

Condition Critical:



Ten Prescriptions for Reforming Health Care Quality, Cost and Coverage

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AMERICAN BENEFITS
COUNCIL

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Executive Summary:

In this time of extraordinary economic turmoil, some have suggested that health reform may need to wait until we address other more urgent economic recovery priorities. We take the opposite view. Addressing the nation's health policy challenges is an integral element of — rather than an obstacle to — economic recovery and personal financial security.

The American Benefits Council (the “Council”) believes we can, and must, achieve a more affordable, more inclusive and higher quality health care system before health care in America reaches the critical condition stage. Our vision of reform was shaped by the diverse expertise and experience of our members, particularly our Board of Directors, which shaped a set of 10 practical prescriptions for our health care system. Each of these prescriptions is aimed at achieving a stronger, more sustainable health care system to serve the needs of all Americans.



The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to retirement and health plans covering more than 100 million Americans.

Our prescriptions build on the solid foundation of the employer-based health care system that now serves as the primary source of coverage for most Americans. We also offer concrete proposals to ensure that those who are outside of employment-based health coverage are able to obtain meaningful, affordable coverage through the individual insurance market or other sources.

Transformation of our health care system will also require significant steps to make health care services more affordable and of higher quality. Indeed, without these measures, it will not be possible to reach the widely shared goal of providing health coverage to all Americans.

The Council and its members strongly believe that we need to close the coverage gap and bring all Americans into the health care system. This goal has guided the development of our ten prescriptions for health care reform.

PRESCRIPTION #1:

Build on What Works

Building on – and not undermining — our voluntary, employer-based health coverage system is the best foundation for health care reform. We believe that the best reform options are those that strengthen, not impede, the voluntary employer-based system.

Transformation of our health care system will also require significant steps to make health care services more affordable and of higher quality.

PRESCRIPTION #2:

Maintain a Federal Framework

A single set of federal rules, rather than a state-by-state approach, for health care reform is essential, particularly for employers with a national or multi-state

workforce. In particular, health care reform should maintain the fundamental concepts and provisions of the Employee Retirement Income Security Act (ERISA).

This framework makes it possible for employers to maintain and administer a uniform set of benefits for their employees and allows for innovative benefit practices to be applied consistently for all plan participants, regardless of where they live.

PRESCRIPTION #3:

Improve the Quality and Efficiency of Health Care

Urgent action is needed to make our health care system more efficient and ensure more consistent delivery of high quality care.

In particular, a nationwide interoperable health information network should be adopted by a specified date to permit the exchange of vital health records and patient information much more efficiently and to provide a backbone for a wide range of emerging quality improvement initiatives.

PRESCRIPTION #4:

Provide Clear, Reliable Information to Make Better Health Care Decisions

A transformed health care system is one that makes price and performance information easily accessible so consumers can quickly determine where to find those providers who have a proven record of delivering high quality care.

A more transparent health care system will also give health care providers the tools they need to compare their performance with other professionals in their field in order to support and encourage continuous quality improvement.

PRESCRIPTION #5:

Make Health Coverage an Individual Obligation for All Americans

All Americans need to be part of a health coverage solution and we each have an obligation to obtain at least a basic level of coverage in a reformed health care system. An obligation to obtain coverage must also be accompanied by income-based premium subsidies to make health coverage affordable for lower-income individuals. To encourage employer-sponsored coverage whenever possible, these subsidies should be applied to assist qualified individuals with their share of the premium whenever such coverage is available.

PRESCRIPTION #6:

Establish a Minimum Standard for Quality, Affordable Health Coverage

A federal minimum standard for a basic and affordable level of coverage should be developed as a benchmark for whether individuals have met their health coverage obligation. Key components of this basic benefit standard would be established by a broad multi-stakeholder advisory panel. The standard should also permit individuals to meet their coverage obligation by enrolling in a plan that is at least actuarially equivalent to the basic benefit standards.

PRESCRIPTION #7:

Reform the Individual Insurance Marketplace for Those Who Do Not Have Access to Employer-based Coverage

All those without access to employer-based coverage should be able to enroll in a basic benefit plan in the individual insurance market that meets federal minimum coverage requirements or in an enhanced and affordable state high risk pool that provides comparable coverage.

PRESCRIPTION #8:

Strengthen State Safety-Net Health Insurance Programs

Sensible improvements are needed in public programs providing health coverage, including establishing a federal eligibility floor for coverage of adults under Medicaid. Stronger incentives are also needed for states to reach the more than 10 million individuals estimated to be eligible for coverage under state-based health programs, but are not yet enrolled. Premium subsidy programs should also be expanded for individuals eligible for coverage under

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both an employer-sponsored plan and Medicaid or the State Children's Health Insurance Program (SCHIP).

PRESCRIPTION #9:

Improve Tax Policy to Make Health Coverage More Affordable and Accessible

Current tax rules must continue to permit employers to deduct their expenses for the cost of health benefits they provide to employees.

