



**Testimony on Comprehensive Health Care Reform**

by

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**for the  
House Energy and Commerce Committee, Subcommittee on Health**

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## **I. Introduction**

Chairman Pallone, Ranking Member Deal, and members of the subcommittee, I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We appreciate this opportunity to testify on comprehensive health care reform and the draft legislation that has been developed by the House committees. We believe that health reform needs to be enacted and signed into law this year, and we are strongly committed to playing a constructive role in this debate.

For more than three years, AHIP's members have been working to develop workable solutions to the health care challenges facing the nation. The end result of these extensive deliberations is that AHIP's Board has endorsed comprehensive proposals for significant restructuring of the health care system with three cornerstone goals: achieving universal coverage; reducing the future growth rate of health care costs; and improving quality of care.

These proposals would reform the U.S. health care system with a broad-based strategy for ensuring that no one falls through the cracks, while also promoting quality improvements and providing greater value for the dollars our nation spends on health care. While building upon the strengths of the current system, our plan includes major insurance market reforms that would fundamentally transform our members' business practices and, in so doing, provide peace of mind to all Americans, regardless of their health status or medical history.

Our testimony today focuses on the following topics:

- proposals AHIP's Board of Directors has endorsed for advancing a high quality, affordable, patient-centered health care system;
- our work with other stakeholders to contain health care costs and enhance value throughout the system;

- the consensus that already exists for enacting bold reforms to meet the health care needs of the American people;
- comments on the House draft health care reform bill; and
- the importance of strengthening Medicare and Medicaid to maintain a health care safety net for our nation's most vulnerable citizens.

## **II. AHIP's Comprehensive Proposals for Health Care Reform**

To achieve comprehensive health care reform, AHIP has proposed a plan that provides universal coverage, cost containment, and quality improvement. Our plan focuses on ensuring that no one falls through the cracks of the health care system, providing all individuals with portability of coverage and continuity of care, fundamentally overhauling regulation in the marketplace, improving information and transparency for consumers, taking bold steps to ensure that coverage is affordable, and clearing obstacles to the next generation of quality improvement innovations. As discussed below, this strategy would achieve universal coverage *without* jeopardizing quality improvement initiatives that are working in the system today, *without* exacerbating cost shifting already occurring, and *without* undermining employer-based coverage.

### Insurance Market Reforms

We are proposing to combine guarantee-issue coverage with an enforceable individual health insurance requirement and premium assistance to make coverage affordable, while eliminating preexisting condition exclusions and eliminating rating based on health status in the individual market.

We envision a rating system based on the following demographic factors: geography, age, and product type, and we note that the legislation proposes an approach built on these factors. Given the need to improve health status and encourage prevention, we also encourage Congress to provide flexibility for plans to offer premium discounts to individuals who make healthy choices, such as not smoking, participating in wellness programs, and adhering to treatment programs for chronic conditions.

Another key element of our proposal calls for premium assistance to ensure that coverage is affordable for lower-income individuals and working families. We are proposing refundable, advanceable tax credits that would be available on a sliding scale basis for those earning less than 400 percent of the Federal Poverty Level. Additional steps are needed to promote tax equity for individuals purchasing health insurance on their own.

### Helping Small Business

Small business owners find themselves in an increasingly difficult marketplace for health insurance because of rapidly rising health care costs and the limited ability of most small businesses to bear risks, contribute a substantial share of costs, or support administrative functions. A policy statement approved by AHIP's Board of Directors in March 2009 outlines solutions, some of which also apply to individuals, for helping small businesses:

