



# National Association of Health Underwriters

*America's Benefits Specialists*

## ***An American Solution—NAHU's Vision for Affordable and Responsible Health Reform***

The National Association of Health Underwriters (NAHU) is the leading professional trade association for health insurance agents, brokers and consultants, representing more than 100,000 benefit specialists nationally. Our members service the health insurance policies of millions of Americans and work on a daily basis to help individuals and employers purchase health insurance coverage.

The members of NAHU believe all Americans need a health care system that delivers world-class medical care and financial security. Americans deserve a system that is responsible, accessible and affordable. This system should boost the health of our people and our country's economy. Americans also deserve a system that is realistic. We should build on the strengths of the current system in a bipartisan manner and guarantee access to coverage for all Americans.

For those considering legislation to reform our nation's health care delivery system, we offer the following ideas for your consideration.

### **Role of Health Insurance Agents, Brokers and Consultants**

As the individuals on the front lines advising and helping select health insurance products for families and businesses large and small, health insurance agents, brokers and consultants occupy a unique place in the health care coverage system. We educate consumers on their health care coverage choices, help them select the most appropriate plans for their specific needs, and serve as their advocate if problems arise. Subject to strict state licensing laws and education requirements, agents, brokers and consultants are critical to not only the health insurance enrollment process, but also in serving the health insurance coverage needs of individuals and employers after the point of sale.

NAHU believes that to be successful, any reformed delivery system must include health insurance agents, brokers and consultants. With the increase in affordable access to private coverage that will come with responsible health care reform, millions of new Americans will have the opportunity to enter our health care delivery system. The nation's agents, brokers and consultants look forward to continuing our role as their advocates in the coverage process.

### **Containing Health Care Costs**

Responsible health reform must begin by addressing the true underlying problem with our existing system: the cost of medical care. Constraining skyrocketing medical costs is the most critical – and vexing – aspect of health care reform. It is the key driver in rising health insurance premiums and it is putting the cost of health care coverage beyond the reach of many Americans. NAHU believes there are a number of steps policymakers could take to help reduce both government and private-sector health care costs and promote medical care cost containment among all Americans.



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Unhealthy behavior and lifestyle choices are two key factors in the increased cost of health care, so promoting wellness through any reform legislation is imperative. We encourage policymakers to allow for the creation of wellness programs in both the Federal Employees Health Benefit Plan and in government-subsidized health coverage such as Medicaid, Medicare, CHIP and the Veterans Health System. These programs should contain premium and cost-sharing incentives for program beneficiaries to spur participation.

Furthermore, any insurance market reforms created should allow for wellness factors to be used as rating characteristics when determining private group and individual market premium rates. This includes for employer groups not only the existence of a wellness program, but also factors that help determine wellness like smoker status, BMI and participation in disease-management programs. NAHU also supports codification of the current Health Insurance Portability and Accountability Act (HIPAA) bona fide wellness plan rules for employer-sponsored health insurance plans with the incentive cap raised to 50 percent. These rules should also be extended to the individual health insurance market. In addition, we encourage federal legislation to establish a safe harbor for those employers promoting wellness and health activities among their employees from non-intentional discrimination charges. It is critical to correct the Equal Employment Opportunity Commission and Genetic Nondiscrimination Act rules that currently prohibit mandated health risk assessments and limit employer wellness programs and referrals to disease-management services.

Another area where legislative action could help reduce medical care costs is changes to our nation's medical liability laws. Medical malpractice insurance costs are increasing at a rate where many physicians are forced to leave their practices and move to other states, leaving millions of Americans with little or no access to adequate and affordable health care, particularly in rural areas. The threat of lawsuit abuse often forces doctors to perform invasive and expensive tests in order to protect themselves, the cost of which are passed directly on to the consumer in the form of higher health insurance premiums. The Congressional Budget Office has estimated that reasonable caps on noneconomic and punitive damage awards could save Americans \$54 billion over 10 years, and NAHU believes a \$250,000 cap on damages for pain and suffering, a \$500,000 cap on punitive damages and deadline of one year for adults and three years for children to file suit after a medical injury could help us recognize such savings.

