



May 22, 2009

The Honorable Max Baucus
United States Senate
511 Hart Senate Office Building
Washington, DC 20510-2602

The Honorable Charles E. Grassley
United States Senate
135 Hart Senate Office Building
Washington, DC 20510-1501

Dear Senators:

Thank you for the opportunity to comment on the Committee's excellent Coverage Options paper. We applaud your commitment to reforms that will lead to guaranteed coverage for all Americans regardless of age, health status, or medical history.

Our detailed comments are attached for your consideration. We would highlight the following recommendations:

■ *Keep it simple; make it work for people.* Currently, health coverage is very hard for consumers to understand and navigate. The committee's proposals aim to create a new marketplace which has the potential to be much simpler. We hope the committee will consider our additional suggestions to further reduce complexity so consumers can understand their choices better, enroll more easily, and gauge their subsidy eligibility.

■ *Avoid actuarial constructs/targets.* We strongly urge the committee to substitute "fixed" benefit designs, specified in terms of their cost-sharing provisions, for the actuarial targets suggested on page 9. This will permit consumers to more easily compare their plan options. Standardizing the plan designs will also pave the way for other consumer protections, such as standardized plan disclosure forms, that will, in turn, create a more competitive marketplace in the health insurance exchanges.

Consumers Union

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We urge that these fixed plan designs be tied to the most common health insurance option purchased by Members of Congress, so that all Americans have access to coverage as generous as that of their elected representatives.

■ *Cap consumer expenses.* Any individual mandate must be tied to the availability of affordable coverage. Affordability must be measured in terms of both out-of-pocket premium expense and out-of-pocket cost-sharing for doctors and hospitals. We urge the committee to consider a “hardship exemption” of less than 10 percent for lower income families. The hardship exemption should be defined in terms of out-of-pocket premium share, co-pays or cost-sharing, and certain specific qualifying direct medical expenses not covered by insurance (such as home health care for a parent or chronically ill family member). When these expenses in combination exceed the specified portion of income (10% or less depending on income), the individuals would be exempt from further medical expenses for that year.

■ *Establish default automatic enrollment.* We urge the committee to consider a default enrollment system in the exchanges and, over time, in other existing or new programs. As the committee knows well, enrollment barriers are a serious problem. Millions of people eligible for Medicaid and SCHIP fail to enroll, and some two million low-income people are still not enrolled in heavily subsidized Part D coverage. Enrollment barriers prominently include lack of awareness of the program and eligibility criteria, low “health literacy,” administrative hassles, and stigma issues. We suggest, for example, that a simplified online (Web based) default enrollment system be established at hospitals, community clinics, doctors’ offices, welfare offices, and via motor vehicle offices nationwide.

We would be happy to assist the committee in any way we can.

Sincerely,

A handwritten signature in black ink, appearing to read "DeAnn Friedholm". The signature is fluid and cursive, with a long horizontal stroke at the end.

DeAnn Friedholm
Director, Health Care Reform Campaign
CONSUMERS UNION



Comments on Coverage Expansion Policy Options

May 22, 2009

Please note that our support or suggested modifications for the detailed proposal options are within the context of comprehensive healthcare reform featuring guarantee issue, guarantee renewability, coverage for pre-existing conditions, premium subsidies, and new insurer regulations at the federal level. Some of the reforms we endorse should not be enacted independently of the other reforms.

Summary Of Recommendations

Proposal	Page(s) in SFC Options Paper	Our Recommendations and Concerns
<i>Benefit Options</i>	8-9	Add stronger language to provide meaningful consumer choices: * All benefit packages sold through the exchange or eligible to receive premium subsidies must cover the <u>same comprehensive</u> set of services. * Benefit options should vary <i>only</i> by their cost-sharing provisions and provider networks, using approximately four standard levels of cost-sharing. * Actuarial equivalency is highly problematic as it will permit continued consumer confusion about their choices.
<i>Premium Rating</i>	2-3	* We support a federal rating requirement for guarantee issue, guarantee renewal, and coverage of pre-existing conditions. * Recommend 5:1 age rating be narrowed to 3:1; add child(ren) only coverage tier; permit young adults to stay on parents policies until age 25.
<i>Health Insurance Exchanges</i>	4-7	*Support national, non-profit, board-governed health insurance exchange * Strongly oppose the option of multiple, competing exchanges.