- **Essential Benefits Plan:** We propose the creation of new health plan options for small employers and their employees, as well as individuals. These “essential benefits plans” would be available nationwide and would include coverage for primary care, preventive care, chronic care, acute episodic care, and emergency room and hospital services. Alternatively, “essential benefits plans” should include coverage that meets an actuarial equivalence standard, along with the opportunity to include enhancements such as wellness programs, preventive care, and disease management. To maintain affordability, the essential benefits plan should not be subject to state benefit mandates that do not apply to the generally larger employers that enter into self-funded health care coverage arrangements.
- **Tax Credits or Other Incentives to Assist Small Business:** We support the establishment of tax code incentives or other types of assistance that encourage both small business owners to offer coverage to their employees and employees to take up coverage. We recognize the special challenges, both administrative and financial, that small businesses face in offering contributions toward their employees' coverage. Providing assistance can encourage these contributions and help enable employees to take up coverage which improves predictability and stability in the small group market.
- **Improving Coordination of Private and Public Programs Strengthens Small Group Coverage:** Premium or other assistance offered to low-income individuals and working

families can be applied to and work with employer-sponsored coverage. This is important whether the assistance is provided through Medicaid, the Children's Health Insurance Program (CHIP), or other expanded programs designed to help individuals and families obtain coverage. Improved coordination allows workers to take up coverage offered by small businesses by leveraging both public and private sources of assistance, and benefits the firms' employees as a whole by increasing rates of participation in the small group plan.

- **Micro-firms:** “Micro-firms” (those with fewer than 10 employees) face special challenges in offering coverage. Statistics show that only about one-third of these firms offer coverage. This reflects the administrative, financial, and logistical challenges many micro-firms face in setting up and establishing plans and offering and contributing to their employees' coverage. To help these firms meet these challenges, enhanced tools could be developed that would allow those micro-firms that have found it impractical to offer coverage, to contribute to coverage purchased on a pre-tax basis by individual employees. As part of comprehensive health care reform, employees could then use these contributions to help purchase coverage in a reshaped health care system that combines an individual requirement to obtain coverage with reforms in the individual market.
- **One-stop information source:** All small firms will benefit from collaborative efforts between health plans and the public sector (e.g., insurance commissioners) to ensure that small employers and individuals have one-stop access to clear, organized information that allows them to compare coverage options. This “one-stop shop” also could allow individuals to confirm eligibility for tax credits or other assistance and even provide a mechanism to aggregate premium contributions from multiple sources. By providing a mechanism to combine even modest contributions from multiple sources (public and private), this new one-stop shop could be especially helpful to employees who may hold multiple jobs.

#### Strengthening the Employer Group Market

We support building upon the existing employer-based system, which currently covers 177 million Americans according to the U.S. Census Bureau. It is a key part of our economic fabric. Although the employer-based system faces challenges, more than 90 percent of employers report that offering high-quality coverage is important to their ability to recruit and retain valuable workers and enhance employee well-being. Thus, as a first priority, the nation's reform agenda should be committed to a policy that “first does no harm” to that system and limits strategies that

would reduce employer coverage. Focus should be placed on retaining a national structure for the employer group market that continues to promote uniformity and ensures the smooth functioning of the employer-based system.

At the same time, the nation's economic uncertainties and job losses underscore the need for new strategies to assist individuals who become unemployed or are transitioning from job to job. While a Congressional Budget Office (CBO) study found that nearly 50 percent of the uninsured go without coverage for four months or less, additional protections are still needed. We propose ensuring that tax credits are available to individuals on an advanceable basis to help them through job transitions along with access during these times to more affordable coverage options consistent with our proposal for a basic benefits plan.

### **III. Containing Health Care Costs and Enhancing Value**

The success of health care reform will be closely linked to the implementation of strategies that contain costs and enhance value, in addition to expanding coverage.

Recognizing the importance of cost containment, AHIP recently joined other stakeholder groups in sending a letter to President Obama, outlining our collective proposals for achieving cost savings as part of the broader health care reform effort. This letter was signed by AHIP, the American Hospital Association (AHA), the American Medical Association (AMA), the Pharmaceutical Research and Manufacturers of America (PhRMA), the Service Employees International Union (SEIU), and the Advanced Medical Technology Association (AdvaMed).

The joint letter addressed to the President was accompanied by recommendations from each stakeholder organization for containing costs. AHIP's submission outlined a series of policy proposals and current initiatives to promote administrative simplification, advance health information technology, reward quality and value, and empower patients to more effectively engage in the health care system.