Delivery-system reforms are important to contain costs not just in Medicare and Medicaid, but in the private sector as well. National reform must include an effort to increase the number of primary care providers and those practicing in rural areas, as provider shortages are a critical barrier to care. Reducing waste, fraud and abuse in our public and private insurance programs and medical assistance plans is another key cost-containment step. We support more of a pay-for-performance model though value-based purchasing. Increased public access to provider quality and cost transparency data, and incentives for doctors and medical facilities to improve system inefficiencies and eliminate errors though best-practice guidelines and support for evidence-based medicine are cost-saving policy ideas that should be extended to the private-market delivery system and to providers who serve publicly funded programs. Additional



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transparency regarding physician financial interests in the referral process and promoting more coordinated care to prevent hospital readmissions will help too.

NAHU also believes that obtaining and making widely accessible objective information on best medical practices and protocols through comparative effectiveness research is imperative to improving the quality of health care and the affordability of insurance coverage. However, the outcomes of such research should only be used as an informational tool between doctors and patients. In no way should such research data be used by the government or other entities in making coverage determinations.

## **Market Reforms**

As an association of benefit specialists who help individuals and businesses purchase private health insurance coverage on a daily basis, we know that the vast majority of Americans are happy with their current health insurance coverage, particularly those who receive it through the employer-based system. But even though it works well for many people, current private health insurance market regulation is not without its gaps. Some market-reform improvements are definitely needed so that all Americans will have fair access to affordable coverage. However, when implementing market reforms on a national level, great care is needed so that coverage stays affordable. No matter how “fair” a market-reform idea might seem on its surface, it’s not at all fair if it prices people out of the marketplace.

## *Guarantee Issue*

From a pure access perspective, it would seem that one of the simplest ways to get individual-market buyers covered would be to require that all individual health insurance policies be issued on a guaranteed basis without regard to pre-existing medical history, as is already required in the small-group insurance market. However, in addition to being accessible to all Americans, coverage also must be affordable. If such a purchase mandate is passed, enforcement will take time to become effective. Without near-universal participation, a guaranteed-issue requirement in the individual market would result in a very significant increase in premiums and have the perverse effect of encouraging individuals to forgo buying coverage until they are sick or require sudden and significant medical care.

If we are going to have a guaranteed-issue requirement, it is very important that some type of financial backstop or risk adjuster be required as well. This will ensure that the result of market reform is not the exorbitant premiums we currently see in states that already require guaranteed issue of individual policies but do not require universal coverage or have a financial backstop in place. A financial backstop or risk-adjustment mechanism is imperative for the individual market, but would also benefit the small-employer group market. Furthermore, we believe that while risk-adjustment mechanisms should operate under federal guidelines, their administration and design should be state-based to allow for flexibility and for states to take advantage of existing risk-adjustment structures like the 35 state high-risk health insurance pools that are already operational.



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## *Pre-existing Conditions*

The idea that always accompanies guaranteed-issue discussions is the elimination of the use of pre-existing condition clauses. A pre-existing condition clause applies to coverage already in force and limits the amount of time a particular condition may be excluded from coverage. Pre-existing condition clauses are used to prevent the adverse selection caused by people failing to obtain coverage until they know they need the benefit.

For those seeking coverage in the individual market, pre-existing clauses can provide a serious barrier in obtaining or, more commonly, changing coverage options. But it is important to keep in mind that since existing federal law under HIPAA established uniform pre-existing condition rules for the group market, pre-existing condition clauses are almost never a problem for those who have coverage through their employer.

Under current law, carriers can look back at a new group member's medical history for no more than the six months prior to when the individual joined the group and may exclude coverage for certain conditions for up to 12 months. However, the law rewards those who have consistently maintained health insurance coverage. As long as a new group member has no more than a 63-day break in coverage, the group health plan must give the individual credit for his prior coverage. This credit for prior coverage, as well as the controlled entry and exit into group plans, means that pre-existing condition clauses rarely need to be exercised in the group market. They only come into play to prevent true adverse selection, and their timeframe is limited and relatively consistent across the states.

