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CONGRESSIONAL TESTIMONY

Statement on the Tri-Committee Draft Proposal for Health Care Reform

Testimony before
The Committee on Education and Labor
United States House of Representatives

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Mr. Chairman Members of the Committee:

My name is Robert E. Moffit. I am Director of the Center for Health Policy Studies at the Heritage Foundation. I wish to express to you my deep appreciation for the opportunity to present my views to you today on major legislation governing the future of the large and growing health care sector of the American economy, now approximately 17 percent of the Gross Domestic Product. I hasten to add that the views that I express today are solely my own, and they do not necessarily represent the views of the Heritage Foundation, its officers or its Board of Trustees.

The Committee is considering ambitious and comprehensive legislation. It covers an enormous range of policy items and issues. Provisions cover the reform of the health insurance markets, the composition of health insurance benefits packages, and health insurance premium and payment policy; new legal obligations on employers and employees to purchase health insurance; the creation of new federal agencies and entities, such as the Health Choices Administration administered by a Health Choices Commissioner, the creation of a new public health insurance option, and new responsibilities for the Secretary of the United States Department of Health and Human Services; new subsidies for individuals and employers, changes to traditional Medicare and Medicaid, Medicare Advantage and the Medicare prescription drug program; new federal policies governing the provision of primary care, prevention and wellness, mental health care, and coordinated care; new quality initiatives and comparative effectiveness research, new initiatives to combat waste, fraud and abuse; new public health initiatives, public health and workforce development, community health centers, and policies governing the health care workforce.

Needless to say, in the next few days and weeks, a variety of independent analysts, as well as the staff of the Congressional Budget Office and others, will have an opportunity to examine the impact of these and other provisions in greater detail.

The draft bill contains both an individual and employer mandate. As the Congressional Budget Office reported in 1994, an individual mandate on American citizens to purchase health insurance is unprecedented. While President Obama has recently stated that he is open to the imposition of such a mandate, his earlier reasoning for opposition should not be forgotten, as he noted that it would be unenforceable as a mechanism to secure universal coverage and that he thought it inappropriate to force Americans to purchase coverage that they determined they could not afford. I appreciate the rationale for the mandate as a means to offset cost-shifting and as a remedy for the “free-rider” problem; individuals have a personal responsibility to protect themselves and impose no unnecessary costs on the rest of us. Nonetheless, an individual mandate is a restriction on personal liberty, and that the use of positive incentives combined with new mechanisms to facilitate ease of enrollment can achieve the broader goal of dramatically expanded coverage. I have suggested such alternatives, and, with your permission Mr. Chairman, would like to submit them for the record.

Since most Americans under the age of 65 are today enrolled in employment-based health insurance, it is easy to see why so many policymakers are enamored by the idea of an employer mandate. I would simply remind the Committee that the costs of an employer mandate are invariably visited upon employees in the form of reductions in wages or other compensation or even a reduction in employment. It is inadvisable to impose such a mandate, especially during a recession.

In the limited time available to me, I would like to focus my remarks on three key areas: the establishment of a national health insurance exchange, the creation of a public plan to compete with private health plans in that exchange, and the creation of a new authorities for the federal government to standardize and regulate health insurance, and a process for federal officials to define and refine the health benefits that will be available to American citizens.

The Health Insurance Exchange. Under Section 141 of the bill of Title II, Congress would create a new independent agency, the Health Choices Administration. The new agency would be headed by a Health Choice Commissioner appointed by the President with the advice and consent of the Senate. Under Section 142, listed among the many duties of the Commissioner, would be the establishment and operation of a Health Insurance Exchange. Under Section 201 of Title II of the bill, the Congress would create the Health Insurance Exchange in order to "facilitate access of individuals and employers, through a transparent process, to a variety of choices of affordable quality health insurance, including a public insurance option."

Under the terms of the provision, the Commissioner would establish "standards for, and accept bids from", " qualified health benefit plans", and negotiate and enter into contracts with these qualified health benefit plans, which must offer at least three different levels of benefits that are statutorily required with a high degree of specificity.

