



June 19, 2009

The Honorable Edward Kennedy
Chairman
Senate Committee on Health, Education, Labor and Pensions
United States Senate
644 Dirksen Building
Washington, D.C. 20510

Dear Mr. Chairman:

We are writing on behalf of America's Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA), whose members collectively provide services to more than 200 million Americans. Our community strongly supports enacting comprehensive legislation this year that ensures all Americans have access to high-quality, affordable health care. In addition, we have worked very hard to develop and bring to the table solutions to ensure that all Americans have continuity of care and portability of coverage, that a reformed system is sustainable over the long-term, and that care is provided efficiently and effectively.

Our members support the goals of the "Affordable Health Choices Act," but they have strong concerns that specific provisions will have unintended consequences that undermine the goals the Committee is seeking to achieve. We understand the Committee is considering adding a government plan proposal to compete with private insurers. A government plan option – in any form – is unnecessary to achieve comprehensive reform and would have devastating consequences on the health insurance coverage that employers and individuals currently have, the federal budget deficit and existing provider systems. We urge you not to include this in your legislation. We appreciate having had the opportunity to participate in the Committee's stakeholder process and we are committed to continuing to offer technical expertise to ensure that reform will result in a stable insurance market that provides access to affordable coverage to all Americans.

Market Reforms

Our members have taken a leadership role in identifying a package of initiatives that ensures no one falls through the cracks of the health care system and that all individuals have portability of coverage and continuity of care. We continue to strongly support reforms that eliminate preexisting condition exclusions and health-status-based rating, provided that such reforms are

coupled with personal responsibility to obtain coverage and premium assistance to make coverage affordable. However, we believe it is critical to allow greater rating flexibility based on age to maintain affordability for younger individuals – who have the highest uninsured rates. Moreover, we also believe that the Committee’s goal of promoting prevention and wellness would be advanced if individuals who make healthy choices such as not smoking are eligible for premium discounts.

We believe it is critical to ensure that the timing of the individual coverage requirement is synchronized with market reforms and the availability of financial assistance to low- and moderate-income families and individuals to bring everyone into the system and ensure that persons who currently have health insurance coverage are not adversely impacted by higher costs. If this objective is not met, individuals and families who are covered in the individual market may experience unintended consequences similar to those experienced by those in several states that enacted insurance market reforms in the absence of universal coverage in the 1990s. A 2007 report by Milliman, Inc. found that these well-intentioned reforms encouraged people to defer seeking coverage until they experienced health problems – resulting in higher premiums for those with insurance and reduced enrollment in the individual health insurance market.

Health reform should be constructed in such a way that Americans can maintain their current coverage if they wish to do so. Implementation of new market reforms should achieve that broadly shared goal by promoting stability, minimizing disruption, and achieving an effective transition. We believe additional mechanisms are needed to assure a smooth transition for consumers. We look forward to working with you to accomplish this.

In addition, rules need to be consistent and lines of regulatory responsibility clear. The draft legislation collapses new and existing markets and establishes new structures that create confusion and duplicative state and federal roles. The government should establish federal rules which are enforced by states. We believe that every state should have a system through which individuals and families can evaluate health care coverage being offered by all health plans.

Access to Coverage

Based on the current draft, we are concerned that the new regulatory structure for the Gateways would replicate functions now being carried out by state insurance commissioners, only adding complexity and waste, with little improvement in access. The presence of sub-state Gateways that would be allowed under the bill could be highly problematic in creating an overly complex regulatory environment. Instead, the responsibilities of the Gateways should be more clearly defined, including clear and objective criteria for plan participation, and should avoid duplication with other regulatory bodies. To promote health plan choices that compete based on quality and price and to improve choices for individuals and employers, it also is important to ensure that the Gateways do not limit competition and that premium assistance is available to all qualifying low- and moderate-income individuals and families, not just to those who pursue coverage that is offered through the Gateways. In this regard, the cause of health care reform would not be

advanced if new structures devised to help expand choices served instead to limit them or to undermine the employer-based coverage that the vast majority of workers like.

In addition, to maintain employer-provided coverage, we believe the Gateways should be a coverage resource for individuals and smaller groups. Opening the Gateways to larger groups of any size would unravel existing risk pools and undermine the current system of employer-sponsored coverage. Such a proposal would incentivize large employers with younger and healthier workers to self-fund, while those larger employers with older and less healthy workers would join the insurance pool – significantly driving up premiums for individuals and small employers.

Benefits Packages

While we support the concept of evidence-based benefit designs and moving the system toward a high-value approach to prevention, improving outcomes and driving greater value require an equal commitment to realigning payment incentives and promoting benefit designs that encourage prevention and chronic care management. Health plans have developed tools to support employer-based prevention initiatives, and we would urge you to consider incorporating flexibility into the legislation to allow employers and their employees to continue to benefit from these tools. We have had positive results in reducing smoking and improving participation in wellness and chronic care management.