Our administrative simplification efforts are focusing on two particularly important priorities:

- Our members have committed to a comprehensive overhaul of administrative processes to standardize and automate five key functions: claims submissions, eligibility, claims status, payment, and remittance. The move to fully automate and standardize these administrative transactions will allow physicians, hospitals, and other health care providers to reduce their administrative costs substantially. This is a critically important component of our nation's overall strategy for containing costs and freeing up funds to achieve universal coverage. We are committed to this initiative, and we appreciate that the House bill addresses the need for investments in these priorities.
- We are preparing to launch a major effort that will make common administrative tasks in physician offices simpler, more efficient, and less expensive. Beginning with pilot tests in Ohio and New Jersey that will inform a national strategy, our community is establishing a web-based system that will allow physicians to conduct business with insurers throughout a region or state at one website, reducing the need to visit multiple websites and/or spend hours on the phone. Common web portals will virtually eliminate paperwork, improve efficiency through the system, and yield significant savings.

In addition to this industry-wide effort, our members are implementing a wide range of plan-specific initiatives to realign payment incentives to reward value and outcomes, rather than reward the volume of services delivered. A recent monograph released by AHIP, entitled "Innovations in Recognizing and Rewarding Quality," highlights key private sector initiatives that have been implemented throughout the nation to move the system toward a value-based structure. This publication demonstrates that innovative care coordination programs that enhance outcomes and reform payment incentives are being implemented in the private market with an infrastructure, which is often lacking in public programs, that will be valuable in reforming the health care system.

One notable example is California's pay-for-performance program, sponsored by the Integrated Healthcare Association (IHA). This program involves 235 physician groups representing approximately 40,000 doctors who provide care for 11 million commercial HMO patients in California. Since 2004, participating plans have awarded more than \$265 million in payment incentives based on the performance of physician groups with respect to clinical quality and patient experience measures and the adoption of information technology to support systematic, evidence-based care. A recent survey of participating physician groups revealed that this

program has increased accountability for quality, accelerated the adoption of health information technology, improved data collection for quality management, and created greater focus and support for quality improvement initiatives.

This model demonstrates the innovation that is possible when stakeholders come together to collaborate and agree on performance measures, and shows that quality improvement and cost containment are compatible goals. Moreover, the IHA's success underscores that payment reform is achievable in the near-term and should be implemented as quickly as feasible.

Health plans are pursuing or recommending additional payment reforms in the following areas:

- establishing prospective payment for defined services that better coordinate care and achieve results through medical homes and similar models which utilize team-based medical care and non-physician practitioners;
- revising scope of practice rules that inhibit the use of non-physician health practitioners;
- recalibrating the Medicare physician fee schedule to eliminate incentives that favor specialty care over primary care, with a transparent public process for determining rates;
- moving from single provider payments to “bundled” payments;
- implementing computerized drug order entry systems and electronic prescribing; and
- eliminating reimbursements for preventable hospital readmissions and for “never events” (i.e., involving preventable medical errors).

These fundamental reforms address the reality that the rising cost of health care in the United States is unsustainable, that the quality of care varies greatly, and that millions of Americans lack access to quality, affordable care. Implementation of these initiatives will represent an important step toward advancing a patient-centered health care system in which care is safe, timely, efficient, effective, and equitable – while at the same time constraining costs to advance the broader goal of achieving universal coverage for all Americans.

#### **IV. Consensus on Framework for Reform**

Despite the strong disagreements that exist on certain issues in the health care reform debate, we believe it is important to recognize that there is a widespread consensus among policymakers and stakeholders about the need for bold legislative action in many key areas.

For example, there is a shared agreement for moving forward immediately with sweeping insurance market reforms and new consumer protections, bringing everyone into the system through an individual coverage requirement, providing premium assistance to make coverage affordable, strengthening the Medicaid safety net, reducing health disparities, taking strong measures to promote wellness and prevention, using health information technology to improve health outcomes and achieve greater cost efficiencies, and employing innovative strategies to meet the needs of patients with chronic conditions.