Proposal	Page(s) in SFC Options Paper	Our Recommendations and Concerns
<i>Public Plan Option</i>	13-14	* Strongly support a public plan option alongside private plan options.
<i>Medicaid and S-CHIP</i>	14-22	<p>* Must improve Medicaid payments to help ensure access and better quality.</p> <p>* Support complete elimination of categorical coverage distinctions and support making traditional Medicaid available to all persons, including childless adults, with incomes below 150% of FPL.</p> <p>* These eligibles should also have the option of purchasing subsidized coverage in the exchange.</p>
<i>Individual Mandate</i>	40-41	* With a restructured market place featuring guarantee issue and renewal, coverage for pre-existing conditions, adequate premium subsidies, greatly improved and simplified insurance choices for the consumer, and significant consumer protections, we would support a requirement that all people (adults and children) have and retain continuous health insurance coverage if affordable, comprehensive coverage is available.
<i>Default Automatic Enrollment</i>	<i>not in the committee's proposal</i>	<p>* To ensure the widest possible compliance with the mandate, Americans must have multiple methods of enrollment (web-based, telephone, and in-person enrollment counseling) as well as greatly simplified enrollment processes.</p> <p>* We suggest the committee consider a default automatic enrollment system.</p>
<i>Employer Pay-or-Play</i>	42	<p>* Support the proposed employer pay-or-play provision (option A).</p> <p>* We urge the committee to consider providing an incentive for employers to scale their employees' premium contributions to wage levels. Sliding scale premium contributions to employer coverage would reduce the disparity in cost between the heavily subsidized coverage in the exchange and the employer's coverage, keeping more employees in their employer's plan.</p>

Our detailed comments:

Benefit Options (pages 8-9)

Defining a standard benefit package is the foundation for the reform platform.

Consumers Union recommends that a standard benefit package be defined as follows:

- All packages sold through the exchange or eligible to receive premium subsidies must cover the same comprehensive set of services, such as those provided through one of the most commonly used FEHBP options, so that all Americans have access to a health plan at least as good as their elected officials.
- Benefit options should vary *only* by their cost-sharing provisions and provider networks. Key insurance terms, such as cost-sharing terms like “deductible”, must be used consistently by all insurers and in all health plans. The policyholder’s maximum-out-of-pocket should be an “absolute” out-of-pocket (i.e., it must not feature exceptions that can drive consumer’s cost far beyond the stated limit.)ⁱ We strongly agree with the provision prohibiting annual and lifetime limits on benefits. Value-based cost-sharing concepts should be included, as appropriate.
- An independent commission should be tasked with further defining the benefit package (subject to the above requirements) and modifying it over time.

Within this structure, Consumers Union supports four levels of cost-sharing, with the most generous level featuring co-pays that are affordable for lower-income families.

If benefit design variation is limited in this way, consumers will be able to reliably gauge their out-of-pocket cost exposure and meaningfully compare plans.

A system that requires actuarial equivalency, instead of a fixed cost-sharing structure, is not an acceptable substitute. As a recent report by Karen Pollitz demonstrates, actuarially equivalent plans can still leave consumers with tremendous uncertainty about their likely out-of-pockets costs and unable to compare plans given their myriad cost-sharing features.ⁱⁱ

Under the new premium rules, we urge you to make it clear that it is absolutely prohibited to offer policies that seek to avoid risk (in the written description the term ‘could prohibit’ is used).

Premium Rating in the Non-group and Micro-group Markets (pages 2-3)

We strongly support a federal rating requirement for guarantee issue, guarantee renewal, and coverage of pre-existing conditions. However, we are concerned that 5:1 age rating rules will leave many older Americans unable to afford quality coverage if their incomes are too high to qualify for premium subsidies. If limited to the differential between young adults and people ages 55 to 64, we recommend age rated bands of not more than 3:1. If children are included, the bands may be designed differently.

