while the private insurance market is not. With respect to coverage for low-income Americans, Families USA recommends: (1) that a national Medicaid eligibility floor be established, and (2) that the enrollment process in Medicaid be streamlined to facilitate easier enrollment for all eligible individuals.

Why Medicaid?

Medicaid is already the backbone of the health care system for the most vulnerable Americans. It covers approximately 60 million low-income people: 29.4 million children, 15.2 million adults, 6.1 million seniors, and 8.3 million people with disabilities. What's more, it is specially designed

to meet the unique needs of these populations, who tend to be sicker and have more intensive health care needs than the general population.[13]

As in any coverage expansion, special attention will need to be paid to ensuring that the Medicaid delivery system is retooled to handle an increase in the number of Medicaid enrollees without compromising access to care. However, Medicaid is the most efficient and effective way to cover more low-income Americans who cannot obtain coverage in the private market. Every state already has a Medicaid program with an existing provider network and administrative infrastructure. It makes sense to build on this foundation, particularly since it has a proven track record of effectively serving low-income individuals.

A little-known fact is that Medicaid is actually *more efficient* at covering low-income people than private coverage. After controlling for health status (since Medicaid enrollees tend to have greater health care needs), it costs more than 20 percent *less* to cover low-income people in Medicaid than it does to cover them in private health insurance.[14] In this cost-conscious climate, it only makes sense to expand coverage in the most cost-effective ways possible. The most cost-effective way to expand coverage for low-income uninsured people is Medicaid.

Cost-sharing protections

Medicaid includes very important protections against out-of-pocket costs to ensure that these costs do not prevent people from getting the health care services they need. Unlike private health insurance, Medicaid typically does not require premiums or enrollment fees, and there are limits to how high other forms of cost-sharing can be. Certain services (preventive care services for children, emergency services, pregnancy-related services, and family planning services) and certain populations (children of certain ages and incomes, foster children, hospice patients, institutionalized patients, and women in the Medicaid breast or cervical cancer programs) are exempt from any kind of cost-sharing, and copayments on individual services are limited to so-called "nominal" amounts of a few dollars or less.

These protections are absolutely imperative to the success of the Medicaid program for low-income people. Low-income adults with private insurance pay more than six times as much on out-of-pocket costs as do low-income adults with Medicaid.[15] Research abounds demonstrating

the serious burden these out-of-pocket health care costs can pose for low-income people.[16] When people cannot afford these costs, they often delay or forgo care, which can result in more costly complications later on.[17] Because Medicaid incorporates such strong cost-sharing protections, people enrolled in Medicaid are more likely to get the care they need, when they need it.

Comprehensive benefits

Medicaid's comprehensive benefit package ensures that the program provides appropriate coverage to people with diverse health care needs. For example, Medicaid has specific protections that are designed to ensure that children get both preventive care and treatments for any health complications they may have (referred to as Early and Periodic Screening, Diagnostic, and Treatment, or EPSDT, services). Medicaid also covers services that low-income people need that are not usually covered in private health insurance. For example, Medicaid covers transportation to doctors' appointments, services that help people with disabilities live independently, and services provided at rural and community health centers. It is unlikely that a private health insurance plan would ever cover these services.

Medicaid is also a key source of coverage for people who are very sick or who have disabilities. While most private health plans have annual or lifetime maximums that people with intensive health care needs can quickly exceed, Medicaid has no such limits. It provides coverage to all those who need it, even people with serious health care problems, whom the private market is simply not interested in serving. Similarly, while private coverage often excludes coverage for pre-existing health conditions, people enrolled in Medicaid are guaranteed to receive the health care services they need, regardless of any past or current health care problems. The Medicaid benefits package is specifically designed to meet the health care needs of low-income individuals, and as a result, people enrolled in Medicaid are less likely than both the uninsured *and* those with private coverage to lack a usual source of health care or to have an unmet health care need.[18]

Medicaid appeal rights and protections

Because low-income people cannot afford health care services that are not covered by their insurance, Medicaid's appeal rights are particularly important. These rights ensure that low-income people who are sick can appeal coverage denials without jeopardizing ongoing treatment.

