



## **National Association of Health Underwriters Federal Legislative Priorities for 2008**

### **State Children's Health Insurance Program Reauthorization**

While Congress did in December 2007 temporarily reauthorize the State Children's Health Insurance Program at current funding levels through March of 2009, that legislation does not preclude Congress from attempting another five-year reauthorization sometime in 2008. NAHU hopes that a long-term funding agreement can be reached before the end of this Congress.

NAHU feels that it is very important that SCHIP retains its ability to partner with the private insurance market. It's our goal to make it even easier for private-market integration by removing some current restrictions that have hindered premium-subsidy efforts of private-market employer-sponsored coverage. Many parents of SCHIP-eligible children have access to employer-sponsored health insurance coverage but cannot afford their portion of the dependent premiums. NAHU would like to see the process for states to use SCHIP dollars to subsidize such employer-sponsored coverage made much simpler so that more families can be covered together.

NAHU has developed some very specific and technical recommendations as to how the existing law can be modified to make premium assistance a workable reality, and we have built a broad and bipartisan coalition of premium-assistance supporters. NAHU will continue to work with members of Congress on SCHIP in the coming year to encourage them to make premium assistance a priority in a long-term reauthorization package

### **Trade Adjustment Assistance Act Reauthorization**

Before adjourning in December, Congress also passed a measure providing for a three-month extension of the existing Trade Adjustment Assistance (TAA) program, including the health care tax credit (HCTC) program that Congress enacted in 2002. This extends the TAA program through March 31 of this year. Approval of this legislation is intended to give Congress additional time to complete action early next year on a five-year reauthorization of the TAA program. The House approved a reauthorization bill, H.R. 3920, in October, but the Senate has not yet taken action on similar legislation.

The full reauthorization measure passed by the House in October includes provisions opposed by NAHU that would expand the HCTC program and establish new rating requirements for HCTC-eligible health insurance coverage offered through an insurer that contracts with a state to cover eligible individuals. Specifically, premiums for such coverage would be required to be community rated or based on a rating system under which the premiums may not exceed 150% of the standard rate. NAHU feels that these changes would likely reduce coverage availability for tax credit recipients. Other provisions of H.R. 3920 would expand COBRA continuation coverage for TAA-eligible

individuals and PBGC recipients. The Bush Administration has issued a veto threat against this bill.

NAHU plans to work with the Senate Finance Committee this year to try to ensure that more reasonable HCTC requirements are included in the final reauthorization of this program. Since the HCTC is the only federal tax credit for the purchase of health insurance in existence, NAHU feels that it is crucial that the credit is structured well, even if it is targeted at a small population. Specifically, we would like to see the purchasing options for recipients revised to allow eligible individuals to purchase any coverage available and approved in their state, eliminating the need for a special state election. Also, we would like to see Congress make the TAA guaranteed-issue requirements mirror HIPAA group-to-individual portability requirements in terms of timeframe AND purchasing option requirements.

### **Mental Health Parity**

Another issue of critical importance is mental health parity. The full House is soon expected to vote on H.R. 1424, an extreme measure opposed by NAHU and our coalition partners. If enacted, this bill would make coverage of “disorders” like caffeine addiction and jet lag on par with not only serious mental health conditions like manic depression, but also with other serious physical conditions like heart disease. In contrast, the Senate-passed parity bill, S. 558, is bipartisan in nature and represents a reasonable compromise on this issue. It was crafted with the input of a coalition of interested parties, including NAHU. Our coalition is currently working to urge members of the House of Representatives to substitute the Senate-passed legislation for the House bill to avoid a conference committee on the two vastly different pieces of legislation. President Bush has already indicated his willingness to sign reasonable mental health parity legislation.

### **Containing Health Care Costs and Improving Quality**

NAHU knows how much the cost of health insurance coverage is impacting our nation’s employers and economic growth, and we also know that health insurance is expensive because of the high cost of health care. As such, we are supportive of federal action in a number of areas that would not only help contain health care costs but also improve the quality of care for all Americans.

Unhealthy behavior and lifestyle choices are two key factors in the increased cost of health care. Behavior is the most significant determinant of health status with as much as 50% of health care costs attributable to individual behaviors such as smoking, alcohol abuse and obesity. We would like to see the federal government incorporate wellness and disease-management programs into the Federal Employees Health Benefit Program, as well as Medicaid, Medicare, SCHIP and the Veterans Health System.

Furthermore, we are very supportive of federal action to encourage employers to adopt wellness programs so that employees and their families are incented to adopt healthier lifestyles. In particular, we would like to see the creation of tax incentives to businesses

that provide opportunities for their employees to lead healthier lives and prevent chronic illnesses through wellness programs.

It is also estimated that improvements to health information technology can reduce health care costs up to 20% each year by saving time and reducing duplication. We are highly supportive of health IT initiatives, and feel that they will help reduce health care expenses and lead to higher-quality care for American consumers by reducing errors and improving patient satisfaction. In particular, NAHU is supportive of efforts to make all health records electronic with interoperable technology, so that all record systems are able to communicate with one another and individual health records are always up to date and complete, and we feel that federal legislation would go a long way toward achieving that goal.

