May 22, 2009

Senator Max Baucus
Chairman,
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510-6200

Dear Chairman Baucus:

The undersigned members of the Coalition for Affordable Health Coverage (CAHC) appreciate the opportunity to submit our comments on the May 14 Finance Committee document "Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans". The undersigned groups represent a range of interests and applaud your efforts to promote affordable health care coverage.

CAHC is a broad-based group with a singular focus: making health coverage more affordable both for those who currently have it and for those who do not. We offer the following suggestions in response to your request for comments.

Tax Credits

We strongly support refundable advanceable tax credits for individuals and families as a way to provide assistance for the cost of private health insurance coverage. We are concerned though about only permitting these subsidies inside the connector. We believe this creates an unleveled playing field and could cause inappropriate spin off from employer sponsored plans by low income employees, resulting in the inability of some small employers to meet health plan participation requirements. In addition, we believe using an enrollment weighted average premium would encourage enrollment in efficient plans in a way tying the premium subsidy to the second lowest cost option cannot.

We also strongly support tax credits for small businesses. Under current law, this group of stakeholders faces several disadvantages that make purchasing adequate health coverage much more difficult. This tax credit will provide much needed assistance to small businesses struggling to afford health coverage for their employees.

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Self Employed

We would also encourage you to include the self-employed among those who are eligible to receive tax assistance to make health insurance more affordable. Self-employed business owners have long been plagued with the disparity in the treatment of deductibility of health insurance costs. Under the current tax code, the self-employed (sole-proprietors) are unable to deduct premiums as a business expense and are required to pay an additional 15.3 percent self employment tax, their payroll tax, on their health care costs. The self-employed are the only segment of the business population that pays this extra tax on health insurance. We're pleased to see that you included lifting the 7.5% of AGI requirement for deduction and hope this will remain in the final bill.

According to a 2007 Kaiser study, an individual pays an average of $12,106 annually in health insurance premiums for family coverage. Since sole-proprietors are not treated equally to other business entities, a self-employed individual with a per-year premium of $12,106 is paying $1,852.22 (15.3 percent) in extra payroll taxes on their health insurance. This is money that could be used to reinvest and grow their business, cover out-of-pocket expenses of their current health coverage or provide funds to afford health insurance if they are currently uninsured.

Allowing self-employed to achieve parity with corporations that are currently allowed to deduct their coverage costs as an ordinary business expense would have broad implications—more than 21 million entrepreneurs would have greater access to affordable health insurance under this proposal. We strongly encourage you to include it in your reform efforts.

Public Option

You also suggest the creation of a public health insurance option as a means to address growing concerns about the costs of health insurance as well as the growing number of those without insurance. We agree that we must address these problems, and we support your proposed Option B, which relies on reforms to the private market.

We have concerns that the creation of public health insurance option, especially one that bases its reimbursement on Medicare payment rates, would create an advantage for the government plan that would lead to a host of market problems damaging to the consumer such as: provider access issues; creation of a death spiral in private insurance that would restrict options available in the private market and result in a government only option as a result.

In addition, there are serious questions whether creating a public option that could compete fairly with private insurers is feasible: if private insurers pay the same rate as Medicare or other government selected amount of payment, many facilities have said they would have no choice but to close their doors; on the other end of the spectrum, if government paid rates consistent with market rates charged by providers, it simply would be incredibly expensive and would become an unaffordable option to taxpayers. The

likely result of this immediate cost over-run would be similar to the fate of Medicare itself, which began on the premise of paying market rates, but quickly switched to today's price setting methodology to help stay afloat.

We recently held a briefing to review the public option that included an analysis by the Lewin Group of the impact this proposal could have on providers and employer coverage. According to Lewin:

- Assuming the public plan is open to all individuals and employers, total hospital margins would fall by $36.0 billion in 2010, which is equal to about 4.6% of total hospital net revenues.

- Physician net income would fall by about $33.1 billion in 2010, which is equal to about 6.8 percent of physician revenues.

- Under these scenarios, health care providers would be providing more care for more people with less revenue.

- If all firms are permitted to buy coverage for their workers through the public plan—assuming Medicare payment levels—about 119.1 million workers and dependents would lose the private employer coverage they now have.