They can also appeal enrollment or eligibility decisions, and have the right to a fair hearing. Also, unlike the private health insurance market, there are no pre-existing condition exclusions in Medicaid, nor are there waiting periods before an otherwise eligible person can enroll. Medicaid is guaranteed to be available to all who are eligible; people cannot be turned away because they are sick or have experienced health problems in the past, and they can begin receiving services as soon as they are determined to be eligible. In addition to the cost-sharing protections and the comprehensive benefits package, these design features make Medicaid particularly well-suited to providing coverage to low-income people.

Create a National Medicaid Eligibility Floor

To be eligible for Medicaid under federal law, a person must not only have a low income; he or she must also belong to one of the following Medicaid eligibility categories: children, pregnant women, parents with dependent children, people with disabilities, and seniors. If a person does not fall into one of these categories, he or she can literally be penniless and still be ineligible for Medicaid. Also, because the Medicaid program is a state-federal partnership, states set their own eligibility levels. There are federal minimums, but eligibility levels vary widely from state to state. Only 16 states and the District of Columbia cover working parents at least up to the poverty level ($18,310 for a family of three), and the national median eligibility level for parents is a mere 67 percent of poverty ($12,268 for a family of three).[19] The picture is even grimmer for low-income adults who do not have dependent children: in 43 states, these individuals are ineligible for Medicaid no matter how low their income. An estimated 45.1 percent of non-elderly Americans with income below the poverty level were uninsured in 2007.[20]

Health reform offers an opportunity to address these gaping holes in the health care safety net, and to ensure that, in addition to improving coverage for those with moderate incomes, the very lowest-income Americans are covered as well. Families USA recommends that Congress establish a national Medicaid income eligibility floor, below which any individual is guaranteed to be eligible for Medicaid, regardless of age, parental, or health status. More than one in three uninsured Americans has an income below the poverty level.[21] Establishing a federal floor for Medicaid would significantly reduce the rate and number of uninsured Americans.

Streamline Medicaid Enrollment

In order to ensure that the new Medicaid expansion attracts the highest possible enrollment among those who are eligible, Families USA recommends that Congress establish a new, simplified enrollment process for both current and newly eligible people. Experience with the Children's Health Insurance Program (CHIP) has shown the importance of establishing simple, streamlined enrollment policies and procedures to help eligible people get and keep coverage.[22] Examples of these simplifications include allowing 12 months of continuous eligibility to individuals once they are enrolled in Medicaid, minimizing the amount of documentation people need to provide when they apply and renew their coverage, eliminating asset tests, allowing application by mail and online, and simplifying the application itself so that it is short and easy to understand.

It will also be crucial that there be coordination in the application process for Medicaid and the subsidy for purchasing private health insurance coverage. Experience tells us that low-income people have fluctuating incomes, and those with incomes "at the margins" may not know in advance for which program they are eligible. It is imperative that the process for screening applications include provisions that facilitate enrollment, such as a "screen and enroll" requirement similar to that in CHIP, be included in any Medicaid expansion and any new program to subsidize private health coverage for low- to moderate-income individuals. Such a requirement would ensure that individuals who apply for the subsidy, but are actually eligible for Medicaid are enrolled in Medicaid and vice versa. The enrollment process should make sure that the right people get into the right program, and should not make people jump through unnecessary hoops to get there.

Conclusion

Strengthening the employer-based health coverage sector and expanding Medicaid are key components of health care reform. By addressing the problems described above, Congress will make great strides towards the goal of ensuring access to high quality, comprehensive, affordable health coverage for all Americans, while reducing the long-term costs of health care coverage.

