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AHIP
America's Health Insurance Plans

Board of Directors' Statement

December 2008

Now is the Time for Health Care Reform:

A Proposal to Achieve Universal Coverage, Affordability, Quality Improvement and Market Reform

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Introduction

Although health care reform has been on the nation's agenda for many years, the complexity of the challenge and the varied interests of stakeholders have held back progress. Next year provides a new opportunity to transcend these traditional barriers and achieve a more sustainable health care system that provides affordable, high-quality health care coverage for all Americans.

During the past year, we have traveled the country and engaged in conversations about health care reform with people from all walks of life – those with coverage and those without, owners of small businesses and their employees, union leaders and members, physicians and other health professionals, and working families from a wide range of backgrounds and communities. They have shared concerns with us about rising health care costs, the inadequate health care safety net, and what may happen if they lose their jobs, fall between the cracks of public programs, or cannot afford coverage.

Informed by these discussions and building on the access, affordability, and quality proposals we've developed over the past two years, the Board of Directors of America's Health Insurance Plans (AHIP) is offering a new set of proposals aimed at moving the nation toward a restructured health care system in which no one falls through the cracks, all Americans have high quality, affordable coverage, and the efficiency and effectiveness of the system are greatly improved.

We have four main objectives:

Controlling costs: A financially sustainable and affordable health care system can only be achieved by bringing underlying medical costs under control. If health care costs are allowed to continue rising at rates far exceeding economic growth, they will thwart all efforts to improve coverage and care.

Adding value: The nation must create a 21st century system where quality and effectiveness are rewarded, administrative efficiency is achieved, and primary care and wellness are encouraged.

Helping consumers and purchasers: Insurance market rules need to be reformed to help individuals and small businesses access affordable coverage, while avoiding duplication of administrative and regulatory responsibilities. These reforms must be coupled with initiatives to provide one-stop access to coverage options and clear, consistent information on the quality and cost of care.

Achieving universal coverage: By addressing rising costs, reforming insurance market rules, strengthening the health care safety net, and enhancing value in care delivery, the nation can provide all Americans – those with and without coverage today – affordable coverage they can keep.

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Soaring Health Care Costs Need To Be Brought Under Control

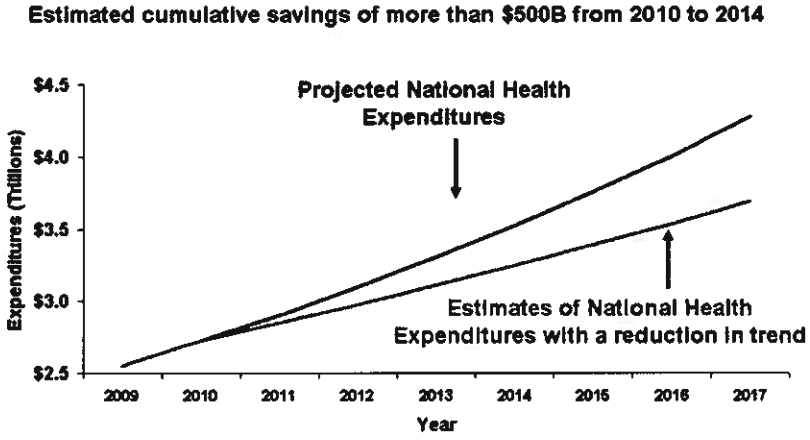
The nation should set a bold goal for reducing future cost growth by approximately 30 percent.

Controlling costs in the health care system and making quality care affordable for all Americans will challenge every part of the health care system. It is a challenge that we must take on to build a sustainable health care system that provides affordable coverage for everyone. For this reason, the nation needs to rally around a bold goal: reducing the future growth of health care expenditures by approximately 30 percent.

Efforts to make our health care system more affordable for the long run will succeed only if the nation as a whole makes a strong commitment to a specific goal and we all work together to achieve it. The critical link between reducing costs and increasing quality should help guide this effort. Spending more on health care does not necessarily equate to better quality; rather, the opposite has been shown. In particular, many regions of the country with higher spending actually have poorer quality of care and exhibit wide variations in practice and treatment patterns.