- A public plan paying Medicare rates would charge monthly premiums for family coverage of about $761, compared with an average of $970 in private plans.

    - This is evidence a public option would spark a migration from private insurance to a public plan by sending strong price signals to consumers.

    - Unfortunately, these price signals are a result of administered prices set by Medicare that do not adequately reflect the cost of care across the country or by the quality of care delivered or by the outcome to the patient.

These changes, if adopted, would create serious disruption in access to care and eliminate the ability of private insurers to exist, much less compete. This will result in fewer, not more, choices. We urge you to reject a public option as an untested experiment in a time of economic uncertainty, rising costs and the significant changes you are proposing throughout the health system.

The many other changes and reforms you propose will likely address all issues of concern.

We believe a far better way is to focus on Option B that reforms the private market, and coupled with an enforceable individual mandate, can successfully extend coverage to the millions who find themselves currently uninsured.

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Benefit Options

You propose to require all health insurance plans in the non-group and small group market to offer all four benefit options you outline (based on the percentage of health expenses paid by the plan of between 93 percent and 76 percent). We believe consumers should at a minimum also have an option to purchase a catastrophic only policy that would protect them from calamitous events and medical bankruptcy. Such an option would be less expensive (i.e., more affordable) and should be included to provide additional choice to consumers seeking to protect themselves and their families from unforeseen and catastrophic medical expenses.

We also question the need to define cost-sharing in this manner for those who do not qualify for low-income subsidies. If someone wants to select coverage with greater cost-sharing and can afford to do so, and is paying the entire cost on his own, why would the government feel the need to decide his coverage needs for him? It is important to note that this would not preclude the need for all policies to include coverage for certain services like hospital services, physician services, lab and x-ray services, and prescription drugs.

Simply put, health coverage options need to be more flexible than those proposed.

Grandfathered Plans

You propose grandfathering those individuals and small employers who currently have or offer coverage under the pre-reform rules. Once a small employer changes a contract for coverage, you propose to require them to purchase a plan that meets the new federal benefit requirements. In addition, no low income tax credits would be allowed for low income individuals in grandfathered plans.

This aspect of the proposal violates the principle of allowing people to keep what they have if they like it.

Because contracts between purchasers of coverage and issuers of coverage typically last one year, any grandfathered plan would need to comply with the new rules one year after the new rules take effect.

At the very least, the proposal appears to create a negative incentive to keep what you have because low income tax credits would not be available unless a purchaser changed coverage to a new policy. Low income individuals should not be denied assistance if an employer decides to keep what they have because they are happy with their current plan and it works for their employees.

We suggest allowing plans to be grandfathered in perpetuity and that the low income credit should apply to both new plans and grandfathered plans inside and outside of the connector to ensure parity and fairness to all Americans.

Temporary Medicare Buy In

You propose to allow people aged 55 to 64 to buy in to the Medicare program on a temporary basis. As currently structured, Medicare is fiscally unsustainable. Allowing additional beneficiaries to buy into the program, even on a temporary basis, would exacerbate the program's precarious financial footing.

Assuming an effective and enforceable individual purchase mandate is enacted, coupled with guaranteed issue, no pre-existing conditions exclusions, adjusted community rating, and subsidies for those who can't afford coverage, we do not see the purpose of risking this type of financial uncertainty. To ensure broader access to coverage while the new market reforms are being phased in, the current HIPAA group to individual portability provisions could be modified to allow eligible individuals to go directly from group coverage to the state's HIPAA individual portability vehicle without exhausting COBRA or state continuation first. The cost of coverage via this mechanism is likely to be less for the consumer, less financially hazardous for the government, and would guarantee considerably more choice for the consumer than a Medicare buy-in.

Should you have questions on any of our suggestions, please do not hesitate to contact us.

The proposals you released on May 14 demonstrates your commitment to comprehensive health care reform. We applaud your efforts and stand ready to work with you to provide assistance to ensure affordable health coverage.

Sincerely,

Assurant Health
Healthcare Leadership Council
International Franchise Association
National Association for the Self Employed
National Association of Health Underwriters
National Retail Federation

cc: Ranking Member Chuck Grassley, Members of the Finance Committee