In addition, rather than subjecting employees to income and payroll taxes on the cost of employer-sponsored health care coverage, we believe that favorable tax treatment should be extended to individuals who do not have access to health coverage under an employer plan and who obtain coverage in the individual insurance market.

PRESCRIPTION #10:

Enable Employers and Employees to Develop Retiree Health Care Solutions

An above-the-line tax deduction should be permitted for retiree health insurance premiums. Employers and employees should also have a wider range of options to fund retiree health care needs, starting by improving existing benefit vehicles.

CONCLUSION

Many of the most enduring legislative accomplishments in our nation's history are born out of bipartisanship. Health care reform will surely require just such an inclusive approach and a willingness to seek out and incorporate the best ideas from many parties.

The most important prescription for health reform may well be the willingness of all major stakeholder groups to engage in a collaborative effort to develop health reform solutions. As an organization whose members either directly sponsor or administer health benefits covering more than 100 million Americans, we are committed to working with all those who believe, as we do, that health reform is both urgently needed and can only succeed if it is developed through an open, consensus-based process. If we take this path and are guided by a set of pragmatic prescriptions, we can succeed in achieving fundamental and urgently needed health care reform.

We look forward to working with the Obama administration, the Congress and other major stakeholders on developing sensible solutions to reform our health care system. If the nation remains committed to this approach, we are confident that this time health care reform will succeed.

Condition Critical:

Ten Prescriptions for Reforming Health Care Quality, Cost and Coverage

Our nation now spends approximately \$2 trillion a year on health care.¹ We already spend far more per capita on health care than any other developed nation, yet rank well below other countries on many vital indicators of health status. More troubling is the well documented evidence that patients receive appropriate care for their conditions only about 55 percent of the time² and medical errors may account for as many as 98,000 fatalities each year.³

It all adds up to an annual rate of increase in health care spending that exceeds by three or more times projected increases in the gross domestic product or the future growth in employee wages, and far outpaces the expected growth in federal or state revenues.⁴ Taken together, these projections make it abundantly clear that no matter who ultimately pays the bill, health care must be made more affordable or it cannot be made more available. In addition, our health care system is marked by wide and unexplained variations in both the overuse and underuse of health services and all-too-frequently subjects patients to preventable medical errors. Most of all, too many people are left without cover-

age entirely, including an estimated nine million children,⁵ despite broad agreement about the importance of extending health coverage for all Americans.

Money alone is not the solution. There is now a broad consensus that our current health care system is in crisis and is unsustainable unless significant changes occur

soon. There is also widespread agreement on the basic diagnoses of the many challenges our health care system faces. A major overhaul is imperative to make health care more affordable, more accountable and more inclusive, and action on all these fronts is urgently needed now.

The American Benefits Council strongly believes that *all* Americans should have health care coverage. Individuals with health coverage have better access to needed medical services, are better able to lead healthy, productive lives, and are more likely to achieve personal financial security.

Health care must be made more affordable or it cannot be made more available.

Meeting this vital national goal means that our health care system must be transformed. This transformation requires reaching agreement on a set of clear, pragmatic steps taken by all major stakeholders as part of a shared solution. These are steps that build on the strengths of each of the key players but also respect their limits and legitimate needs. In fact, we believe that lasting health care reform can only succeed if it is based on sensible solutions around which consensus can be found.

We recognize that finding the right prescriptions for health care reform will

be difficult even if all parties commit to working together and share common goals. Our recommendations are intended to offer a cohesive and workable plan for placing our health care system on the right path. Equally important, we are committed to doing all that we can to help develop consensus on health system reform by forging alliances with all those who agree that serious problems are best solved by working collaboratively and pragmatically. This is the only approach that ensures we can all deliver on the long overdue promise to shape a health care system that truly meets the needs of all Americans.

Prescription #1: Build on What Works.

We believe that building on – and not undermining — our voluntary, employer-based health coverage system is the best foundation for health care reform. This system now serves more than half of the U.S. population⁶ and is largely financed by a combination of employer and employee contributions, both of which are encouraged and supported by effective federal tax policy.

In this system, employers have strong incentives to offer health care coverage to recruit and retain a talented workforce to

best meet their unique needs. Employment-based health coverage also broadly pools health risks and lowers administrative costs for health coverage.

In addition, it engages the creativity and commitment of the diverse employer community to find the best strategies to help keep employees healthy and productive.

In this system, employers are highly motivated to continually search to improve the management and delivery of

the coverage they sponsor. Perhaps the most important reason to build on our proven employer-based system is that employees have ranked employer-sponsored health coverage as one of their most valued benefits of employment and report high levels of satisfaction with their health coverage.⁷

Mandating that employers provide a minimum level of health coverage is neither necessary nor appropriate. Most large employers are likely to be competing in a global marketplace and we need to avoid costly mandates that either make American products and services less competitive or encourage employers to shift more of their workforce outside of the United States. Many smaller employers with highly constrained resources are already unable to offer health coverage to their employees and clearly should not be forced to provide benefits they cannot afford. Instead, health reform solutions should focus on strategies to make health coverage as affordable as possible for employers of all sizes and improve the individual insurance market so that a basic benefit plan is available to those who obtain coverage outside of the employer-based system.