Under Section 202, the bill says that a person is eligible to enroll in the exchange unless that person is enrolled in another qualified health benefit plan or other statutorily defined "acceptable coverage" For the enrollment of eligible employers and employees, and individuals, the bill provides a three year transition period for the categories starting with the smallest employers (with ten or fewer workers), to the smaller employers (20 or fewer workers) and to larger employers. The bill specifies that individuals, with some exceptions, who are enrolled in existing government programs such as Medicare, Medicaid, the military health programs("Tri-Care") and the Veterans Administration (VA) program are ineligible for enrollment in the Health Insurance Exchange. A noteworthy exception to this set of categorical exclusions are what are deemed "Non-Traditional" Medicaid enrollees, persons who had a "qualified health plan" or who were enrolled in a "statutorily grand-fathered" health plan (an individual or group insurance plan) in the previous six months. The several states, under certain conditions, are also given the opportunity to enroll Medicaid beneficiaries in the Exchange.

Under Section 203, The Commissioner "shall specify the benefits" to be made available in the Exchange for "Exchange Participating Plans" each year, but these specifications

are to be consistent with other health benefit requirements that are elsewhere established in the statute. The provision also prohibits the Commissioner from entering into a contract with an insurer unless the insurer offers the three benefits levels that are required by statute: the "basic", "enhanced" or "premium" benefit plans for the service areas in which they offer coverage.

Under Section 204, the Congress would enact standards for the insurers who offer qualified health benefit plans that are eligible to participate in the Exchange. Specifically, they must be licensed under state law where their insurance coverage is offered; they must report data and other information to the Commissioner that he may require; implement the "affordability credits" that are offered to enrollees; accept all eligible enrollees; provide "wrap around coverage" for Medicaid enrollees; participate in pooling mechanisms established by the Commissioner; contract with " essential community providers" as specified by the Commissioner; provide "culturally and linguistically appropriate services and communications" to enrollees; and comply with "other applicable standards" such as billing and premium collection practices, that the Commissioner may specify.

Interestingly, the plans participating in the Health Insurance Exchange would still be required to offer benefit packages within the states that they serve that comply with state legislative requirements for state mandated benefits. This is a significant requirement, inasmuch as there are today more than 2000 state mandated benefits and provider services that are required for inclusion in health insurance offerings. The number and cost, of course, vary significantly from state to state.

For insurers who participate, the initial contract is to be for not less than one year, but subsequent contracts with the Exchange may be automatically renewed from year to year. Insurers would also be under statutory requirements to comply with "network adequacy" standards that are determined by the Commissioner, and comply with Commissioner's standards and procedures for "grievances and complaints". In the enrollment of persons in the Health Insurance Exchange, the Commissioner is not only required to provide comparative plan information, but also "shall establish " outreach activities for particularly "vulnerable" segments of the population, including adults and children with disabilities or cognitive impairments.

Under Section 207 of Title II, the Congress would create a Health Insurance Exchange Trust Fund. This new trust fund would contain monies appropriated by Congress, as well as a class of dedicated funds, including taxes levied on individuals who do not obtain "acceptable coverage" and employers who do not provide "acceptable coverage" to their employees and certain excise taxes on insurance.

Under Section 208, individual states, or a group of states, are permitted to set up a state based health insurance exchange or a multi-state exchange. But they can only initiate such an action with the approval of the Commissioner, and the Commissioner may only approve the creation of a state-based health insurance exchange only if they can demonstrate to the satisfaction of the Commissioner their capacity to undertake such an

enterprise; contract with health plans that meet the federal health insurance benefit requirements and standards outlined under Title I of the bill; enroll the eligible employers and employees and individuals; and if they do not have another exchange already operating within the state. If the Commissioner determines that the state health insurance exchange does not meet federal rules and standards, the Commissioner can with notice, terminate the state exchange.