With respect to the coverage requirements, instead of allowing the proposed Medical Advisory Council (MAC) to take a highly prescriptive approach to designing benefits, we believe the legislation should be clear in establishing categories of coverage and reasonable actuarial value ranges to allow greater innovation and flexibility for a range of benefit offerings.

Administrative Simplification

Closely related to health plan innovations in chronic care and disease management and payment models that increase value, is the area of administrative costs and simplifying the system for patients and providers. Our members have committed to a comprehensive overhaul of administrative processes to standardize and automate five key functions: claims submissions, eligibility, claims status, payment, and remittance. We strongly support these provisions in the proposed legislation and believe they will allow physicians, hospitals, and other health care providers to reduce their administrative costs substantially.

At the same time, we are very concerned about a provision of the “Affordable Health Choices Act” that would impose limits on the investments health insurance plans can make on reforms unrelated to health care claims. This requirement has the potential to undermine health plans’ administrative simplification efforts and other initiatives that are helping to improve quality and contain costs. Because funds spent on administrative simplification are not directly linked to health care claims, the provision addressing medical loss ratios could limit the ability of health insurance plans to devote funds to improving the system for patients and providers and,

ultimately, to improving the quality of care that patients receive. As our community continues to offer and implement reform solutions, we strongly believe that these caps will limit our ability to invest in changes that simplify administration, and limit our flexibility in developing the new tools and patient support systems that will improve efficiency and effectiveness in the delivery system.

Cost Containment and Enhancing Value

We recognize that key strategies that have the opportunity to lower costs and improve quality lie outside of the Committee's jurisdiction, but we want to reaffirm our view that cost containment is crucial to implementing and sustaining a universal health system. The goals of expanded access, improved quality and reduced costs are inextricably linked, requiring equal commitment in reform.

In addition, the Committee's approach to payment reform and promoting high-quality care would require health plans to follow the payment policies of the Medicare program, which is an outdated fee-for-service structure that reform is trying to fix. We are concerned that this section could result in holding back the transition to new payment models or new mechanisms to reward quality.

Efforts to achieve cost containment also should include legislation to provide a pathway for approval by the Food and Drug Administration (FDA) of generic versions of biological products. For millions of patients, this legislation offers the hope of significant cost savings and greater access to promising advances in biotechnology, and we look forward to supporting the Committee's efforts.

Government-Run Plan

Finally, we share the concerns that employers, providers, and patients have raised about the significant unintended consequences of a new government-run health insurance plan. A government-run plan – no matter how it is initially structured – would dismantle employer-based coverage, significantly increase costs for those who remain in private coverage, and add additional liabilities to the federal budget. Alternatively, strong market rules and consumer protections will ensure that nobody falls through the cracks without disrupting the coverage of tens of millions of Americans who like and want to keep their current health plans.

Recognizing the substantial disruption to consumers and health care providers that a government plan based on Medicare would create, some policymakers are looking at alternatives that would attempt to achieve a level playing field. We do not believe that it is possible to create a government plan that could operate on a level playing field. Regardless of how it is initially structured, a government plan would use its built-in advantages to take over the health insurance market.

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We are particularly concerned that a government-run plan would undermine efforts to transition to a high quality health care delivery system. Recognizing that the Medicare fee-for-service program has made very little progress in developing innovative care management programs, we are concerned that creating a government-run health insurance plan for the broader population would result in tens of millions of Americans being enrolled in a new coverage option that lacks a meaningful commitment to care coordination, disease management, health promotion, and other pro-active initiatives that have been successfully implemented by private sector health plans.

In addition, a government-run plan would exacerbate the cost-shifting that already occurs from public programs to private payers as a result of the inadequate reimbursement rates that Medicare and Medicaid pay to hospitals and physicians. According to a recent Milliman study, an average family of four already pays a hidden tax of more than \$1,700 annually on their premiums because Medicare and Medicaid significantly underpay hospitals and physicians, compared to their actual costs of delivering medical care. To offset these inadequate payments, providers pass on higher costs to individuals, families and employers in the private sector.

If Congress establishes a new government-run health plan, this hidden tax on consumers could undermine the entire health care financing system. In short, as the insured population migrates from employer coverage to the new government-run plan because of the lower payment rates (and therefore lower premiums), providers would have a declining base to shift costs to in the remaining commercial market. Eventually, this dynamic would accelerate with rising costs in the private market because of the exacerbating cost shift, causing further declines in private coverage and leaving hundreds of billions of dollars to be covered by the federal budget.

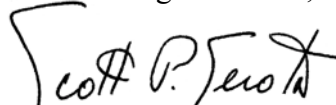
We urge the Committee to move forward with patient-centered reforms that provide a workable and sustainable path to covering all Americans, bending the cost curve, and improving quality. We stand ready to continue to work with the Committee to accomplish these objectives.

Sincerely,



Karen Ignagni
President and CEO
America's Health Insurance Plans

Yours in good health,



Scott P. Serota
President and CEO
Blue Cross and Blue Shield Association