Public policy that recognizes and supports our employer-based system simply makes good sense. It keeps in place a system that works well for most Americans as we collectively focus on finding

additional coverage solutions for those who lack employer-sponsored coverage or are unable to obtain affordable health coverage from other sources.

Recommendations:

R Build on the employer-based system. Most Americans rely on and support the existing employer-based health system and health reform should build on this strong foundation. For those without access to employer-sponsored health coverage, our prescriptions for health reform also include a range of policy solutions aimed at making health coverage more affordable and accessible for all Americans, regardless of their source of health coverage.

Mandating that employers provide a minimum level of health coverage is neither necessary nor appropriate.

R Choose reform options that strengthen, not impede, the employer-based system. The key components of any proposed health reform initiative should be carefully assessed to determine if they will strengthen, impede or reduce participation in the employer-based health system.

Prescription #2: Maintain a Federal Framework.

A single set of federal rules, rather than a state-by-state approach, for health care reform is essential, particularly for employers with a national or multi-state workforce. Preserving national, uniform rules for employer plans is also the most efficient, least complicated way for employers to sponsor health benefits. This translates into better benefits and lower costs for employees who participate in these plans.

We strongly support the federal regulatory framework established by the Employee Retirement Income Security Act (ERISA).

In addition, a uniform set of federal rules permits and encourages employers to develop and implement innovative benefit strategies which they can apply for all their plan participants

without being subject to conflicting state or local regulations. Finally, uniform rules for benefit plans translate into lower costs and better benefits for employees by increasing employers' purchasing leverage and maximizing the economies of scale.

Holding employer-sponsored benefits accountable under a single set of rules, interpreted by a single regulatory authority is also fundamentally fair to all employees covered by the same plan regardless of where they may live. For this reason, we strongly support the federal regulatory framework established by the Employee Retirement Income Security Act (ERISA). This framework plays a critical role in encouraging employer-sponsored health coverage by embracing the common sense concept that employer-sponsored benefits ought to be subject to a single set of rules.

State and local governments have important roles to play in reforming our health care system. ERISA does not interfere with innovative state programs such as the establishment of high-risk pools to expand access to health coverage, reform of the medical liability system, reallocation of state and federal Medicaid funds to extend health coverage to more low-income residents, or the development of strategies to promote healthy lifestyles. However, permitting state or local governments to regulate employer-sponsored plans — or add state rules

above a federal “floor” — would rapidly lead to an untenable situation where multi-state employers were subject to dozens, or potentially hundreds, of differing sets of rules from different jurisdictions. This would undermine the employer-based system by discouraging employers from sponsoring health benefits and needlessly add to the cost for health coverage paid by employees.

Recommendations:

R Maintain the fundamental concepts and provisions of ERISA. ERISA permits employers to offer and administer uniform benefit plans to their employees without being subject to costly state and local regulations.

R Build federal reform solutions on a single set of rules. Federal reform initiatives should not establish ERISA waivers, “carve-outs” or similar provisions that would permit state or local regulation of employer group health plans.

R Keep any new rules simple and flexible for employers. Any new federal rules for employer-sponsored health plans should promote the goals of simplicity and flexibility. It is essential to minimize additional costs paid by employers and employees and maximize greater health and financial security for more working Americans.

Prescription #3: Improve the Quality and Efficiency of Health Care.

Urgent action is needed to make our health care system more efficient and ensure more consistent delivery of high quality care. Some of the largest contributing – and most controllable – factors fueling the rapid rise in health care costs

are the uneven quality of care and a system that too often provides unnecessary, ineffective, or insufficient treatment.

One vital step that would support a wide range of innovative quality improvements

is the implementation of nationwide interoperable health information technology. This is needed to link together health care providers and other key stakeholders to help ensure that critical patient records and similar information is available at the right time and in the right place. Overall, the health care system lags far behind other industries in the use of information technology to advance efficiency, consistency and safety.

Moreover, reform must respond to the reality that market forces alone have not yet made information technology the norm in our health care system. If health

One of the largest contributing factors fueling the rapid rise in health care costs is the uneven quality of care.

reform is to succeed, it must first succeed in making it both possible and expected for information to be transmitted seamlessly, electronically and securely.

Many other steps also need to be taken. For example, we need medical liability reform to make our health care system less litigious and to lower those costs which are driven by “defensive medicine”. We need to strengthen incentives for individuals to take greater personal responsibility for their own health and to participate in effective programs to

promote wellness, manage chronic health conditions and make regular preventive care a priority.

Finally, existing benefit mandates should be scrutinized to determine if they are unnecessarily contributing to increases in health costs or restricting the ability of individuals to obtain more affordable basic health care coverage.