We will urge that Congress set a target for reducing future health care costs over a five-year period and designate a public-private advisory group to develop a specific plan for achieving this goal. The importance of this effort cannot be overstated. Reducing annual increases in the projected growth rate of national health expenditures by approximately 30 percent could produce an estimated cumulative savings of more than $500 billion over five years.

National Health Spending: Significant Savings Possible By Reducing Trend from 6.6 percent to 4.7 percent



Savings of this magnitude could go a long way toward ensuring that every American has access to affordable, quality coverage and care. These savings could help finance part of the costs of providing coverage to the uninsured, as well as reduce costs for those who are currently covered.

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We believe that a public-private advisory group representing a broad range of stakeholders with relevant policy expertise should be tasked with the responsibility of developing broad recommendations that do three things:

1. **Evaluate the best strategies to restrain and reduce wasteful and unnecessary spending across all sectors of the health care system.**

   A place to start would be to address the variations in care that result in inappropriate use of health care services. Respected studies have shown that patients do not consistently receive high-quality health care and receive care based on best practices only 55 percent of the time. In addition, thousands of patients die each year from preventable medical errors. This tragic and costly situation underscores the essential need for creating solutions that improve patient safety.

   A commitment to reducing variation will, in turn, help spur the development of evidence-based recommendations to increase the appropriate use of wellness and preventive services and lead to better coordination of care for chronic conditions. Evidence-based standards will also help inform an assessment of the key drivers of health care costs which should include consideration of capital investments in new technology and capacity. A key goal of the assessment should be to identify options for producing greater value in care delivery, recognizing the fact that Americans spend more per capita on health care than other developed countries without achieving better results.

   The nation should also explore approaches for replacing our medical liability system with a new dispute-resolution process that is fair to patients and protects physicians against liability if they follow best-practice standards.

   Finally, we need a more concerted focus on addressing fraud as a way of controlling health care costs, consistent with stepped-up anti-fraud efforts in traditional Medicare.

2. **Change the way we pay for care in public and private programs so that doctors and hospitals are rewarded for quality and outcomes rather than volume.**

   We need a payment system that rewards excellence and improves patient safety. To work most effectively, payment reforms need to be coupled with better information for patients about treatments and alternatives. These innovations are needed throughout our entire health care system, including Medicare and Medicaid. We can achieve this goal by promoting payment reform that rewards clinicians for spending adequate time with patients and emphasizing primary care, prevention, and wellness. These reforms include making improvements to the existing fee-for-service system (including Medicare's Resource-Based Relative-Value Scale system) through alternative models such as paying for episodes of care, bundling payments for inpatient and immediate post-hospitalization care, and building upon successful shared risk models. We must also reward clinicians for delivering optimal care by linking payment to uniform performance measures that can be fairly applied to all health care providers, encouraging providers to assess individual patients' risk for certain chronic diseases, and ensuring all patients receive the right care in the right setting.

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3. **Streamline administrative processes to increase efficiency, make the system easier for patients and providers to navigate, and reduce costs.**

Administrative processes should be streamlined across the health care system. In advancing this recommendation, we recognize the need for our industry to come to the table with proposals for how we can do our part. We have committed to develop a multi-payer online portal to give providers a uniform method to communicate with health plans and afford them access to current information on eligibility and benefits. This will ease the administrative challenges that physicians and other providers face, and will help them and their patients better understand coverage and predict out-of-pocket costs. We are also working with providers on a standard data aggregation approach with the goal of giving providers and consumers useful performance information. Administrative streamlining should be viewed through the eyes of consumers, with the goal of making the health care system easier to navigate and more consumer friendly. A key part of this effort is our focus on the reform of market rules to enhance access for consumers and provide them with clear, useable information on coverage and care options.

* * *

Driving Higher Value For Those In The System Today and Those Entering The System Tomorrow

The goal of containing costs can only be realized if it is coupled with parallel efforts to improve the ability of our health care system to deliver high-quality care that is in line with best practices and addresses the disparities in care experienced by cultural and ethnic minorities. Driving a high-value health care system requires focusing on several critical areas:

1. **Refocusing our health care system on keeping people healthy, intervening early, and providing coordinated care for chronic conditions.**

Proactive steps need to be taken to identify individuals at risk for chronic conditions, help them access care, and encourage them to maintain healthy lifestyles. One in three Americans has a chronic condition. Five chronic diseases (heart disease, cancer, stroke, chronic respiratory disease, and diabetes) cause over two-thirds of all deaths each year. For a pro-active approach that keeps people healthy and productive, two things need to happen: First, we need to address the growing shortage of physicians and nurses in selected disciplines, including primary care and general surgery; and second, we need to reward providers for spending time with patients and coordinating their care.