[1] Karyn Schwartz, et al., *Spending to Survive: Cancer Patients Confront Holes in the Health Insurance System* (Washington: Kaiser Family Foundation and American Cancer Society, 2009).
[2] Cheryl Fish-Parcham and Claire McAndrew, *Squeezed! Caught between Unemployment Benefits and Health Care Costs* (Washington: Families USA, 2009).
[3] Mila Kofman and Karen Pollitz, *Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change* (Washington: Georgetown University, April 2006).
[4] Kathleen Stoll, *Paying a Premium: The Added Cost of Care for the Uninsured* (Washington: Families USA, 2005).
[5] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2007 Annual Survey* (Washington: Kaiser Family Foundation and Health Research and Educational Trust, September 2007); Paul Fronstin and Sara R. Collins, *Findings from the 2007 EBRI/Commonwealth Fund Consumerism in Health Survey* (Washington: Employee Benefits Research Institute and Commonwealth Fund, March 2008).
[6] Paul D. Jacobs and Gary Claxton, "Comparing the Assets of Uninsured Households to Cost Sharing under High Deductible Health Plans," *Health Affairs* 27, no. 3 (2008): W215-W221.
[7] Massachusetts Division of Health Care Finance and Policy, *Comprehensive Review of Mandated Benefits in Massachusetts: Report to the Legislature* (Boston: DHCFP, July 2008); Susan K. Albee, Esther Blount, Mulloy G. Hansen, Tim D. Lee, Mark Litow, and Mike Sturm, *Cost Impact Study of Mandated Benefits in Texas, Report #2* (Austin: Texas Department of Insurance, September 28, 2000); Maryland Health Care Commission, Annual Mandated Health Insurance Services Evaluation (Baltimore: MHCC, January 1, 2008).
[8] Massachusetts Division of Health Care Finance and Policy, op. cit.
[9] Kaiser Family Foundation and Health Research and Educational Trust, op. cit.
[10] Sarah Rubenstein, "Novel Approach to Health Care Gains Traction," *Wall Street Journal*, April 19, 2009.
[11] Tom Murphy, "Health Insurance Caps Leave Patients Stranded," Associated Press, July 13, 2008.)
[12] Samantha Artiga and Molly O'Malley, *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences* (Washington: Kaiser Commission on Medicaid and the Uninsured, May 2005).
[13] Teresa A. Coughlin, Sharon K. Long, and Yu-Chu Shen, "Assessing Access to Care under Medicaid: Evidence for the Nation and Thirteen States," *Health Affairs* 24, no. 4 (July/August 2005): 1073-1083.
[14] Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry* 40, no. 4 (Winter 2003/2004): 323-342; Leighton Ku and Matt Broaddus, "Public and Private Insurance: Stacking Up the Costs," *Health Affairs* 27, no. 4 (July/August, 2008): w318-w327.
[15] Leighton Ku and Matt Broaddus, op. cit.
[16] Leighton Ku, *The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings* (Washington: Center on Budget and Policy Priorities, May 2005).
[17] Key Findings of the RAND Health Insurance Experiment Study are described in Geri Dallek, *A Guide to Cost-Sharing and Low-Income People* (Washington: Families USA, October 1997).
[18] Kaiser Commission on Medicaid and the Uninsured analysis of 2007 National Health Interview data.
[19] Families USA calculations.
[20] Kaiser Family Foundation, StateHealthFacts.Org, "**Health Insurance Coverage of Adults 19-64, states (2006-2007), U.S. (2007),**" available online at http://www.statehealthfacts.org/comparebar.jsp?cat=3&ind=130&typ=2&gsa=1.
[21] Kaiser Family Foundation, StateHealthFacts.Org, "**Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL), states (2006-2007), U.S. (2007),**" available online at http://www.statehealthfacts.org/comparebar.jsp?cat=3&ind=136&typ=2&gsa=1.
[22] Victoria Wachino and Alice Weiss, *Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children* (Washington: National Academy for State Health Policy, February 2009).