In consideration of the committee's proposal to phase out SCHIP (page 21), the tiering regulations should permit a child-only tier to handle family situations where a parent has access to affordable self-only coverage through the employer but cannot afford family coverage with the employer. (A common situation in today's insurance market where employee premium shares for family coverage can be quite high.) In this case, the parent must have the ability to affordably purchase coverage for just the children.

We recommend that parents be allowed to keep children on their family or adult-with-child policy until the child is age 25, regardless of student status. Currently, young adults transition off of their parents' health insurance policy at ages as young as 18. Many states have enacted similar policies so that this health insurance transition occurs at an older age when young adults are more knowledgeable and financially able to take on responsibility for their own health insurance.

Use of Risk Adjustment (page 3)

Consumers Union supports the use of a risk adjustment mechanism to reduce the incentive for insurers to "cherry-pick" healthy applicants. If the risk adjustment mechanism is to do this job well, it is critical that sufficient resources be allocated at the federal level to improve the methodology. The risk adjustment system should be set at the federal level.

Health Insurance Exchanges (pages 4-7)

Consumers Union supports the formation of a national health insurance exchange featuring income-based premium subsidies, strong consumer protections, and new insurance regulations. We recommend that these exchanges be non-profit, governed by a board with full disclosure of Conflicts of Interest and include adequate representation of consumer-patient members.

Consumers Union strongly opposes the option of multiple, competing exchanges. This approach would fragment the market, cause unnecessary duplication of effort, and make choices more complex for consumers. We foresee no compensating advantages for consumers.

We believe consumers benefit from meaningful choice, not excessive choice. Within the new exchange, the number of companies/policies available for sale in a given service area (or state) should be limited, such as through competitive bidding. States could set more stringent requirements to use in allowing insurance companies to offer plans, and these would be offered for their area in the national exchange. Insurer competition would provide incentives for the winning firms to do a good job and win renewal of the contract. Having a limited number makes consumer choices easier and would allow the government to carefully monitor plan quality. Such a system will avoid a situation like the excessive number of options confronting Medicare Part D beneficiaries. In Medicare Part D, beneficiaries face an average of 40 plan choices. Surveys indicate they find this number of choices overwhelming and studies of plans selected under this system indicate

that seniors often don't pick the plan that minimizes their out-of-pocket prescription drug expenses.ⁱⁱⁱ

Role of State Insurance Commissioners (pages 7-8)

New federal regulations should provide the floor for state regulation of insurers and consumer protections. States should be allowed to enact further protections and would serve as the primary source of enforcement.

We also support an oversight authority at the Federal level that protects against uneven enforcement of consumer protections at the state level. Emulating Medicare, the federal government should require insurers to have a truly independent external grievance and appeals procedure. Further, the federal government should have some authority that allows insurers to be suspended or expelled if they commit fraud, and punished for marketing abuses. We also hope you will include a system to report on the quality of supervision offered by the various states—the number of complaints filed, the resolution of those complaints, the accuracy of the 'UCR' type co-payment data given consumers, etc.

Premium Subsidies for Lower Income Families (pages 10-12)

Consumers Union strongly supports the creation of sliding-scale premium subsidies that are available for coverage only through the exchanges. No subsidies should be available outside the exchanges. This restriction will ensure that risk is spread broadly within the exchange and that taxpayer monies are being used for high value coverage.

The amount of the subsidy should be tied to the cost of health plans that feature cost-sharing levels that are affordable for that type of family. In other words, families with incomes below 200% of FPL should have a premium subsidy that allows them to purchase the plan with the lowest patient cost-sharing.

The committee's proposal to tie the size of the subsidy to the second lowest cost plan in the patient's service area is sensible. However, we strongly urge that some quality standards be established. It would be easy for a terrible plan to be the low cost, and hence only fully subsidized plan. Issues of network adequacy, complaints, resolution of complaints, past histories of disenrollment, civil and criminal court cases, should all be publicly available for consumers and be considered in setting the benchmark determination. Significant business can be expected to flow to this benchmark plan, so the process should force insurers to compete on overall value, not just premiums.