In the individual market, there are no consistent rules. Right now, state exclusionary and look-back periods for pre-existing conditions for individuals range from none at all to five years. NAHU believes greater standardization could easily be achieved in a similar way as was done relative to the small-group market in HIPAA when a federal maximum look-back window of six months and a 12-month exclusionary period was established for the states. Having pre-existing conditions rules that are consistent in both the individual and group model would be much simpler for consumers to understand. Also, insurers should be required to give pre-existing condition credit for prior coverage in the individual market just as they do for the group market. If these changes were made, the pre-existing condition problems for individual health insurance market consumers would all but be eliminated, in a way that both promotes affordability and preserves the private market.

## *Rating Reforms*

The individual and small-group health insurance markets would benefit from greater pricing standardization, and an idea under widespread consideration is to require the use of a modified community rate to determine premiums. However, in order to protect against runaway costs, the federal government should ensure that wide-enough adjustments may be made for several key factors. At a minimum, variations need to be allowed for applicant age at the natural age breakdown rate of at least five to one (meaning that the rate of the oldest applicant may be no more than five times the rate of the youngest applicant). In addition to age, variations in premium rates should also be allowed for wellness factors, smoking status, family composition



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and geography. Also, a uniform application for coverage should be required in these markets, as it would ensure full disclosure of accurate and consistent information and make the process easier for consumers applying for coverage with several different insurance carriers.

When standardizing premium rating requirements for the individual and small-group health insurance, the terms of such markets must be defined. Under current federal law established by HIPAA, a federal standard defines the individual market as one individual or family seeking coverage, a small group as two to 50 employees, and employer groups over 50 employees as large groups, and allows the individual states to expand the definition of a small-employer group. NAHU recommends that the group size definitions in existing federal law remain as they are.

In particular, we feel that the standard definition of a fully insured large employer group should remain at 51 or more employees with a state-by-state option for expansion if desired. For the purpose of determining premium rates, under current law these larger groups are treated very differently than the small-group market and typically rated based on their past claims experience. This market is the health insurance market working best today, and applying a modified community rating standard to these groups would significantly increase costs in this market. It also would create adverse selection to the fully insured market, as the larger groups that choose to fully insure would only do so if they had concerns about their group's claims experience.

## *Policy Rescissions*

Another area where Americans deserve greater health insurance market reform protections concerns the rescission of health insurance policies after they are sold. Under current law, individual health insurance carriers may rescind an insurance policy based on a submission of fraudulent information on an application or an intentional omission of required information. Surveys of individual health insurance plans indicate this happens to far less than one percent of individual market consumers annually, but there have been a number of reported cases in recent years of abuses in the rescission process that need to be addressed.

Much like the problems some consumers face with pre-existing condition clauses, problems with rescissions occur almost exclusively in the individual health insurance market. Group health insurance consumers are already protected against unfair coverage rescissions by existing federal law under HIPAA. In the extremely rare cases where fraud is committed on a group application for coverage, or one member of an employer intentionally omits information from a group application for coverage, the problem is addressed and resolved directly by the carrier with the employer. The discovery of such information could cause a group health insurance contract to be altered or priced differently, but it would almost never result in the cancellation of an entire employer's group coverage program, and federal law already prevents the employer or the carrier from singling out one individual group member for a coverage rescission.

However, all individuals buying individual coverage deserve assurances that they will not be subject to unfair policy rescissions or pre-existing condition determinations. States should be



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required to develop an independent medical review process to resolve disputes concerning policy rescissions and/or pre-existing condition determinations. In addition, health plans should be required to limit rescissions to only Health plan consumers should be clearly informed of their rights relative to rescissions and pre-existing condition determinations. Consumers also should be informed of their obligation to provide complete and accurate responses on health plan applications and to provide additional information at the time of application upon request of the health plan.