We applaud the House committees for developing a bill that addresses these important priorities, particularly the basic structure of combining insurance market reforms with an individual coverage requirement and premium assistance to make coverage affordable. These provisions could serve as the building blocks for consensus legislation that would be widely supported by Congress, by the American public, and by a wide range of stakeholders. Recognizing the potential that exists for major legislative accomplishments on these critical issues, we believe the uncertainty surrounding other issues – including a government-run health insurance plan, which we discuss below – should not be allowed to delay congressional action on key reforms that could be enacted with widespread support in the immediate future.

#### **V. Comments on the House Draft**

While we agree with many elements of the House bill, we believe that there are some fundamental problems in this legislation that would work against the objective of ensuring that those who like their existing coverage are allowed to keep this coverage under a reformed health care system. We are concerned that some of the bill's provisions – most notably, the creation of a government-run health insurance plan – would undermine this important goal and disrupt a

system in which, according to a recent *New York Times* survey, 77 percent of Americans are satisfied with their existing health insurance coverage.

We have three major concerns about a government-run plan: that it would hamper the development of the best-quality delivery system for consumers; that it would undermine the current health care financing system, including increasing rather than lowering costs for consumers; and finally that it would not deliver the necessary value to consumers in terms of preventive measures.

#### Government-Run Health Insurance Plan Thwarting the Creation of the Highest-Quality Delivery System

We share the concerns that employers, providers, and patients have raised about the significant unintended consequences of a new government-run health insurance plan. A government-run plan using Medicare reimbursement rates would erode the employer-based system, significantly increase costs for those who remain in private coverage, and add additional liabilities to the federal budget. Alternatively, strong market rules and consumer protections will ensure that nobody falls through the cracks and will do so without disrupting the coverage of tens of millions of Americans who like and want to keep their current health plans.

We are particularly concerned that a government-run plan would undermine efforts to transition to a high quality health care delivery system. Recognizing that the traditional Medicare program has made very little progress in developing innovative care management programs, we are concerned that creating a government-run health insurance plan for the broader population would result in tens of millions of Americans being enrolled in a new coverage option that lacks a meaningful commitment to care coordination, disease management, health promotion, and other pro-active initiatives that have been successfully implemented by private sector health plans.

#### Government-Run Plan Undermining the Current Health Care Financing System and Ultimately Increasing Costs

While we have many serious concerns about establishing a government-run plan, there is one issue that deserves particularly close scrutiny. Specifically, we are concerned that a government-run plan would exacerbate the cost-shifting that already occurs, from public programs to private payers, as a result of the inadequate reimbursement rates that Medicare and Medicaid pay to hospitals and physicians. According to a recent Milliman study, an average family of four already pays a hidden tax of more than \$1,700 annually on their premiums because Medicare and

Medicaid significantly underpay hospitals and physicians, compared to their actual costs of delivering medical care. To offset these inadequate payments, providers pass on higher costs to individuals, families and employers in the private sector.

If Congress establishes a new government-run health plan, this hidden tax on consumers could add billions of dollars to the federal budget. Because of lower payment rates, the insured population would migrate from employer coverage to the new government-run plan and providers would have a declining base to shift costs to in the remaining commercial market. Eventually, this dynamic would accelerate with rising costs in the private market because of the exacerbating cost shift, causing further declines in private coverage and leaving significant costs to be covered by the federal budget.

To better understand the severity of this problem, it is helpful to examine real world data on the impact a government-run health insurance plan, using Medicare reimbursement rates, would have on specific hospitals. In recent months, AHIP's Center for Policy and Research has conducted a research project analyzing data from California to demonstrate how a switch to Medicare fee-for-service reimbursement rates would affect the revenues and net income margins of 381 hospitals in California.

The findings of our study are very revealing. They show, for example, that California's acute care hospitals would collectively experience a net revenue loss of \$3.5 billion annually if 50 percent of individuals who currently are privately insured are moved into a government-run plan that pays hospitals using Medicare rates. (This projection assumes that a reformed system would achieve universal coverage, providing relief to hospitals from the costs of uncompensated care.)