Consumers Union recognizes that there are both pros and cons to using advanceable, refundable tax credits as the method for paying the subsidy. Accordingly, we would also support other mechanisms for paying the subsidy, for example, direct payments from the health exchange to insurers on behalf of eligible enrollees.

We urge strong consumer protections around the use of taxpayer social security numbers (SSN) for purposes of determining income eligibility for subsidies. The use of SSN identifiers should be restricted to (1) as needed to demonstrate subsidy eligibility and (2) as needed to determine compliance with the individual mandate. Such numbers should not be used as policyholder identifiers.

Public Plan Option (pages 13-14)

Consumers Union strongly supports the need for a public plan option alongside private plan options if competition is to reduce health care costs and improve quality. While CU believes there are benefits to having a single Medicare-like public plan, the key feature will not be its governance structure, but its public charge. The public plan option should be tasked with maintaining the highest standard of patient and provider satisfaction, and working with providers to develop innovative measures (such as aggressive disease management programs and centers of excellence) that improve the quality of care, reduce costs, and eliminate waste. We strongly believe that competition from a non-profit, public insurer charged with these significantly higher levels of accountability will inspire – indeed propel – similar activity on the part of private insurers. Years of state experience with regulatory approaches have demonstrated that insurance regulations alone cannot guarantee affordable, quality health care. In addition, many states currently operate a public option side-by-side with private insurers in their state employee health insurance systems. This type of competition has not destroyed the market, nor has it disadvantaged the private insurers.

Medicaid and S-CHIP (pages 14-22)

We believe it is imperative to increase the number of and improve access to high-quality Medicaid providers, and we support reducing payment disparities between Medicaid and Medicare. However, the description in the Committee's paper is not enough. As the yearly MedPAC's reports demonstrate, Medicare overpays in a few areas, but in general pays the costs of a well-run provider. To institutionalize Medicaid at 80 percent of Medicare payment rates is to confirm the old adage, 'programs for poor people are poor programs.' Unless we eliminate the payment disparities, we will never be able to achieve the needed reduction in health outcomes disparities. A plan for payment parity between the two programs is needed.

CU strongly supports simplifying the Medicaid program and streamlining its interaction with the subsidized coverage offered through the exchange or through employers. We support complete elimination of categorical coverage distinctions and making traditional Medicaid available to all persons, including childless adults, with incomes below 150% of FPL. Studies show that families below 150 percent of FPL spend all of their income on necessities, leaving little room to bear insurance costs or large co-pays.^{iv}

We assume that Medicaid will be at least as generous as the standard package and have low co-pays. States should not be allowed to impose “scope of benefit” limitations that result in less generous benefits, although they could offer more generous benefits.

In addition, we support providing all Medicaid eligibles with the option of purchasing coverage through the exchange using the same subsidy rules established for families with incomes just above this Medicaid threshold. It is important to ensure that the plan options available to low-income families truly cover necessary benefits. As already discussed, these plans should cover a comprehensive scope of services, including dental and vision if possible. The plan that the premium subsidy is tied to must feature affordable cost-sharing. It is important to avoid the problem in Medicare Part D where low-income individuals were assigned to plans with low premiums but high cost-sharing for drugs.^v

Any individual or family applying for coverage through the exchange must be told if it appears they are eligible for Medicaid.

Health plans participating in the exchange should be encouraged to include traditional safety-net providers in their networks so that lower-income families can continue to see familiar providers who may have special cultural competencies that are essential to good medical care.

In the discussion of prescription drug coverage for all Medicaid categories, we support efforts to encourage the use of generic substitution, and hope that additional states, in the development of their formularies, can be encouraged to give consideration to the latest comparative effectiveness research (as some 13 states do now under the Drug Effectiveness Review Project, DERP). DERP states have achieved savings that may be score-able, if required as part of this legislation.

We oppose any higher payment level for Medicaid prescription drugs, and urge you to reconsider the cost of the proposed 300 percent of the weighted average AMP. The increase in drug utilization created by the reduction in the number of uninsured should be reward enough to the pharmaceutical industry.