Recommendations:

⌘ Adopt and implement a nationwide interoperable health information network by a date certain. An interoperable health information network is essential to permit the exchange of health records and similar information among health care professionals, institutions, payers and patients. The new information network should assure the integrity and security of information in the new system without creating disincentives or burdens for the use of the network by key stakeholders.

⌘ Enact medical liability reform legislation to limit excessive and frivolous litigation and reduce defensive medicine. Liability reform should also encourage alternative procedures for resolving disputes and limit unwarranted attorneys’ fees and damage awards.

- R Provide safe harbor protections for health care providers and payers for decisions and practices that are evidenced-based.** Determinations which are consistent with national consensus-based quality measures or comparative effectiveness research should be protected by liability safe harbors.
- R Establish a national review process to rigorously examine existing and proposed state and federal benefit mandates.** This review process should aim to sunset existing benefit mandates that are not evidence-based, consistent with best practices in benefits design and clinical care, or are contributing unnecessarily to increases in health care costs.
- R Promote personal wellness and ownership for maintaining a healthy lifestyle.** Incentives should be strengthened for the expansion of benefit plans, workplace wellness programs and educational programs that promote wellness and encourage greater personal responsibility for adopting a healthy and safe lifestyle.
- R Increase participation in chronic disease management programs.** The availability of, and participation in, focused initiatives to address chronic diseases and other health care priorities should be significantly expanded.

Chronic conditions such as diabetes and heart disease and high blood pressure can be addressed by appropriate care management and individual action to promote better health through programs such as those for smoking cessation, weight management or improved nutrition.

- R Develop a clear regulatory pathway for bio-generic (or bio-similar) drugs.** The FDA should establish a clear regulatory pathway for the review and approval of bio-generic (or bio-similar) drugs to allow for the introduction of products that are shown to be safe and clinically proven.

Appropriate and balanced intellectual property protections should be provided to product innovators, while maintaining a predictable pathway for market entry of products that meet bioequivalence standards or other FDA requirements.
- R Expand the understanding and availability of appropriate end-of-life care options.** Best practices research should be expanded to improve the ability of health care providers, patients and other caregivers to determine therapeutically appropriate end-of-life care options.

Prescription #4: Provide Clear, Reliable Information to Make Better Health Care Decisions.

A transformed health care system makes price and performance information easily accessible so consumers can quickly locate health care providers who have a proven record of delivering high quality care. A more transparent system also gives health care providers the tools they need to compare their performance with other professionals in their field and encourages continuous quality improvement. Finally, a transparent health care system should provide incentives to move consumers and health care providers in the direction of evidence-based care by relying on clear, objective information on treatment options and costs.

A transformed health care system makes price and performance information easily accessible.

Employers can play a unique role in making the health care system more transparent by working with health care providers, insurers, consumer groups and government officials to help identify the type and amount of information needed for better health care decision-

making and the best tools and strategies for its dissemination. Many employers also have extensive experience in developing effective incentives to encourage broad employee participation in a wide range of health improvement initiatives. This experience will be essential in creating a critical mass of users of cost and quality information in order to establish a consumer-centric health care system.

A more transparent health care system is also one that serves to protect patients from unsafe or unproven care. While consumers should certainly be armed with information to identify high performance health care providers, they should also be able to steer clear of those with high rates of medical errors or who fail to deliver evidence-based care.

In addition, no payer should be expected to reimburse for serious preventable medical errors. A clear and consistent practice by all payers to end payments for preventable medical errors, also known as “never events”, will strengthen internal controls within the health care

delivery system and help make health care safer and more responsive to consumer expectations for high quality care.

Finally, all Americans highly value the vital advances that are made in the treatment of diseases and rely on innovations in medical technology and treatment to improve individual health status and promote a healthier society. Public policy should encourage medical innovation to improve the quality of health care and reduce the human and economic burden of disease. These advances should be complemented by highly objective, rigorous research to facilitate better evidenced-based decisions on the appropriate treatment options and services to meet patients' health care needs.

Recommendations:

R Advance the implementation and development of consensus-based quality and cost measures. Public-private partnerships representing all major stakeholders in the health care system have proven to be effective in the development of initial sets of quality measures. Cost measures should also be developed based on episodes of care rather than unit prices for components of health care services. The public-private partnerships should be supported with federal funding and should continue

to play a central role in the development of additional quality and cost measures for each major sector of the health care system.

R Transform the current payment system from a procedure-based, fee-for-service system to a value-based system. This approach should reward health care providers through a payment system that initially provides financial incentives for routine reporting of quality and cost information based on nationally adopted consensus measures. Ultimately, health providers should be rewarded for their demonstrated performance in the delivery of quality care, rather than simply the volume of services provided.

R Support more informed health care decisions by consumers through the development of better information tools. User-friendly information tools are needed to allow the comparison of health care providers, treatment options and services on the basis of key quality indicators and costs.

R Support continuous improvement by health care providers. Health care providers should be equipped with comparative clinical performance information to support continuous improvement in patient care.