Comment. The concept of a health insurance exchange, to facilitate access to a choice of coverage for individuals and employers, especially small employers, is hardly new. It has had only limited application at the state level, though some may argue that the Federal Employees Health Benefits Program, a defined contribution arrangement that is characterized by a wide variety of private health benefit options (ranging from traditional health plans to health savings accounts, from relatively inexpensive health plans to very expensive benefit offerings), is analogous to a health insurance exchange. Of course, there is no government sponsored health plan in the FEHBP; nor does the FEHBP have anything remotely approaching the statutory or regulatory regime embodied in Title I and Title II of the bill.

In its practical application, a key policy question is whether policymakers want the health insurance exchange to serve as an administrative body or a regulatory body. They are widely different in their conception and practical effects. As an administrative body, an exchange would provide comparative information on prices, plans and benefits, facilitate enrollment of individuals and employees, collect and transmit premiums payments, and thus reduce the administrative costs for small businesses and thus the premium costs of the individuals and families employed by them. As an administrative body, the exchange would serve as a mechanism to permit a defined contribution on the part of employers for their employees, enabling them to pick and choose the health insurance plan of their choice while securing the existing tax advantages of group health insurance. This would enable individuals to buy and own the health plan they determine as best for them, and thus be able to take with them from job to job. This added portability in health insurance would, in and of itself, result in a dramatic reduction in the number of the uninsured, most of whom are persons who had coverage and lost it, and experience spells of un-insurance, in what is clearly an unstable and deficient health insurance market.

If the exchange is conceived as more than an administrative body, and is designed as another regulatory agency, it can become a mechanism to constrain personal choice and frustrate competition by limiting the kind and number of suppliers that can enter the market, and thus increase the costs of coverage.

It is not necessary to create a national health insurance exchange for the purpose of creating a national market for health insurance. The United States already has a national market for a variety of goods and services, and the distribution of those services is not contingent upon the creation of anything remotely resembling a national exchange for these goods and services. If Congress wanted to create a national market for health insurance, all it would have to do is repeal existing federal laws that are a barrier to such a market, and exercise its authority to promote interstate commerce under Article I

section 8 of the Constitution, and authorize the U.S. Department of Commerce to issue such regulations as are necessary to ensure that promotion.

For state officials, such as those who framed the major 2006 reform in Massachusetts, one of the key advantages of a state based health insurance exchange (called "the connector") was that it would allow employers and employees in small business to get access to personal and portable health insurance tax free, since the coverage available through the exchange would be considered group coverage and thus enjoy the powerful advantages of the existing federal tax treatment of health insurance. If Congress wanted to assist individuals and families, particularly those employed in small businesses who do not have access to group coverage, and who are penalized by the federal tax treatment of health insurance if they attempt secure coverage outside of the place of work, then all Congress would have to do is to reform the federal tax treatment of health insurance, and guarantee tax breaks for individuals regardless of where they work, eliminate the inequities and disparities in the tax code and thus make health insurance affordable and available for everyone.

For lower income persons, those who do not have federal tax liabilities, the correct remedy would of course be the provision of generous assistance, either in the form of premium assistance, some sort of refundable tax credit or direct, income related subsidy to offset the cost of health insurance and thus guarantee coverage.

Health insurance markets differ radically from state to state. For some states, a health insurance exchange may be appropriate; for others, there may be other, perhaps more innovative options. Federal policy should recognize and accommodate that diversity among the states, and foster state creativity in finding workable solutions to coverage, especially for the most vulnerable, the poorest and the sickest who need the most help.

Finally, I would note that the draft bill vests extraordinary power in the hands of the Commissioner, including the power to decide what state or group of states can or cannot set up or manage or maintain a state health insurance exchange. Federalism is a remarkable constitutional achievement. It means that the national government and the state governments are each supreme in their respective constitutional spheres; that the encroachment of one upon the other violates the spirit of federalism, the unique division of power enshrined in our Constitution. This is not a federal state partnership; it is federal domination of the states. It is also a prescription that could, and probably would, undermine much needed innovation in the provision of new health insurance options.