The findings for specific hospitals are equally alarming. Cedars-Sinai Medical Center, which was reimbursed by Medicare at 72 percent of its actual costs in 2007, would lose \$268 million annually if even 50 percent of its patients moved from private coverage to a government plan paying Medicare reimbursement rates. Stanford University Hospital, which was reimbursed by Medicare at 82 percent of its actual costs in 2007, would lose \$160 million annually under the same scenario. Hundreds of other hospitals throughout the state, and thousands throughout the nation, would be driven into financial crisis by shortfalls of this magnitude.

The economic realities surrounding this issue are directly related to the ability of a government-run plan to set reimbursement rates below the actual cost of delivering care and below the rates

paid by private plans. The assumed consequence of lower reimbursement rates is lower premiums and cost-sharing in the government-run program, attracting those with private coverage to the government-run option.

Ultimately, with the loss of cross-subsidization by the private sector, we estimate that public programs would face hundreds of billions of dollars in additional costs that are not accompanied by a commensurate revenue offset. This is in addition to the existing Medicare trust fund deficit.

Value-Based Competition

Despite the serious concerns we have raised about a government-run plan, we want to emphasize that private health plans would outperform a government plan if the competition was based solely on value, and not on the ability to impose government-administered reimbursement rates. To illustrate this reality, we call attention to two other AHIP analyses that compare the performance of Medicare Advantage plans and the Medicare fee-for-service program in keeping beneficiaries healthy and avoiding unnecessarily hospitalizations and emergency room visits. The tables below show that, by taking a pro-active approach to coordinating patient care, Medicare Advantage plans have been highly successful in reducing hospital admissions, readmissions, and emergency room visits for diabetes patients and heart disease patients, as well as the broader population of Medicare Advantage enrollees. By reducing the need for hospitalizations and emergency room care, private plans are not only improving the health and well-being of Medicare beneficiaries – but also achieving greater efficiencies and cost savings.

**California Data from AHRQ on Hospital Discharges**

Data from 2006	All Hospitals, Patient Age 65-89	Diabetes Patients	Heart Disease Patients
MA Rate vs. FFS Rate (Per Risk Score Value)			
Inpatient Hospital Days	-34%	-40%	-34%
Re-Admissions, Same Quarter, Same DRG	-17%	-23%	-16%
13 "Potentially Avoidable" Admissions (AHRQ definitions)	-4%	-9%	-3%
Source: AHIP analysis of AHRQ data for discharges from all hospitals in California in 2006.			

## Seven MA HMOs vs. FFS in Same Counties Adjusted for Risk Scores, Simple Averages

Data from 2005 and 2006 (pooled)	All Enrollees	Diabetes Patients	Heart Disease Patients
MA Rate vs. FFS Rate (Per Risk Score Value)			
Hospital Days	-18%	-21%	-14%
Hospital Admissions	-10%	-13%	-7%
ER Visits	-32%	-35%	-31%
Re-Admissions, Same Quarter, Same DRG	-41%	-45%	-37%
13 "Potentially Avoidable" Admissions (AHRQ definitions)	-12%	-15%	-8%
Source: AHIP analysis of FFS 5% sample claims files and data from 7 regional MA plans.			

### Issues With the Proposed Health Insurance Exchange

We believe that every state should have a system through which individuals and families can evaluate coverage options offered by all health plans, and receive assistance in understanding their choices. We are concerned, however, that the regulatory structure for the proposed Health Insurance Exchange would replicate functions now being carried out by state insurance commissioners, creating an overly complex regulatory environment without providing an equally meaningful improvement in access. To address this concern, we believe the responsibilities of the Exchange should be redefined to promote a more workable regulatory structure. Moreover, to promote health plan choices that compete based on quality and price and to improve choices for individuals and employers, we encourage you to revise the bill to allow health plan choices to be offered to individuals outside of the Exchange and to ensure that premium assistance is available to all qualifying individuals and families, not just to those who pursue coverage that is offered through the Exchange.

In addition, to maintain employer-provided coverage, we believe the Health Insurance Exchange should focus on serving individuals and micro-groups, and we recognize the committee's caution in this area. Opening the Exchange to larger groups would unravel existing risk pools and undermine the current system of employer-sponsored coverage. Such a proposal would incentivize large employers with younger and healthier workers to self-fund, while those larger

employers with older and less healthy workers would join the insurance pool – significantly driving up premiums for individuals and small employers.