## *Coverage Limits*

A market reform idea NAHU has concerns about are limitations to annual and lifetime caps on benefits. While we don't want any individual to have coverage arbitrarily cut off from a medically necessary service due to a limit, some non essential services can be appropriately limited, which helps keeps policies affordable. If annual limits are restricted, the restrictions should be based on medical necessity to avoid overuse of some services. Relative to lifetime caps, they are rarely met, even by the sickest individuals, but they do help provide a control on pricing for medical costs for all covered individuals. A federal financing/reinsurance backstop for those rare individuals whose medical expenses are so great they would exceed lifetime caps might better serve the affordability goals we share for all consumers.

## *Medical Loss Ratio Requirements*

Another market-reform idea NAHU opposes is a minimum loss ratio requirement for private insurers. While we agree with the goal of providing consumers with more value for health care dollars spent, minimum loss ratio requirements significantly and negatively impact coverage choice and affordability. Many administrative functions performed by insurers, such as providing customer service lines and processing claims, are largely fixed costs. These fixed costs are, of course, a smaller percentage of the premiums of higher-cost policies, so a minimum loss ratio requirement would perversely incent carriers to offer higher-premium plan choices rather than lower-cost options. In addition, a loss ratio requirement would limit many key insurer cost containment practices including claims adjudication, fraud prevention, medical homes and various types of pay for performance measures that reduce overall operational costs. We should be encouraging insurers to invest in these kinds of value-added services instead of punishing them.

NAHU also questions why Congress would not seek to include similar administrative strictures on other health care industries, including hospitals, doctors, pharmaceutical companies, medical device manufacturers, nursing homes and the like. If the goal is to have government reduce administrative costs for health care dollars spent, it would only be sensible and equitable to apply similar requirements to all health care providers who will be involved in a reformed health care system.

Most important, a minimum loss ratio requirement does not take into account the need to address underlying cost drivers in health care. Unless those issues are addressed directly, no market-reform measure will result in more affordable policies for the uninsured or those who



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already have coverage. Subsidies required to cover these individuals will correspondingly increase.

## **Means of Encouraging Americans to Purchase and Maintain Coverage**

NAHU has historically approached the idea of an individual mandate to obtain health insurance coverage with great caution. Similar mandates for auto insurance coverage have failed to reduce the number of uninsured motorists. We also have concerns about whether or not a government requirement to purchase any good or service is both inherently fair and even constitutional. However, in addition to reforming our nation's private sector health insurance markets so that they operate more fairly, we need to ensure that as many Americans as possible purchase and maintain private health insurance coverage. The best way to do that is to make private health insurance coverage more accessible and affordable through cost-containment changes and reasonable market reforms. Other ideas to encourage more Americans to join the private coverage system include:

- Insurance-related consequences for healthy people who forego coverage but subsequently attempt to obtain coverage if needed when sick or injured. Such individuals should be subject to late-enrollment penalty in addition to other penalties for those who have more than a 63-day break in coverage. Both Medicare Part B and Medicare Part D have such penalties for a very good reason.
- An annual open enrollment period for individuals to purchase coverage under the guarantee-issue provisions and to allow plan changes. Exceptions should be made for individuals who undergo a life-changing event, such as the addition of a new child or a change in employment. The HIPAA qualifying event standards in current law could serve as a model for these exceptions.
- An increase in the role of employers in health insurance enrollment. Health insurance coverage should not be required to be offered by an employer but, if it is, newly eligible individuals in available employer-sponsored health insurance plans could be auto-enrolled in groups of 50 and more with an employee opt-out. In addition, if federal assistance were provided to even smaller employers to assist with the associated administrative costs, it is possible that they could auto-enroll newly eligible people too.

## **Exchanges**

NAHU has thoroughly evaluated the policy ideas behind exchange proposals and has concluded that our lawmakers need to carefully weigh the pros and cons and structural options of any exchange rather than assume its automatic inclusion in comprehensive reform. Exchanges are merely a form of purchasing pool, and while purchasing pools may provide more health plan options for individuals to choose from, history shows that they do not reduce health insurance costs. If an exchange is part of greater health reform, it is critical that such an entity be structured in such a way that it does not damage or eliminate the traditional private insurance marketplace. If pools totally replace other private-market options, there may be no other vehicle for coverage if the pool fails.