The country can support these objectives by:

- Ensuring medical schools make available and promote training in, positions in primary care fields;

- Enacting legislation to expand loan forgiveness programs for medical students who choose primary care;

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- Implementing advanced care coordination models such as patient-centered medical homes to ensure that patients throughout the country have access to health professionals who offer education and support for prevention, effective care management, and the most appropriate use of health services;

- Conducting outreach to racially and ethnically diverse populations to help promote healthier lifestyles, timely preventive screenings, and appropriate medical care; and

- Providing incentives for all patients to embrace healthy lifestyles and to follow their recommended treatment regimens.

2. **Improving care nationwide by adopting uniform standards for quality, reporting, and information technology.**

Health care providers, consumers, payers, and policymakers are hampered by the limited amount of consistent and useful data that is available on the quality of care delivered. As part of any national health care reform initiative, steps taken to address this problem should include:

- Agreeing on standard, uniform metrics to measure, report, and evaluate information across all public and private providers and payers;

- Standardizing racial and ethnic data categories to enable appropriate assessment of care and develop targeted programs for diverse and underserved populations;

- Making the vision of an interoperable health information system a reality by creating uniform standards for the transmittal of information and connectivity of the system; and

- Improving the availability of data concerning the quality and price of health care to support consumer decision making.

3. **Investing more in research to better understand which treatments and therapies work best – for the nation as a whole and for specific patients.**

We need to close gaps in research, organize information on practices yielding the best outcomes for patients, and diffuse this information among practitioners and patients. We also need to establish an independent comparative effectiveness entity that compares and evaluates the benefits, risks, and incremental costs of new drugs, devices, and biologics.

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4. **Creating accountability for consistently delivered, high-quality care based on the best evidence.**

All stakeholders should promote the delivery of the best clinical outcomes and patient experience while ensuring the most effective and appropriate utilization of health care services. To accomplish this objective, investment in the development of new and improved measures that assess episodes of care and efficiency must be fast-tracked as a part of health care reform.

5. **Making targeted investments in our public health infrastructure.**

Our public health infrastructure needs to be better positioned to implement strategies that prevent or ameliorate health care concerns and promote well being and healthy lifestyles as part of health care reform. We need to focus attention and allocate sufficient resources — particularly at the community level — to address significant public health issues, such as obesity and tobacco dependence that cause an increasing prevalence of chronic illness. We advocate a new, targeted national initiative to increase public awareness of the links between preventable conditions and chronic illness and to support new and existing prevention programs in our schools, worksites, and communities. Health plans are uniquely positioned to assist in this effort and are committed to working directly with communities to promote safe and healthy living and provide models for targeted investments in public health across the country.

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All Americans Need To Have Affordable, Portable Coverage

Two years ago, AHIP's Board offered a plan to provide health care coverage to all Americans. By combining the best of private- and public-sector strategies, we proposed to create a uniquely American system that builds on the strengths of the existing infrastructure while refocusing it to improve quality and constrain costs. We propose to update this plan by offering additional innovations to make individual and small-employer coverage more affordable and secure while also strengthening the public safety net.

1. **Improving the Individual Market.**

Policymakers, as well as members of our community, are concerned that individuals with pre-existing conditions often have difficulty obtaining coverage. The flip side of this problem, however, is that many people put off getting insurance until after a medical problem has developed, thereby driving up coverage costs for everyone else. We propose to address this dual challenge head-on by making coverage broadly and fairly available:

- *Combine guarantee-issue coverage with no pre-existing condition exclusions with an enforceable individual mandate:* For guarantee-issue to work, it is necessary for everyone to be brought into the system and participate in obtaining coverage. Achieving this objective will require specific attention to the mechanisms for making the mandate enforceable and may require coordinated action at multiple levels of government.