We support the committee’s counter-cyclical FMAP proposals but suggest additional “maintenance of effort” measures may be needed so that, over the longer term, state financing for health care for the low-income is not “crowded out” by new federal initiatives.

Individual Mandate (pages 40-41)

In the context of a restructured market place featuring guarantee issue and renewability, coverage for pre-existing conditions, adequate premium subsidies, greatly improved and simplified insurance choices for the consumer, and significant consumer protections, we could support a requirement that all people (adults and children) have and retain continuous health insurance coverage if affordable, comprehensive coverage is available.

An individual mandate like the one above requires the establishment of an “affordability standard,” also called a hardship exemption. We urge the committee to consider a “hardship exemption” that (1) considers overall health spending and (2) slides with income. That is, any person or family having to spend above that portion of income out-of-pocket on premium share, any co-pays or cost-sharing for any medical service, and certain specific qualifying direct medical expenses not covered by insurance (such as home health care for a parent or chronically ill family member) would be exempted from additional medical expenses in that year. For example:

Income as a percent of Federal Poverty Level	Threshold for Hardship Exemption (premium share and plan cost-sharing as a percent of income)
<150% FPL	1%
150-200% FPL	2.5%
201-300% FPL	5%
300%-499% FPL	7.5%
500%+	10%

This hardship exemption/affordability standard must be closely coordinated with the methods used to determine premium subsidy eligibility. “Income” should be defined using the same method in both settings. Premium subsidies and permitted plan cost-sharing levels must be set at levels which place consumers under the established hardship thresholds.

Default Automatic Enrollment (not in the committee’s proposal)

We strongly urge the committee to consider a default automatic enrollment system in the exchanges and over time in other new and existing programs. As the committee knows well, millions of people eligible for Medicaid and SCHIP fail to enroll, and some two million low-income people have failed to enroll in heavily subsidized Part D coverage. Enrollment barriers vary and are numerous but prominently include lack of awareness of the program and eligibility criteria, low “health literacy,” administrative hassles, and stigma issues.

To ensure the widest possible compliance with the mandate, Americans must have multiple methods of enrollment (web-based, telephone, and in-person enrollment counseling) as well as a greatly simplified enrollment processes. We suggest, for example, that a simplified online (Web based) default enrollment system be established at hospitals, community clinics, doctors’ offices, welfare offices, tax-preparation centers and via motor vehicle departments nationwide.

Small Employer Tax Credit (page 12)

Consumers Union supports the proposed small employer tax credit, but cautions that an evaluation of the program’s effectiveness should be included in the legislation. Based on state experience with small employer premium subsidies, the program is unlikely to incent many new offers of coverage among small, low-wage employers. Further, given

the low-wage level of the target firms, many of their employees will likely have access to heavily subsidized coverage in the health exchange, greatly reducing the “value” of the employer contribution in terms of providing access to health care for employees.

Employer Pay-or-Play (page 42)

Consumers Union supports the proposed employer pay-or-play provision (option A). We urge careful engineering of this requirement. With the advent of affordable coverage options for people purchasing through the exchange, it will be important to ensure that a movement of individuals to the exchange will not de-stabilize the current employer contributions to health care.

We believe that relatively few employers with payrolls over \$500,000 will find themselves subject to the excise tax, given the requirements. However, the provision that requires employers to pay their premium contribution to the health exchange when employees decline employer coverage is likely to have profound implications for the nature of employer financing. Most employers currently have employees who decline coverage. In an effort to maintain their current level of benefits spending, employers are likely to reduce their contributions to coverage (or the value of the benefits package) just enough to make up for the new expense associated with paying for “decliners.” The typical employer has the latitude in their contribution level and their plan’s actuarial value to make a downward adjustment and still avoid the proposed excise tax.

We urge the committee to consider providing an incentive for employers to scale their employees’ premium contributions to wage levels with the lower paid workers receiving more.^{vi} Sliding scale premium contributions to employer coverage would reduce the disparity in cost between the heavily subsidized coverage in the exchange and the employer’s coverage, keeping more employees in their employer’s plan.

Medicare Disability Waiting Period (page 37)

We strongly support elimination of the Medicare disability waiting period.