The Public Plan Under Title II, Subtitle B, Section 221 of the draft bill, Congress would require the Secretary of the U.S. Department of Health and Human Services to establish a "public health insurance option" in the national health insurance exchange. In the language of the legislative text, the option is designed to ensure "choice, competition, and stability of affordable, high quality coverage throughout the United States in accordance with this subtitle."

The range of competition for the new public plan is to be limited to the national health insurance exchange. In competing with private health plans, the public plan is to play on "a level playing field." In the language of the legislative text: "The public plan shall comply with the requirements that are applicable under this title to an exchange participating health benefits plan, including requirements related to benefits, benefit levels, provider networks, notices, consumer protections, and cost sharing." Like private health plans competing in the exchange, the new public plan is to offer three types of coverage: basic, enhanced and premium coverage.

In terms of the rights of enrollees, the legislative text specifies that the same rights that are enjoyed by Medicare beneficiaries today will be extended to enrollees in the new public plan, and that these enrollees will have access to the federal courts for the enforcement of their rights in the same way that Medicare beneficiaries have access to the courts. This is a key provision defining the range of action available to enrollees in the public plan.

Under Section 221, the Secretary can enter into contracts for the administration of the public plan, but that contractual arrangement with these entities cannot "involve the transfer of insurance risk to such entity." This is also a key provision.

The Secretary is also authorized to set premiums for the public plan: "The Secretary shall collect such data as may be required to establish premium and payment rates for the public insurance option and for other purposes of this subtitle, including to improve quality and to reduce racial and ethnic disparities in health care." Under Section 222, the authors of the bill further specify that the Secretary "shall establish" geographically adjusted premium rates for the public plan that comply with the premium rules set by the Commissioner for private plans at a level " sufficient to fully finance" the costs of the benefits, the administrative costs and "contingency margins" of the new public plan. Within the Department of the Treasury, Congress would create an account to handle receipts and disbursements for the operation of the public plan, including the finds necessary for start up costs. Under Section 222, there is no other authorization for additional appropriations for the account. This is also a noteworthy provision, though there is nothing to prevent Congress from appropriating additional funds to the account.

Under Section 223, the Secretary is to establish payment rates for services and procedures under the public plan. Initially, these payment rates, under Section 223(2)(a) are to be based on the payment rates for medical services and providers under Medicare Parts A and B. The Secretary is given some leeway in adjusting or modifying payments rates, particularly for services, such as well child visits, that are obviously not covered under Medicare. Moreover, the rates for payment for prescription drugs will be "negotiated" directly by the Secretary. The Secretary is also to adopt anticipated payment reforms for the public plan, based on those initiated in the Medicare program designed to secure better value for taxpayer dollars.

Comment. In a normally functioning, consumer-driven private market, the price of goods and services is determined dynamically by the conditions of supply and demand, the

goods and services available by suppliers and the demand for those goods and services. In a consumer driven health insurance market, the premium payments reflect a reasonable relationship between the benefits that are offered, including any discounted payments to providers, and the demand for those benefits.

In this case, the Secretary is to set premium payments in such a way that they would fully finance the benefits, as well as meet other goals, such as the provision of quality care and the reduction in racial and ethnic disparities. This would require the Secretary to go beyond an assessment of prevailing market conditions, and also do so in accordance with rules for premium payment set by the Commissioner. This is likely to be a challenge.

In basing the public plan's payment to providers on the Medicare payment rates, which are routinely set below those of the private sector payment rates, the public plan would naturally enjoy an advantage over competing private health plans. Because, by law, the payment rates would be set at such a level, rather than at the market rates that would otherwise prevail on a level playing field, the public plan would be given a legal advantage in competition with the private sector plans. This would undercut the claim of a level playing field. Under Medicare, physicians, for example, are paid at a rate of 81 percent of average market rates. Independent analyses, by the Lewin Group and others, have shown that the use of Medicare payment rates would not only result in a significant reduction in revenues for doctors and hospitals, but also an erosion of private health insurance coverage.

The simplest way to achieve the stated goal of the level playing field is to require the public plan to compete for doctors and hospitals and other medical professionals by negotiating market rates with such providers just like the officials of private health plans do routinely.