If it is decided that exchanges are to be included in a reform effort, they should be state-based. While national unifying standards could be implemented, such as through model legislation and



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regulations developed by the National Association of Insurance Commissioners, each state should have the ability to design and maintain its own exchange and be granted the ability to seek waivers in order to accommodate for the needs of our diverse population. In creating these state-based exchanges, it's crucial that existing state-based flexibility and regulatory authority be preserved. A federal regulator should not duplicate the role of existing state insurance commissioners and governors. In addition, to preserve consumer choice, the individual and group private insurance markets, independent of the exchange, should continue to be allowed, and any health insurance exchange should include state-licensed health insurance agents and brokers as its sales and marketing force.

In structuring any exchange, NAHU much prefers the "portal" model over a bricks-and-mortar institution and regulatory body that also sells private coverage and/or offers a public program option. A portal approach would provide consumers with easier access to coverage options and subsidy and quality information in a standardized format without disrupting the existing private insurance market. Furthermore, we believe all portals or exchanges should include an option to contact a certified, state-licensed agent/broker for assistance.

Greater stability will also be realized by not mixing market types (i.e., not combining individuals purchasing coverage independently with small businesses or other group coverage) within the exchange. Actuarially, these market segments are quite different and combining them would cause adverse selection to the pool. And although including the self-employed in a connector is an attractive idea, it should be done cautiously as it can cause the same problems as combining individual and small-employer markets. If both small groups and the self-employed are eligible for participation, extra restrictions should be made on the self-employed to control entry into the pool and to ensure the existence of a business.

If exchanges are utilized as a means of subsidy administration, such subsidies should be broad-based and available to eligible individuals and businesses purchasing coverage both inside and outside the exchange. If subsidies are available only inside the exchange, "crowd out" from existing private plan coverage will be dramatic and could destabilize the market. Subsidies only available in the pool can also result in higher-than-expected costs for those in the pool and an apparent larger number of uninsured than actually exist. The means for distributing subsidies through both purchasing avenues—an exchange and the traditional private market—could be modeled on the Massachusetts Connector, which allows for private-market subsidies through the state's premium assistance program, the Insurance Partnership.

## **Subsidies**

Another essential element to the success of a national health reform effort is providing adequate help to those who truly cannot afford to purchase private health insurance coverage or need some degree of assistance towards the cost of private coverage premiums. One of the means discussed most often to provide consistent coverage assistance to all of the lowest-income Americans equally is an expansion of the federal Medicaid program. NAHU believes that any expansion of this program should be limited to the truly needy—no more than 100% of the Federal Poverty Level (FPL). Furthermore, to prevent reduce the crowd out of the private market



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that could occur with a Medicaid expansion and save public money at the same time, NAHU supports mandatory premium assistance for employer-sponsored coverage when qualified private coverage is available.

NAHU also supports targeted premium-assistance programs and/or refundable and advanceable tax credits for low-income individuals with family incomes of up to 200% of FPL and small businesses purchasing private coverage. A subsidy program could be national in scope, or each state could be required to create one that suits the unique needs of its citizens in partnership with the federal government. Several states have already created successful subsidy programs and their existing structures could be used as a model framework for a national reform.

Finally, some changes need to be made in our tax system simply to provide equity for individual market consumers with their counterparts in employer-sponsored plans. For example, removing the 7.5% of adjusted gross limit of medical expenses on tax filers' itemized deduction Schedule A form and allowing the deduction of individual insurance premiums as a medical expense in itemized deductions would help many people who are part-time workers or who work for employers that don't offer health insurance coverage. And to put self-employed individuals who are sole proprietors or who have Sub-S corporations on a level playing field with businesses organized as "C" corporations, their current deduction from gross income should be changed to a full deductible business expense on Schedule C.

