

## KEY BCBSA SENATE HEALTH CARE REFORM ISSUES

December 3, 2009

The Blue Cross and Blue Shield Association supports enacting bipartisan health care reform. However, several provisions would make health care coverage unaffordable for many people. Key concerns are:

**Government-run Plan:** A government plan -- in any form -- is unnecessary and would cause millions of people to lose their existing private coverage, underpay providers, undermine delivery system reforms critical to controlling costs, and inevitably increase the debt.

- *BCBSA recommendation:* Do not include any government-run plan or “trigger.” An affordability-based trigger is likely to be pulled almost immediately in many states as a result of provisions in the bill that will increase the cost of insurance.

**Individual Mandate:** An effective individual mandate is critical so that everyone – young/healthy and older/sicker individuals – participate in the system. The Senate mandate is very weak. Many would be exempt (if premiums are 8% or more of income) and the nominal penalties phased in to \$750/person in 2016 (only 16% of annual premium) are inadequate to assure universal coverage. The combination of a weak mandate and the insurance reforms (GI/CR) will mean that people can wait until they are sick to buy coverage – making insurance more expensive for everyone.

- *BCBSA recommendation:* Strengthen the mandate by including stronger incentives to maintain coverage and institute a Medicare Part B-like enrollment policy for those people who do not purchase coverage in the initial open enrollment period or who have a lapse in coverage greater than 63 days (HIPAA standard). These individuals would wait 9 months after enrolling in the next open enrollment period before coverage begins.

**Age Rating:** Age bands of 3:1 would increase premiums for the youngest third of the population by 35 percent assuming an effective mandate according to Oliver Wyman. Without a stronger mandate and appropriate age discounts, millions of young people will forego coverage, making premiums even higher.

- *BCBSA recommendation:* Restore 5:1 age bands to assure young people obtain coverage and reject efforts to narrow age bands.

**Insurer Fees:** The \$6.7 billion annual insurer fee beginning in 2010 would substantially increase premiums, with this burden growing as more employers self-fund to avoid the tax.

- *BCBSA recommendation:* Drop new insurer fees.

**Exchange:** The bill includes a highly structured exchange model, where choice of plans will be limited to those selected by the government and functions and staff of the state exchanges will duplicate resources already in place in states. This model was tried with state purchasing

coops and failed to lower costs or provide meaningful choice of products. The Senate Finance Committee's exchange model would assure greater competition and lower costs.

- *BCBSA Recommendation:* Replace exchange provisions with the Senate Finance proposal. At a minimum, states should have the flexibility to implement alternative models that best meet their local needs, including determining which functions are performed by the exchange or insurance department or whether to restrict choice of plans. Permit employers to select plans on behalf of their employees to reduce administrative costs and adverse selection.

**High Risk Pools:** Creating a new national high-risk pool program for those who have pre-existing conditions is not the most efficient way to target limited federal resources. A better approach would be to build on existing state access mechanisms and create options in the limited number of states without such programs in place. This would assure resources are available quickly and the \$5 billion would be targeted toward those most in need of assistance.

- *BCBSA Recommendation:* Assure all states have an access mechanism available that meets federal standards and targets those who are not able to obtain private coverage.

**2010 Rate Review:** The bill requires insurers to submit premium rate justifications to HHS. This is tantamount to a federal rate approval system that could create significant solvency risks if adequate rates are not approved. States already have authority to review rates in the individual and small employer markets and should continue to do so.

- *BCBSA Recommendation:* Drop provision.

**Risk Corridors:** Mandatory risk corridors in the individual and small group markets would increase the federal government's financial exposure for insurers that underestimate enrollee costs, while penalizing insurers that more accurately estimate enrollee costs.

- *BCBSA recommendation:* Make risk corridors optional (as in Finance Committee bill).

**Taxation of BCBS Plans:** The bill would change the tax treatment of not-for-profit Blue Plans that do not meet an 85 percent medical loss ratio (MLR). This not only subjects most BCBS plans to a higher MLR threshold than the bill requires for other health insurers, but would also place BCBS Plans at a competitive disadvantage relative to nonprofit HMOs who are tax exempt and undermine the future of non-profit health plans. It is inappropriate to change the tax status for certain BCBS Plans because not-for-profits do not have access to the tax free equity markets of stock companies and the tax-free financing of nonprofit HMOs.

- *BCBSA Recommendation:* Maintain the current rules for taxation of BCBS Plans so they can raise the capital needed for adequate reserves.

**Small Group Size:** Including mid-size employers (51 – 100) in small group reforms would spur self-funding by healthier, mid-sized groups, resulting in higher rates for small employers.

- *BCBSA Recommendation:* Limit insurance reforms and exchanges to small employers with 50 or fewer employees. Have NAIC conduct a study of employers with 51 to 100 employees to determine whether these groups should be Exchange-eligible.

**MLRs:** An MLR requirement will result in higher costs because it will hinder many important quality improvement initiatives such as disease management, care coordination, health IT investments and anti-fraud initiatives that are currently calculated as administrative expense. In addition, to assure accurate comparisons, state and federal taxes and fees should be excluded since different insurers have different obligations and certain nonprofit HMOs are tax exempt.

- *BCBSA recommendation:* Drop MLR requirements or at a minimum, require HHS to include the cost containment activities listed in the NAIC Statement of Statutory Accounting Principles No. 85 in defining “activities that improve health care quality.” Also exclude both state and federal taxes and fees from MLR calculations.

**Benefit Design Limitations:** While the Senate bill includes a lower minimum actuarial value for Bronze plans, it has minimum benefit requirements that will increase the cost of coverage.

- *BCBSA Recommendation:* Improve affordability by eliminating explicit cost sharing limits (e.g., \$2,000/\$4,000 cap on deductibles for small employers), modifying the requirement for benefits to be equal in scope to a typical employer sponsored plan to require that coverage is not required to be any more comprehensive than a typical employer policy, and narrowing the definition of “essential benefits,” especially with regard to potentially costly requirements to cover “behavioral” and “habilitative” services.