#### The Bill Imposes a Confusing and Costly New Regulatory Structure

We also are concerned that the bill proposes an overlapping and potentially conflicting regulatory structure for employers and health insurers. In general, the bill would divide responsibility for oversight, rulemaking, and enforcement between six governmental entities: (1) a new independent federal agency, the Health Choices Administration and a Health Choices Commissioner appointed by the President; (2) a newly created Health Insurance Ombudsman; (3) the Department of Health and Human Services; (4) the Department of Labor; (5) the Department of the Treasury; and (6) state insurance regulators.

We believe the federal government should establish consistent rules that are applied across the country and enforced by the states. We encourage the committee to establish consistent rules and clear lines of regulatory responsibility, instead of establishing new structures that create confusion and duplicative state and federal roles.

We also suggest that in establishing new rules for the insurance market, consideration should be given to clarifying what types of coverage will be covered by the new rules. We believe the bill should clarify that the market reforms aimed at major medical coverage do not apply to products that currently are considered to be “excepted benefits” under HIPAA.

#### Health Choices Commissioner

We have concerns that the proposed legislation delegates too much authority to the new Health Choices Commissioner, and we would recommend that the legislation provide clear and consistent standards that could be implemented inside and outside the Exchange. Under the House bill, the Health Choices Commissioner would be given broad authority over employer and union sponsored group health plans, group and individual health insurers, the public health insurance option, Federal Employees Health Benefits plans, and state and local government employee plans, as well as supervision of the Health Insurance Exchange and state-based exchanges.

#### Age-Based Rating

We are concerned that the House bill fails to sufficiently balance the importance of making premiums affordable for all purchasers with the goal of building a universal system. By strictly

limiting premium variation based on age to a ratio of 2:1, the bill would force young people to heavily subsidize the naturally higher health care costs of older individuals. We believe the balance would be better aligned with subsidies to ensure those with higher costs are not penalized, while allowing premiums to more accurately reflect the natural characteristics of health expenditures that rise with age.

According to the Census Bureau, people in the 18-34 age category currently are twice as likely to be uninsured as those in the 45-64 age category. If Congress establishes a 2:1 ratio for age-based rating, young people will be paying premiums that are significantly higher than their actual health care costs. Moreover, because young people have below-average incomes relative to the broader population, the existing bill language would increase the likelihood that they would qualify for an exemption from the bill's individual coverage requirement – thereby undermining the committee's goal of achieving universal coverage. To avoid this outcome, we urge the committee to consider expanding the ratio for age-based rating.

#### Synchronization of Market Reforms and Individual Coverage Requirement

It is critical to ensure that the timing of the individual coverage requirement is synchronized with market reforms and the availability of financial assistance to low- and moderate-income families and individuals to bring everyone into the system and ensure that persons who currently have health insurance coverage are not adversely impacted by higher costs. If this objective is not met, individuals and families who are covered in the individual market may experience unintended consequences similar to those experienced in several states where insurance market reforms were enacted in the absence of universal coverage in the 1990s. A 2007 report by Milliman, Inc. found that some people in these states responded to these reforms by deferring coverage until they experienced health problems – resulting in higher premiums for those with insurance, reduced enrollment in the individual health insurance market, and no significant decrease in the number of uninsured.

#### The Need for Flexibility in Benefit Packages

Our members have been leaders in proposing ideas to not only assure health care coverage to all Americans, but to drive a transformation of our health care system to ensure that our country can support innovation by determining what procedures and technologies are safe and most effective, and to improve clinical quality through better dissemination and transparency of information on safety, effectiveness, and performance. Thus, we are concerned that the bill employs language that would seem to “turn back the clock” and allow the “essential benefits package” to be defined

in terms of “generally accepted standards of medical or other appropriate clinical or professional practice.”