R Expand the use of consumer incentives in a broader range of health plan options. Increase consumer engagement in health care decision-making through greater use of “consumer-directed” plans and an expanded range of innovative health plan options that encourage consumers to be more actively involved making choices among health care services and providers. In particular, health plans should provide incentives for plan participants to choose services from health care providers who deliver care consistent with consensus-based quality measures and demonstrate a commitment to quality improvement.

R Expand the practice of nonpayment for serious preventable medical errors (also known as “never events”). All payers for health care services should adopt the practice, also used by Medicare, where no payments are made for certain serious preventable medical errors, also known as “never events”. A consistent response by all public and private payers to end payments for these “never events” will lead to more effective internal controls to

improve patient care and safety. In addition, health care providers should be required to report all medical errors as a condition of payment by Medicare.

R Establish a national entity with a broad-based governance body to significantly increase the capacity for independent, valid comparative research on clinical and cost effectiveness of medical technology and services. Rigorous comparative effectiveness research is needed to examine clinical and cost evidence to support decisions on medical technology, treatment options and services to help ensure that more patients receive the right care for their condition.

A broad group of stakeholders should provide oversight and governance for issues relating to the integrity, standards, and priorities for comparative effectiveness research. In addition, federal funding for comparative effectiveness research should be provided, rather than relying on insurance premium assessments that only add to the costs of health coverage for employers and individuals.

Prescription #5: Make Health Coverage an Individual Obligation for All Americans.

There is a growing consensus that we all need to be part of the health coverage solution and that we each have an obligation to obtain coverage in a reformed health care system. In fact, establishing a universal obligation for all individuals to obtain and keep coverage is essential if we are to reach the widely shared goal of covering all Americans.

While we believe that employment-based group health coverage will be the primary and preferred source of coverage for most Americans, we recognize that those who are outside of the employer system must also be able to obtain quality, affordable health coverage. Our recommendations include practical and achievable improvements in the non-group insurance market and in public insurance programs so that all Americans will be able to fulfill their individual coverage obligation by enrolling in at least a basic health benefit plan.

We also recognize that it is neither fair nor feasible to call on all Americans to obtain health coverage unless it is accompanied by appropriate financial support

for lower-income individuals and households that cannot afford health coverage without assistance. We acknowledge that premium subsidies must be carefully structured in order to minimize potential disruption in the stability of the risk pools for employer-sponsored coverage.

For these reasons, we believe that it is important that when individuals have the opportunity to obtain coverage through an employer plan and are eligible for premium subsidies, this assistance should be used for the payment of their share of the premium for coverage available through their employer plan rather than creating a financial incentive to opt out of available coverage.

Establishing a universal obligation for all individuals to obtain and keep coverage is essential if we are to reach the goal of covering all Americans.

Making health care coverage an individual obligation would be a significant shift in current policy, but this shift is a

necessary one. We need to extend coverage to all Americans not only because it is the right thing to do, but because the costs of uncompensated care are shifted to employers, insurers, individuals and the government and result in a hidden tax on coverage.

This hidden tax is itself a significant contributing cause to the increasing number of uninsured individuals. It results in more employers — especially small employers — unable to offer health coverage, more individuals unable to pay their share of insurance premiums and more restrictions on eligibility and payments by government health insurance programs, including those intended to serve as a “last resort” source of health coverage.

Expanding health coverage to all Americans will have other benefits, too. For example, not all those who are uninsured are high risk or high cost. According to recent census figures, nearly 20 million of those who are uninsured are estimated to be young adults between the ages of 18 and 34.

Expanding coverage to this population should improve the overall risk pool, but most important of all, it means that these young adults are more likely to have their health conditions detected and treated at earlier stages, before they become much more costly and complicated to address.

Recommendations:

- R Establish a federal obligation for all Americans to obtain at least a minimum level of health coverage.** This requirement should be effective only after an initial transition period of at least one year to educate individuals on this new responsibility and to allow changes to be made in current sources of coverage. After the initial transition period, the coverage requirement should be phased-in to further ease its application.
- R Permit individuals to meet their coverage requirement through employer-based health coverage or other sources.** Individuals would demonstrate that they have met the coverage requirement by either electing health coverage offered by their employer, or by enrolling in coverage offered in a reformed individual insurance market, or, if eligible, through public programs such as Medicare, Medicaid, the State Children’s Health Insurance Program or a state high risk pool.
- R Connect individuals to appropriate sources of coverage if they fail to make a coverage decision on their own.** For individuals who fail to enroll in qualified coverage in a timely manner, mechanisms should be established to connect them to an appropriate source of coverage. Late

enrollees would have responsibility for the payment of their share of applicable premiums and any late enrollment penalties. Additional financial penalties for those who fail to enroll in *any* source of coverage should be considered only if the mechanisms and incentives to connect individuals to appropriate sources of coverage are insufficient to adequately close the coverage gap.