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Indeed, the importance of combining guarantee issue with an enforceable individual mandate is borne out by research and experience from the states. For example, a report by Milliman, Inc. found that states that enacted guarantee-issue laws in the absence of an individual coverage requirement saw a rise in insurance premiums, a reduction of individual insurance enrollment, and no significant decrease in the number of uninsured.

- *Create tax equity:* Currently, individuals purchasing insurance on their own cannot deduct expenses for health insurance coverage unless total health care expenses exceed 7.5 percent of adjusted gross income. This should be corrected to promote tax equity and help make health care more affordable whether coverage is obtained through an employer or the individual market.

- *Create a broadly funded reimbursement mechanism to ensure a stable market:* A broadly funded mechanism which spreads costs for high-risk individuals across a broader base needs to be put in place to ensure premium stability for those with existing coverage.

- *Provide premium assistance to ensure coverage is affordable for lower-income individuals and working families:* Refundable, advanceable tax credits should be available on a sliding scale basis for those earning less than 400 percent of the Federal Poverty Level (FPL), as indicated below.

2. Helping Small Business.

Small business owners find themselves in an increasingly difficult marketplace for health insurance because of constantly 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. We propose marketplace improvements that will offer a broad range of help, including:

- *Support for Tax Code Incentives or Other Assistance:* Tax code incentives or other types of assistance are needed to encourage small businesses to offer or contribute to coverage for their employees. Eligibility should be targeted to small businesses with workforces largely consisting of lower-wage workers and could be designed to provide a match for dollars contributed above a particular threshold.

- *Targeted Assistance to Small Businesses to Promote Rate Stability on Renewal:* Although small businesses with employees that have medical conditions can get coverage, a key issue is the predictability of premiums on renewal. To help enhance predictability, the government could offer additional, targeted assistance to small firms that commit to encourage employee participation in coverage. Encouraging greater participation in coverage and offering additional, targeted support would help promote greater stability and improve the small group market. It would also help make small firms less vulnerable to the impact of increased episodes of illness, while providing greater assistance to the firm and its employees in the event of illness.

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- *Adoption of an "Essential Benefits Plan":* Small firms would benefit from the establishment of an essential benefits plan (outlined below), available nationwide, that provides coverage for prevention and wellness as well as acute and chronic care, and that is not subject to varying and conflicting state benefit mandates.

- *Improved Coordination of Private and Public Coverage:* Steps need to be taken to ensure that public programs such as Medicaid and SCHIP can effectively 'wrap around' private plans (for example., via premium assistance) so that employees can retain their existing coverage, while encouraging continued employer contributions toward the cost of coverage and ensuring that limited public resources are most effectively targeted to those without coverage options.

- *Enhanced Transparency:* A coordinated industry-wide effort must be made to ensure that individuals and small businesses have access to clear and consistent information about coverage options.

3. Strengthening the Large Group Market.

We support building upon the existing employer-based system, which currently covers more than 160 million Americans. 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 morale. Thus, as a first priority, our 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 large 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 the tax credits outlined below 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.

4. Confronting the 'cost-shifting surtax' currently imposed on employers and consumers purchasing health care coverage.

As part of any national health care reform initiative, Congress must address the fact that reducing outlays in one area inevitably means shifting costs elsewhere. Underpayment of physicians and hospitals by public programs shifts tens of billions in annual costs to those with private insurance – essentially creating a surtax equal to as much as 15 percent of the premium costs for an average family policy. The transfer of these costs to those with private coverage cannot be sustained and is critical to addressing concerns over affordability.

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In addition, the U.S. currently spends approximately $50 billion each year to provide health services to those without coverage, leading to high levels of uncompensated care for hospitals and clinics. This results in cost-shifting to those with coverage in the form of higher premiums and other related costs. We believe now is the time to eliminate the inefficiencies that occur when uninsured individuals who lack access to preventive care or care for chronic illnesses use emergency rooms as a regular source of care. Achieving universal coverage will create a more sustainable approach for providing all Americans access to affordable, high-quality coverage.

5. Improving Public Programs.

For health care reform to succeed, we need to improve the public safety net. This includes:

- *SCHIP eligibility:* Eligibility should be extended to children in families with incomes up to 300 percent of the federal poverty level.