Instead of delegating to an advisory committee the task of establishing benefit packages, we believe the House bill should establish categories of coverage and reasonable actuarial value ranges to promote innovation and flexibility, while allowing the availability of an affordable range of benefit offerings. For example, health insurance plans have developed tools to support employer-based prevention initiatives. Recognizing that these tools have had positive results in reducing smoking and improving participation in wellness and chronic care management, we urge the committee to consider making the legislation more flexible to allow employers and their employees to continue to benefit from these tools. By promoting benefit designs that encourage prevention and chronic care management, we can take important steps to improve health outcomes and provide greater value for the dollars we spend on health care.

We recognize and appreciate that the bill takes into account the financial burden of state benefit mandates, which are not always based on clinical evidence or outcomes.

#### “Medical Loss Ratio” Requirements as Counterproductive

Additional concerns are raised by a provision of the bill that would establish medical loss ratios that fail to measure the value provided by a particular health plan. This requirement has the potential to undermine the bill’s objective of advancing administrative simplification and other initiatives to improve quality and contain costs. It also would adversely affect private sector initiatives, as we discussed earlier, to standardize and automate key health plan functions to simplify administrative processes for patients and clinicians.

Because funds spent on administrative simplification are not categorized as patient care expenses for purposes of calculating medical loss ratios, this provision could limit the ability of health insurance plans to devote funds to improving the system for patients and providers and, ultimately, to improving the quality of care that patients receive. Similar challenges would result for initiatives addressing health information technology, disease management, health disparities and culturally and linguistically appropriate services, and other activities that provide value to consumers.

### Medicare Advantage Funding

We are deeply concerned that the Medicare Advantage funding cuts proposed by the House bill would have a harmful impact on health care choices and benefits for the 10 million Medicare beneficiaries who rely on Medicare Advantage plans to meet their health care needs. The proposed cuts would cause major disruptions for millions of Medicare beneficiaries, eliminating health plan choices for many and leading to reduced benefits and higher out-of-pocket costs for others. Another serious concern is that if Congress enacts this legislation, many beneficiaries will lose the care coordination and other innovative strategies that Medicare Advantage plans have implemented to help keep beneficiaries healthy, detect diseases at an early stage, and coordinate care across the full range of health care settings and services.

The proposed cuts would have a particularly deleterious effect in rural and other areas with low fee-for-service costs that have benefited from previous congressional decisions to increase plan participation and beneficiary enrollment in the Medicare Advantage program. To ensure that a minimum level of payment would be maintained in every county, Congress deliberately established payment floors that caused health plan payments to be higher than Medicare FFS spending in certain geographic areas. The impact of these payment floors, first enacted in 1997 and then revised in 2000, continues to be seen today in the benchmarks that form the basis for bidding under the current Medicare Advantage payment system.

Numerous members of Congress – both Democrats and Republicans – sponsored bills proposing higher payment floors as far back as ten years ago. These payment policies were enacted in recognition of market conditions that historically have made it difficult for Medicare health plans to contract with providers who may have local monopolies in certain rural or small urban areas. The establishment of the payment floors has allowed a wide range of Medicare Advantage plans to offer health plan choices to beneficiaries who previously had no options outside of the Medicare FFS program.

The additional value that Medicare Advantage plans provide is especially valuable to low-income beneficiaries. Analyses of CMS data demonstrate that Medicare Advantage plans are the most popular option for beneficiaries with incomes between \$10,000 and \$20,000. The importance of Medicare Advantage is further demonstrated by the results of an AHIP survey which found that 62 percent of beneficiaries who identified themselves as having annual incomes below \$20,000 said they would skip needed health care services their Medicare Advantage plans provide if their plans were to no longer participate in the program.

Previous analysis indicates the impact the House bill would have on Medicare beneficiaries. The Congressional Budget Office's analysis of the 2007 CHAMP Act, which included similar provisions, found that Medicare Advantage enrollment would decline by approximately 3 million beneficiaries within five years – almost one-third of the beneficiaries currently receiving care through Medicare Advantage plans. Recognizing that Medicare Advantage plans offer a coordinated and quality-focused approach to patient care, we urge you to reject funding cuts that would undermine the availability of these important health plan choices.