Temporary Medicare Buy-in For Adults Ages 55-64 (pages 38-39)

We strongly support immediate enactment of this proposal with appropriate protections for enrollees that provides a defined limit to their exposure to higher premiums after age 65 (i.e., each age cohort that enrolls should be told what the higher post age 65 premiums will be, and that number will not be later adjusted due to actuarial revisions).

Quality Reporting (pages 22)

We applaud your suggestion for improved quality reporting in Medicaid/CHIP but we recommend that uniform quality standards be broadly adopted for all plans in the

exchange as well as tax-payer financed plans like Medicare. Providers want one set of rules to react to, not quality standards that vary depending on the insurer.

Prevention, Chronic Disease and Wellness Grants (pages 43-49)

Consumers Union strongly supports expansion of evidence based preventive services to Medicare and Medicaid beneficiaries, pegged to the recommendations of the U.S. Preventive Services Task Force. We also support your proposal for employer wellness tax credits. See, for example, legislation by Senator Harkin S. 803. We also support the proposed option “personalized prevention plans.”

Disparities (pages 56-61)

We support public reporting of quality data by ethnic and minority groupings, and hope that you specifically include the public reporting of healthcare acquired infection data—an area where many minorities are particularly vulnerable because of the prevalence of certain infections in the community. We also hope you will ensure that more attention is given to including minorities in the Comparative Effectiveness Research advisory boards—and of course, in the conduct of drug and device clinical trials.

Additionally, we strongly support proposals to:

- Require the Social Security Administration (SSA) to collect race, ethnicity, and language data on Medicare enrollees, and fund upgrades to its database - we suggest that you strengthen this proposal by requiring SSA to directly provide this information to the Medicare enrollment database;
- Require federally-funded population surveys to collect sufficient data on racial and ethnic subgroups to generate statistically reliable estimates in studies comparing health disparities populations;
- Establish uniform categories for collecting race and ethnicity data, require these standards in Medicaid, require CMS to collect primary language data on CHIP enrollees and parents, and require CMS to collect data on where people with disabilities access primary care and providers with accessible facilities and equipment to meet their needs;
- Require health care quality data to be published by race, ethnicity, income, geography and gender;
- Extend the 75% match for translation services to all Medicaid beneficiaries for whom English is not a primary language, establish culturally and linguistically appropriate service standards for private insurers in the Exchange, and establish grants for outreach and enrollment efforts for multi-lingual help lines and for data collection efforts - we suggest you strengthen this proposal by strengthening language access provisions in Medicare;
- Eliminate the 5-year waiting period for Medicaid coverage of non-pregnant adult legal immigrants and provide funding to states, tribes, and territories to develop and implement targeted approaches to reducing infant mortality.

We also urge that you:

- Strengthen the Office of Civil Rights' capacity – including provision of adequate resources – to enforce race and national origin access requirements;
- Provide adequate reimbursement for language services in Medicare; and
- Increase health care workforce cultural diversity and competency.
- Encouraging HHS to work with the Institutes of Medicine to evaluate, report, and make recommendations on language services and best practices for collecting language data and interpreter utilization across all health care and public health programs and insurers.

Ensuring that grants for outreach and enrollment (included now under the Language Access subsection) extend beyond language access and include funding and support for community-based outreach activities, specifically for organizations working with hard to reach populations (including, but not limited to language, race, geography, and income

ⁱ Karen Pollitz, Eliza Bangit, Jennifer Libster, Stephanie Lewis, and Nicole Johnston. *Coverage When It Counts, How much protection does health insurance offer and how can consumers know?*, Center for American Progress Action Fund, May 8, 2009. This report describes real health plans whose provisions lead to consumer costs for covered services that vastly exceed the plan's stated out-of-pocket maximum.

ⁱⁱ Ibid.

ⁱⁱⁱ Jonathan Gruber. *Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?*, Henry J. Kaiser Foundation, March 2009.

^{iv} <http://econ-www.mit.edu/files/128>

^v As a revenue raiser, we hope the Health Reform bill will include the 'intelligent assignment' provisions of HR 3162 of the 110th Congress.

^{vi} Some large employers already do this, for example, Stanford University.