If one of the stated goals of the bill is to ensure a "level playing field", there are other features of this legislation to be addressed. In Section 221, as noted, Medicare enrollees are to be given access to the federal courts in the same way as Medicare beneficiaries in securing their rights under the Medicare entitlement, presumably over the same range of questions and controversies as routinely apply in these cases. This may be necessary, but it is not a sufficient legal protection. First, private health plans are everywhere subject to various laws governing torts and contracts, and private health plans and their officers can be sued for contract violations or torts. To secure a level playing field, the same should apply to the public plan and its officers. This point should be clarified in statute, assuming the range of legal actions available to enrollees in the public plan are not to be limited. Second, private health insurance companies, as with other private firms, are subject to strict accounting standards governing liabilities and financial standards. Perhaps this is implied within the broad authority of the Commissioner to set rules for plan participation in the exchange; nonetheless, it should also be clarified that the public plan is subject to the same rules. Specifically, Congress should, under no circumstances, allow the public plan to accumulate the kind of massive un-funded liabilities that burden the current Medicare program, and threaten a crisis in the government's entitlement programs. Third, as specified under Section 221, the Secretary is authorized to contract

with administrators to carry out the functions of the public plan, but that contractual authority cannot involve the transfer of risk. This obviously means that the entire risk of the public plan will remain with the taxpayers, not the public plan itself, as a government-sponsored enterprise. Since private health plans competing with the public plan have no such taxpayer guarantee, regardless of the wisdom or folly of providing such a guarantee, the public plan would have an advantage incompatible with the goal of a level playing field.

In the final analysis, in competitive markets, where consumers' preferences prevail, some firms are extraordinarily successful in offering individuals and families what they want, and other firms are not. On the level playing field, some firms are highly profitable and other firms rack up losses. In the field of health insurance, the history of the Federal Employees Health Benefits Program (FEHBP) is one of a free entry and exit of health plans. If Congress wishes to achieve a level playing field between public and private health plans, then the public health insurance option, just like any private health option, should also be allowed to fail, without being kept on artificial life support through the infusion of taxpayer monies. That would be a key test of congressional commitment to a level playing field.

Federal Benefit Setting. Under Division A, Title I of the bill, the Congress would require every American to have health insurance coverage that Congress would define as "acceptable coverage". This is defined in Section 202 as coverage in a series of categories: a "qualified health benefits plan"; a "grand-fathered" health insurance plan (individual and group coverage in effect for individuals and groups during a specified period of time); coverage under Part A of Medicare, Medicaid, "Tri-care", the Veterans Administration program, and "other such coverage" as the Commissioner, in consultation with the Secretaries of Treasury and Labor, shall define as "acceptable coverage".

Under Title I, the bill specifies the various standards that must apply for a plan to be acceptable coverage, including "grand-fathered" coverage. Grand-fathered coverage, as noted, is coverage that persons and employers would have and would be in effect for a time to be specified, and it would be subject to specific limitations. There would be limitations on the enrollment in such a plan, limit on changes to any terms and conditions of coverage and premium increases. After a given period of time, individual health insurance, as it exists today, would no longer qualify as "acceptable coverage". For group insurance, however, there would be a "grace period" for current group health coverage before such coverage would have to meet the new federal standards to be considered "qualified health benefits plans" that are in accord with federal benefit standards and levels.

Under Title I, Subtitle B, Sections 111-116, the Congress specifies standards for access for a plan to be designated as a "qualified health benefits plan". These include a prohibition on pre-existing condition exclusions; guaranteed issue and guaranteed renewability of coverage; insurance rating limited to age, geography and family enrollment; "non-discrimination standards" to be set by the Commissioner; the adequacy

of provider networks, to be determined by the Commissioner; and a federal minimum loss ratio.

Under Title I, Subtitle C, the bill specifies standards for access to "essential benefits". Under Section 121, there is a distinction between standards for health plans that participate in the national Health Insurance Exchange and those who do not. For plans that do not participate, they may offer coverage *in addition* to the "essential benefits" that are defined in statute. For health plans that participate in the Exchange, the health plans are required to offer "specified levels of benefits"; a more detailed and higher standard of compliance.