#### Medigap Provision

The bill also includes a provision that would establish a one-time open enrollment period for Medicare beneficiaries under the age of 65 to purchase a supplemental Medigap policy, regardless of their health status. While AHIP supports addressing the needs of individuals with disabilities, this provision would raise premiums for current Medigap policyholders, many of whom are living on fixed incomes, and could have the unintended consequence of making coverage unaffordable for these policyholders. We encourage the committee to consider this impact as it addresses the needs of under-age 65 Medicare beneficiaries.

## **VI. Improving Public Programs**

Separate from the debate on comprehensive health care reform, it is important for policymakers to maintain a strong focus on preserving Medicaid and Medicare as health care safety nets for our nation's elderly, disabled, and low-income citizens.

The Medicaid program has been tremendously successful. Medicaid spares millions of low-income Americans from joining the ranks of the uninsured. A great deal of this success can be explained by the program's focus on the unique needs of the populations it serves. Studies demonstrate that Medicaid beneficiaries are more likely to report they are in fair or poor health and have higher rates of chronic health conditions and a host of co-existing characteristics such as low literacy and inadequate housing. Recognizing these unique needs, we believe it is important that traditional Medicaid beneficiaries continue to be guaranteed coverage outside of the Health Insurance Exchange that the House bill would establish under a reformed health care system.

Medicaid health plans have been key contributors to the success of the Medicaid program. These health plans have developed systems of coordinated care for ensuring that Medicaid beneficiaries are able to access the full range of health care services on a timely basis, while emphasizing prevention and providing access to disease management services for those with chronic conditions. Recognizing that Medicaid health plans are designed to meet the unique needs of low-income individuals, we would like to work with you to ensure that Medicaid beneficiaries continue to have access to the integrated care provided by these plans. This means more vigorous enforcement of federal actuarial soundness requirements for Medicaid health plan rates and addressing the growing trend of states during the economic downturn to carve out prescription drugs from Medicaid health plan benefits which undermines Medicaid health plan care coordination activities.

We also would like to work with you to promote the increased availability of health plans and the systems of care and services they offer for beneficiaries who have long-term care needs and are dually eligible for Medicare and Medicaid. AHIP's members are working to build upon their experience offering dual eligible special needs plans (SNPs) under the Medicare Advantage program to expand partnerships with state Medicaid programs to serve these beneficiaries. The successful initiatives in several states where health plans and states have worked together to create innovative programs for individuals with disabilities and chronic conditions offer examples of the positive results that can be achieved. These programs typically focus on increasing the opportunities for the elderly and individuals with disabilities to choose home and community settings, decreasing the need for nursing home care, and reducing hospitalizations.. For beneficiaries, this means improved health outcomes and better quality of life. AHIP appreciates the House bill's focus on better coordinating Medicare and Medicaid benefits. We are closely reviewing the provisions for fully integrated dual eligible SNPs and look forward to working with you to promote these common goals.

Our members also believe that Medicare Advantage should be an integral part of any solution for ensuring the long-term stability of the Medicare program. Medicare Advantage plans play an important role in strengthening the Medicare fee-for-service program for beneficiaries by demonstrating the value of coordinated care through integrated delivery systems that are lacking in the traditional program. Medicare Advantage plans focus on prevention and offer disease management programs for beneficiaries with chronic diseases, promote access through

comprehensive provider networks, and share performance data with providers to support quality improvement activities.

Medicare Advantage plans also have been an important resource for many low-income Americans who are not eligible for coverage in the Medicaid program. By providing affordable access to coverage of services beyond those covered by the Medicare program and reducing cost-sharing for Medicare-covered services, Medicare Advantage plans have been instrumental in ensuring that many low-income beneficiaries receive the health care services they need.

## **VII. Conclusion**

AHIP appreciates this opportunity to outline our recommendations for comprehensive health care reform and our views on the House's draft legislation. Our complete set of policy proposals are outlined in a series of Board statements we have released since December 2008. We are strongly committed to working with committee members and other stakeholders to develop solutions for ensuring that all Americans have access to high quality, affordable health care coverage.