To further reduce costs, we support federal incentives for doctors and medical facilities to improve system efficiencies and eliminate errors with pay for performance, best-practice guidelines and support for evidence-based medicine.

Transparency of medical costs is another cost-reduction issue that is critical for NAHU. We believe that the advent of a more consumer-directed approach to health insurance coverage is essential to reducing overall health care costs as it will help curb excessive utilization and claims, and drive down costs by increasing competition among providers.

However, to be fully successful, American consumers need to be fully aware of the cost of the health care that they are purchasing. Since the vast majority of American health care expenses are paid by a third party through the administration of health insurance claims, most Americans have no idea what the health care that they receive costs, and they have been conditioned not to even ask. As a result, the ability for consumers to compare costs and quality when making decisions as to which providers to use and which health care services to select has been virtually eliminated.

NAHU strongly encourages health insurance carriers, hospitals, physicians and other health care providers to voluntarily disclose the prices they pay and charge for care to all consumers. However, since we believe increased medical transparency for health insurance consumers is so critical to reducing costs and promoting consumer-directed care, we support legislative and regulatory efforts at the state and federal levels to require increased transparency should voluntary efforts fail, provided that such governmental efforts are not overly burdensome.

Encouraging the expansion of consumer-directed health insurance products, like Health Savings Accounts, Health Reimbursement Arrangements and Flexible Spending Accounts will also help reduce the over-utilization of health care services. In December 2006, legislation was enacted that made many improvements to HSAs, but more could be done to make HSAs an even more attractive health coverage option to employers and individual consumers.

Some changes to current law NAHU would like to see include permitting employees to contribute to a HSA even if their spouses have an FSA, allowing prescription drug coverage to be offered without a high deductible, and a federal clarification that individuals with a family HSA policy simply need to meet the individual deductible requirements rather than the whole family deductible. We also think that permitting employers to reserve their contributions for disbursements to pay for qualified medical expenses only would increase employer willingness to contribute.

In addition, we would like to see a number of changes made to benefit HSA owners closer to retirement age. For example, we would like to see early retirees be able to use accumulated HSA funds to pay for health plan premiums, as current rules that limit this privilege to those aged 65 and older. Furthermore, HSA funds should be allowed to be used to pay for Medigap coverage, as many beneficiaries, particularly in rural and urban areas, only have this option available to them to supplement basic Medicare coverage. Finally, we would favor a measure allowing individuals over age 65 to contribute to an HSA as long as they are not yet retired, even though they may automatically be enrolled in Medicare Part A.

The amount health care providers must pay for medical liability insurance coverage is also directly affecting health care costs in this country. But an even more costly side-effect of rising medical malpractice insurance rates is when doctors order more tests, medications and referrals than are medically necessary to protect themselves against accusations of negligence. NAHU supports comprehensive medical malpractice reform that limits non-economic damage awards, allocates damages in proportion to degree of fault, places reasonable limits on punitive damages and attorney fees, and imposes reasonable statutes of limitations on claims.

### **Ensuring Access to Health Insurance Coverage**

Right now, in a number of states there are people with serious medical conditions and no access to employer-sponsored health insurance; they cannot buy health insurance at any price. Federal access protections in the Health Insurance Portability and Accountability Act of 1996 ensure that small-group health insurance customers and individuals leaving group health insurance coverage must always have at least one guaranteed purchasing option, but they do not apply to everyone. People purchasing coverage in the traditional private individual health insurance market who are not transitioning from an employer's plan do not have federal guaranteed-issue rights.

Most states, but not all, have independently established at least one mandatory guaranteed purchasing option, with the vast majority of states choosing a high-risk health insurance pool to serve this important purpose. While the mechanism for access to health care coverage may vary from state, access should not be denied any American. The federal government should require that all states have at least one private guaranteed purchasing option for all individual health insurance market consumers. Furthermore, we need to investigate new forms of access that could be made available by increasing the function

of state high-risk pools to be a more transparent backdrop to guarantee access to coverage for those in poor health.

Cost is also a key barrier to health insurance access and there are some people who legitimately can not afford the full cost of health insurance. Some of these individuals and families do not have available coverage from an employer and others can't afford their share of employer-sponsored premiums. Since coverage availability differs in each state, a program of grants to states should be established through the Department of Health and Human Services to reward state health insurance innovations that utilize the strengths of the existing private health insurance marketplace and fund state-based programs to provide assistance with payment for private health insurance premiums on a sliding scale.

### **Long-Term Care**

NAHU has long sought legislation to include long-term care insurance premiums in Section 125 plans to encourage group LTCI sales. LTCI premiums are between 20 and 30% less in the group market, and these products are also fully portable. Plus, buying private coverage guarantees consumers the greatest possible degree of choice when it comes to their long-term care needs. Finally, if more individuals were able to privately finance their LTC 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.