- R Provide income-based premium subsidies to make health coverage affordable.** Lower income individuals and households that are not eligible for coverage under a public health insurance program should be eligible for federal premium subsidies to make the purchase of health coverage more affordable. Subsidy payments would be income-based so that a higher percent of the cost of cover-

age would be subsidized for the lowest qualifying income levels. Subsidies would gradually phase out at the point where all those who are able to pay full premium amounts would be expected to do so.

- R Apply subsidy payments to employer-sponsored coverage when it is available.** Subsidy payments should be available to assist qualified participants in employer-sponsored health plans as well as those who obtain coverage in the individual insurance market or through a state high risk pool.

When individuals have the option to enroll in an employer-sponsored plan and are eligible for subsidy payments, they would be required to apply the subsidy to their premium share for their employer plan.

Prescription #6: Establish a Minimum Standard for Quality, Affordable Health Coverage.

Establishing a requirement that all individuals have health coverage also requires the development of a minimum standard for qualified, or “creditable”,

coverage. While there are numerous challenges in defining a minimum coverage standard, one of the first is reaching agreement on what the goal should be

for a minimum benefit standard. Some believe that a minimum standard should focus on catastrophic coverage and that the goal should be to protect individuals from the possibility of devastating financial burdens resulting from a sudden or serious health care condition. Others have called for a much more comprehensive coverage standard, such as the Blue Cross and Blue Shield standard option plan offered through the Federal Employee Health Benefits Program. Many others would go even further and advocate for the inclusion of additional specific services or procedures in any minimum coverage requirement. Each of these approaches has its strong proponents and each poses unique challenges or lacks broad consensus.

Our recommendations call for a middle ground approach by establishing an affordable basic benefit standard through a two step process. Step one would be to define by legislation each of the broad categories of coverage that should be included in the minimum benefit requirement. Step two would be to establish a broad multi-stakeholder advisory panel that would make consensus recommendations on more discrete aspects of plan design such as appropriate limits on cost-sharing (e.g., deductibles, co-payments,

out-of-pocket limits and day or visit limits) for different categories of coverage. The multi-stakeholder advisory panel would not have the authority to specify benefits or broad categories for the minimum benefit standard, but instead would be asked to advise on ongoing implementation issues as a minimum benefit standard is introduced in the marketplace. Finally, the advisory group should be asked to make annual

recommendations on changes in cost-sharing or other aspects of the minimum benefit standard in order to keep a basic benefit plan affordable, particularly in the employer and individual insurance marketplaces.

Under this approach, employers, insurers and government programs

should retain needed flexibility to determine whether to cover particular services within the minimum standard's broadly defined categories of coverage. In addition, the minimum benefit standard should not interfere with plan medical management practices or the extent to which benefits are offered through networks of participating providers. These essential plan design and benefits management tools will continue to be essential in developing a wide range of affordable plan options in a robust

There are numerous challenges in defining a minimum coverage standard. We must first reach agreement on what the goal should be for such a standard.

marketplace and ensuring that health benefits are managed effectively.

We believe that a federal minimum benefit standard is needed only for the purpose of determining whether individuals have enrolled in qualified health coverage and have met their individual coverage obligation. Once this standard is defined, employers and insurers will have strong incentives to ensure that their plans meet or exceed the minimum requirements. Individuals who enroll in these employer-based plans will therefore satisfy their individual coverage obligation and should also be able to do so by enrolling in a plan that is at least actuarially equivalent to the minimum benefit standard.

Recommendations:

- R Establish a federal minimum benefit standard for the purpose of determining whether individuals have satisfied their coverage obligation.**

A federal “minimum creditable coverage” standard should be developed to establish a benchmark basic, affordable level of coverage which, at a minimum, all Americans should obtain.

- R Establish the minimum coverage standard through a two-step process.** Step one would be established by

legislation and would describe the broad categories of coverage required for the purposes of the minimum benefit standard.

Step two would be based on consensus recommendations from a broadly representative independent advisory panel consisting of major stakeholder groups that would consider issues such as appropriate limits on cost sharing or other financial requirements or durational limits on coverage. The independent panel would not have the authority to add further categories of coverage or specific benefits to the minimum benefit standard.

- R Provide a safe harbor for qualified high-deductible health plans.** High deductible health plan (HDHP) coverage that qualifies to be offered under existing federal standards in combination with a health savings account (HSA) should also qualify under a safe harbor standard for the purpose of the minimum benefit standard.

- R Permit actuarially equivalent coverage to satisfy the minimum coverage requirement.** Individuals who enroll in employer-sponsored plans would meet their coverage obligation by electing to participate in a plan that at least meets the minimum coverage

standard or provides actuarially equivalent coverage. Employers would not be mandated to offer coverage that meets the minimum benefit standard, but would have strong incentives for doing so in order to ensure that employees who participate in their plans will be able to fully satisfy their individual obligation to enroll in qualified health coverage.