## **Government-Run Public Plan Public Option**

NAHU strongly supports efforts to enact real and substantive private market reform to provide all Americans with access to affordable health care and insurance, and to lower health care and insurance costs. However, the inclusion of a government-run public plan option in any health reform package would fail to help us meet these goals. A public program and private insurance coverage are inherently different and could never truly compete on a level playing field in a competitive marketplace. Millions of Americans covered by private insurance would be burdened with the cost shift from the public option as a result of these discrepancies, and our already-suffering state budgets would be impacted by a substantial loss of tax revenue. Any public option would likely displace tens of millions of happily insured Americans from the conventional marketplace and exacerbate the worst elements of the current system: gross inefficiency, high costs and bureaucracy. As such, NAHU opposes the inclusion of any type of government-run public plan option provisions in any comprehensive health reform legislation.

## **The Responsibility of Employers**

NAHU believes that the employer-based system must be at the core of any health reform effort. However, we believe that the provision of benefits must be a voluntary action on the part of employers. We are opposed to an employer mandate to provide coverage because, while well-intentioned, such a mandate would do little reach the currently uninsured population and would actually hurt American workers by negatively impacting new job creation, causing the loss of millions of current jobs, suppressing wages and perpetuating instability in what is an already fragile American economy.



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## **Long-Term Care**

If more individuals were able to privately finance their long-term care needs, the cost savings to both the federal government and the states in reduced Medicaid expenditures would be enormous, as Medicaid is currently the primary payer of American long-term care costs. Comprehensive health reform proposals considered previously included the establishment of a new nationalized long-term care program for American workers that would threaten the private long-term care insurance market, even though the private market provides better benefits for lower cost. While the idea of offering long-term care coverage to working Americans is well-intentioned, policymakers could much more easily and cost-effectively encourage millions more Americans to plan for their futures and purchase private long-term care coverage by enacting some market-based incentives.

One simple change that would have far-reaching benefits would be to include long-term care insurance premiums in Section 125 plans to encourage employers to offer such coverage to their workers as either a voluntary or subsidized benefit. Group long-term care insurance can lower the after-tax premium by 25-30% for employees, and these products are fully portable under current law. Sales made in the employer market typically have fewer underwriting restrictions, creating a private coverage option that gives consumers the greatest possible degree of choice when it comes to their long-term care needs.

NAHU also supports an above-the-line federal income tax deduction for long-term care insurance premiums. This would allow taxpayers to claim a tax deduction regardless of whether they itemize their deductions and whether they have other medical expenses. Tax deductibility of long-term care premiums will encourage the purchase of LTC insurance by everyone, including younger Americans, who will benefit by making their initial purchase when premiums are most affordable. Over the lifetime of those individuals purchasing coverage, it is also anticipated that such a change would save the Medicaid system more expense than it costs the tax system in lost revenue.

## **Financing Issues in Health Reform**

NAHU believes that policymakers should not attempt to finance health care reform on the backs of Americans who already are doing the responsible thing and purchasing private health insurance coverage and creating American jobs as small business owners. This would include financing reform through an excise tax on private coverage, cuts to the private Medicare Advantage program, changes to the existing federal tax exclusion for employer-provided health insurance and changes to the tax status of account-based health coverage options. Instead, it is wholly appropriate for Congress to consider health-related excise taxes in financing health reform that can help deliver revenue and simultaneously discourage unhealthy lifestyles that are a major component in fueling growing health care costs.

## **Conclusion**

NAHU members urge policymakers to carefully consider these ideas to improve health insurance coverage options for consumers nationwide. Our private health insurance market is innovative,



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flexible, efficient and, most important, up to the task of responding to well-structured reforms. We encourage you to work together on a bipartisan basis to develop an affordable and responsible means of achieving the needed changes to our nation's private health care delivery system. America's licensed and professional benefit specialists stand ready to work with you in crafting meaningful comprehensive health reform that guarantees access and choice, lowers costs, improves health care quality and puts the needs of the American people first.