Under Section 122, the bill defines "essential benefits". The provisions are subject to other provisions of the bill , however, that impose limits on cost sharing for covered items and services, and it would eliminate both "annual and lifetime" limits on services or covered health care items. The "minimum services" to be covered are: hospitalization; outpatient services; physicians services and the services of other health professionals; supplies and equipment incident to the provision of physician and hospital services; drugs; rehabilitative services; mental health and substance abuse; preventive services; maternity benefits; well baby and well child care; oral, vision and hearing services and equipment and supplies for children under 21 years of age. The bill specifies that there is to be no cost sharing for preventive services and well baby and well child care. It also specifies that preventive services are to be updated on the basis of the recommendations of the U.S. Preventive Services Task Force and vaccines to be included are those to be recommended by the Director of the Center for Disease Control and Prevention.

Under Section 123, the bill establishes a Health Benefits Advisory Committee, comprised of federal and non-federal employees, and chaired by the Surgeon General of the United States. The Committee would make recommendations on benefit standards, and specify the kinds of cost sharing that should be adopted in the basic, enhanced and premium health plans packages that participate in the Health Insurance Exchange. According to the legislative language, the Committee, in making its recommendations, "will take into account innovations in health care" and work to "ensure that the essential benefits coverage does not lead to rationing in health care". This is a key provision.

Under Section 124, the bill specifies how the benefit recommendations are to be adopted. The Advisory Committee makes its recommendation to the Secretary of HHS. The Secretary then must review these within 45 days, and determine whether or not to adopt them and publish them in the *Federal Register* to become applicable to qualified health benefit plans. For health plans participating in the Health Insurance Exchange, the Commissioner would enforce federal benefit standards.

Comment. Health insurance is one of the most highly regulated sectors of the American economy. Today, with the exception of the ERISA and the provisions of the Health Insurance Portability and Accountability Act, the bulk of this regulation is within the jurisdiction of the states. The bill would concentrate enormous regulatory authority over health insurance in the federal government, where the content of health benefit packages,

and even the levels of these benefits, would be under the direct authority of the Secretary of HHS and the Advisory Committee. The obvious problem is that this centralization of decision- making and the attendant special interest lobbying that must and will accompany it will almost certainly result in dynamics similar to what has taken place in state legislatures and agencies, where health benefit decisions are often highly politicized.

As in so many other areas of domestic policy, the states have been leaders in reform efforts, whether it has been education reform or welfare reform, providing graphic examples of progress, and a platform for change that can be further encouraged by federal authorities. In a search for a federal remedy, Congress ought to be wary of pre-empting progress in the 50 state capitols of this vast and very diverse country.

In health care reform, states as different, culturally and politically, as Massachusetts and Utah, have embarked on profoundly consequential and far-reaching health care reforms. Whatever one may think of the specific reforms in either state, there is no doubt that they are serious and they hold lessons for other states.

Finally, I would ask the Committee to consider the large areas of agreement that exist in Congress and the nation at large on health care reform. Americans agree that all citizens should have adequate coverage to protect them and their families against the financial devastation of catastrophic illness. Americans generally agree that the working Americans who have no health insurance at the place of work, particularly low income working Americans, should be the beneficiaries of direct assistance to enable them to get health insurance coverage. There is also increasing agreement, across the political spectrum, that we must end the inequities of the existing tax treatment of health insurance. No taxpayer should be denied tax relief, merely because of an accident of her employment.

Within Congress, there is widespread agreement, stretching the ideological spectrum from Democratic Representative Tammy Baldwin of Wisconsin to Republican Representative Tom Price of Georgia- that Congress would do well to encourage in concrete ways, with generous grants and technical assistance, state experimentation and promote innovation in coverage expansions, improvements in quality of care, and the adoption of health policy proposals that best accommodate the very different cultural and political dynamics of the several states.

Thank you Mr. Chairman and Members of the Committee, I would be happy to answer any questions you may have.

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