R Apply minimum coverage standards to public programs. Federal and state health insurance programs would be expected to at least meet the minimum coverage standards, because eligible enrollees in these public programs typically do not have other coverage opportunities and would need to be assured that their coverage through the federal or state program satisfies their individual coverage obligation.

Prescription #7: Reform the Individual Insurance Marketplace for Those Who Do Not Have Access to Employer-Based Coverage.

It has been more than a decade since Congress last addressed the issue of improving the availability of coverage in the individual insurance market. Since the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), individuals who have had continuous health coverage for at least 18 months, most recently under a group health plan, are guaranteed access to individual health insurance coverage and have a right to renew that coverage each year after their initial enrollment.

Despite these legislative improvements, HIPAA is only a partial solution. More needs to be done to strengthen the opportunity for health insurance coverage for those who do not have access to employer-sponsored coverage or who are not eligible for coverage under a public program.

Personal health status can often be a formidable obstacle for those seeking coverage in the individual insurance market, particularly if the applicant has

not previously been enrolled in an employer group health plan – or who has had more than a 63 day break in coverage — and therefore does not have a protected right under HIPAA to enroll in an individual insurance market plan. For example, depending on state insurance laws, individuals who have potentially serious preexisting health conditions may be denied individual health insurance coverage or their coverage might not be renewed following the occurrence of an adverse health event.

Others who are offered coverage may not be able to afford the premiums for an individual insurance policy or may only be able to afford a plan with very limited coverage, leaving them with significant financial exposure in the event of a serious illness or injury.

Once individuals have an obligation to obtain coverage, the availability of affordable, quality coverage in the individual insurance market becomes even more essential than it is today.

Our proposals to ensure access to all those who are outside of the employer-based system build on two important concepts. First, we propose that every state establish a high risk pool plan that provides coverage that meets or exceeds the new federal minimum coverage standard. To ensure its affordability, premiums for the coverage offered under these state plans would be subject to

federal rating restrictions and premium subsidies would be available for those with limited incomes.

Second, we propose that at least one basic health plan that meets the federal minimum coverage standard be available in the individual market in every state. These plans would remain subject to state insurance regulation, as they are today, except that coverage would be available on a guarantee issue basis unless the applicant is eligible for comparable coverage under a state high risk pool. As with coverage under the state risk pools, those with limited incomes who enroll in an individual insurance basic benefit plan would be eligible for premium subsidies to ensure that the coverage is affordable.

We believe that these reforms will lead to significant improvements in the individual insurance market, making it a more stable, more affordable, and more rational source for health coverage for millions of Americans. We also recognize that many alternative solutions will be considered to reform the individual insurance marketplace. While the details of differing approaches vary, the common and essential elements of any successful solution include an individual obligation to obtain coverage to broaden participation in health insurance markets, guarantee issue to permit access to meaningful, affordable coverage regardless of health status, and mechanisms to share and spread risk. All proposals that include

these core elements should be considered seriously and the best solutions for the individual insurance market may ultimately need to incorporate concepts from several sources.

Recommendations:

- R Ensure access in all states to a basic benefit plan in the individual insurance market through a product that meets federal minimum coverage requirements.** At least one basic benefit plan product in the individual insurance market should be available in all states on a guarantee issue basis that is consistent with the federal minimum creditable coverage standard. These products would be exempt from additional state benefit mandates. For all other purposes — such as consumer protections, solvency, rating rules, and other requirements — state regulatory standards for the individual insurance market would continue to apply.
- R Provide states a range of options to ensure that a basic benefit plan is available in the marketplace.** To ensure that state residents are able to obtain at least one product that meets the federal minimum coverage standard and is exempt from state benefit mandates, states should have the authority to provide regulatory relief, financial incentives or, only if neces-

sary, establish a requirement that carriers offer such products in the marketplace.

- R Make high risk pool coverage affordable and available in all states.** All states should be required to establish high risk pools with coverage that at least meets the federal minimum creditable coverage standard. To keep this coverage affordable, state restrictions on premiums paid by enrollees would apply in accordance with federal rules and the claims expenses from the high risk pools that exceed funding from enrollee premiums would be shared by federal and state governments.
- R Facilitate enrollment into an individual market basic benefit plan or comparable coverage in a state high risk pool.** Individuals with an expected claims experience significantly higher than the average claims experience in the individual market would be eligible for coverage on a guarantee issue basis under state high risk pools. Individuals who are not otherwise eligible for coverage under a state high risk pool would be guaranteed the ability to enroll in one of the basic benefit plans in the individual market plans that meets the federal minimum coverage standards and is free of state benefit mandates.

Prescription #8: Strengthen Safety Net Health Insurance Programs.

Although nearly two-thirds of nonelderly U.S. residents obtain health coverage through the private marketplace,⁹ public programs play a vital coverage role for nearly 100 million Americans.¹⁰

While public programs should not displace coverage available in the private market, we must do a better job of reaching the more than 10 million individuals who are currently eligible for, but not enrolled in, existing programs for low-income Americans. These include Medicaid and State Children's Health Insurance Programs (SCHIP). Most urgent of all is that nearly six million of those eligible for coverage, but not enrolled in these critical safety net programs, are children.¹¹ Aggressive efforts to enroll these individuals should begin without delay and should not wait for the enactment of further legislation.