- *Medicaid eligibility:* Categorical eligibility requirements should be abolished. Instead, eligibility should be granted to all individuals with incomes at or below 100 percent of the FPL.

- *Increasing enrollment and improving quality:* Incentives should be provided to help states boost SCHIP and Medicaid enrollment among the hardest-to-reach individuals, to improve quality by enhancing access to vital services (e.g., immunizations and well-child visits), and to help coordinate public programs and private insurance to reduce "crowd-out" and make it easier for parents, spouses, and children to obtain coverage under a single plan.

- *Tax Credits:* To help lower-income working families, advanceable and refundable tax credits should be available, phasing out as income approaches 400 percent of the FPL.

- *Community Health Centers:* Adequate support should be provided to community health centers, recognizing the critical role they play in providing access to services for vulnerable populations and to ensure they can continue this role in the future.

6. Protecting Americans from Bankruptcy.

To guard against medical bankruptcy, a system of tax credits should be designed for lower-income individuals and working families that would cap their total health care expenses (to include spending on premiums and cost-sharing) as a proportion of income. Achieving the goal of universal coverage is also critical to preventing medical bankruptcies, as research shows medical expense related bankruptcy is most prevalent among those without health insurance coverage .

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7. Establishing an Essential Benefits Plan.

Individuals and small businesses should have access to an affordable "essential benefits plan" available in all states that provides coverage for prevention and wellness as well as acute and chronic care. To maintain affordability, the essential benefits plan should not be subject to varying and conflicting state benefit mandates.

An essential benefits plan should include:

- Coverage for primary care, preventive care, chronic care, acute episodic care, and emergency room and hospital services; or

- Coverage that is at least actuarially equivalent to the minimum federal standards for a high-deductible health plan sold in connection with a health savings account, along with the opportunity to include enhancements such as wellness programs, preventive care, and disease management.

Allowing benefit packages to vary based on actuarial equivalence is crucial to ensure that any package can evolve naturally based upon new innovations in benefit design and the latest clinical evidence.

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Our Regulatory System – The 'Ground Rules' Of Health Care – Needs To Be More Consistent, Effective, and Protective of Patients and Practitioners

Today, our health care system operates within a patchwork of federal and state regulations that often hinder, rather than help, efforts to improve care and contain costs. A national health care reform initiative must have as one of its goals the implementation of a more streamlined and effective regulatory system.

1. The Federal Role.

The federal government needs to provide a framework for reform based on adopting the best features of public programs and the private marketplace, strengthening the public safety net, providing incentives through the tax system for the purchase of insurance, and setting out uniform guidelines for reform. As discussed above, we also propose the creation of a public-private advisory group representing a broad range of stakeholders with relevant policy expertise. The core mission of this group would be to develop a recommended plan for bringing unsustainable health care costs under control via methods that improve health care quality based on realistic goals and with strategies coordinated among stakeholders.

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2. **State Partnerships.**

States should continue to administer the SCHIP and Medicaid programs and to fulfill their traditional enforcement roles within a federal framework designed to ensure consistency nationwide.

State agencies charged with insurance or health plan regulation should work with carriers through a public-private partnership to ensure that small employers and individuals have one-stop access to clear, organized information that allows them to compare premiums, benefits, and cost-sharing across all plans offering coverage in the state, as well as check eligibility for public programs. States also should work with carriers to provide other key administrative support services, including aggregating premium contributions from multiple sources, which is especially important for part-time workers and those eligible for subsidies.

* * *

Conclusion

Although health care reform ranks high on the nation's to-do list, achieving the broad goals of universal access, affordability, and cost containment – in ways that are fair to all Americans – will require dedication and commitment on the part of everyone with a stake in the outcome. Even as we confront unprecedented economic challenges, we are reminded that health care reform is also critical to our economic competitiveness.

We offer our proposals with a pledge to work in a spirit of cooperation and determination, with physicians, physicians, hospitals, consumers, employers, unions, lawmakers, and government leaders – who want to work toward the day when all Americans can count on being served by a health care system second to none.

Working together – starting in 2009 – we can reach that goal.

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