Beyond these steps, we believe that a federal minimum eligibility standard should be established for Medicaid so that all qualifying adults have the same opportunity for coverage regardless of where they have state residency. Setting

a federal eligibility standard for Medicaid is also important in a reformed health care system where all Americans will have an obligation to obtain health coverage and all low-income individuals will be eligible for federal premium subsidies. Without a federal minimum eligibility standard, some states might have incentives to lower their own Medicaid eligibility standard and shift more of the cost of health coverage for their low-income residents to the federal premium subsidies program.

A third improvement would be to coordinate public and private sources of coverage for those who are eligible for coverage under a public safety net program as well as an employer-sponsored plan. In these cases, states could subsidize the employee's premium share so that the individual could enroll or remain covered under the employer plan. In these situations, the employer-sponsored coverage could be coordinated with the state plan so that these individuals would still be entitled to any additional public program benefits beyond those available under the employer plan.

Recommendations:

- R Set a federal eligibility floor for Medicaid coverage.** A federal minimum eligibility standard would be established so that all adults with income below 100 percent of the federal poverty level (FPL) would qualify for coverage under Medicaid. Enhanced federal funding should be available to assist states to enroll adults up to the eligibility floor.
- R Expand state outreach to enroll individuals who are currently eligible for coverage under public programs.** States would be expected to engage in aggressive outreach efforts to reach more than 10 million uninsured individuals – including six million children – who are currently eligible for coverage under public safety net programs, but not enrolled

in these plans. Federal outreach standards would be established based on best practices in states with effective outreach programs.

- R Expand premium subsidy arrangements for individuals who are eligible for coverage under employer-sponsored plans.** For individuals who are eligible for coverage under Medicaid or SCHIP as well as an employer-sponsored health plan, States would be directed to develop programs to enter into agreements to subsidize the employee premium for those individuals eligible under an employer plan. Under these arrangements, the employer plan would serve as the primary source of coverage and the state program would cover any additional benefits that the individual is also entitled to receive under Medicaid or SCHIP.

Prescription #9:

Improve Tax Policy to Make Health Coverage More Affordable and Accessible.

Under current tax policy, the cost of health coverage is not taxable to employees for income and payroll tax purposes. Because of the rapid escalation in health care costs, this single feature of the tax code is now the largest federal tax expenditure, exceeding tax preferences for homeowners' mortgage interest, charitable contributions or contributions to retirement savings or pension plans.¹² In addition, employers are allowed to take an ordinary and necessary business expense deduction for the amount they spend on health care coverage for their employees. As a result, current tax policy strongly influences how health coverage is financed for most Americans and has played a significant role in encouraging our employer-based health care system.

Starting nearly 30 years ago, numerous proposals have been made to limit, replace or eliminate the employee tax exclusion. More recently, there have been proposals to establish a standard deduction for health coverage limited to the average cost of family and individual coverage. Under this approach, em-

ployer contributions for health coverage which were above the amount of the standard deduction would be subject to both income and payroll taxes. Individuals who purchase health coverage on their own in the non-group insurance market would also be permitted to deduct the cost of the coverage up to the amount of the standard deduction.

Proponents of changes to the tax treatment for employer-sponsored coverage have generally argued that current law provides an overly generous tax preference for employer-based coverage while those who purchase coverage on their own in the non-group market (except self-employed individuals) have no comparable tax benefit. A second argument is made that current tax policy encourages employers to provide, and employees to elect, more costly and comprehensive health coverage than they actually need. As a result, proponents assert, employees spend more on health care than they would if they had leaner health coverage and more health spending were made on an after-tax basis.

Much has changed over the past 30 years when proposals to limit or eliminate tax preferences for employer-sponsored health coverage were first considered. Clearly, one change during this period has been that fully subsidized employer-sponsored health plans that provide “first-dollar coverage” are now nearly extinct. Employers have introduced a range of strategies intended to mitigate annual increases in health care costs.

Tax policy strongly influences how health coverage is financed for most Americans and has played a significant role in encouraging our employer-based health care system.

Even without a change in tax policy, many employers have introduced plans with much stronger incentives for participants to make more cost-effective and appropriate use of health care services. In addition,

in nearly all cases, employees now share a portion of the cost of their health coverage and the annual increases in health premiums.

Also during this time, many employers have become much more demanding purchasers of health care coverage. They have engaged health plans to address both the overuse and underuse of health care services, and to contract with health care providers on the basis of proven performance and not just price. These

efforts also have focused on strategies to improve the health status of employees, particularly those with chronic health conditions. Importantly, these shifts to more cost-conscious, performance-driven health coverage have not emerged because of a change in federal tax policy, but because employers have realized that shared solutions that engage and change their employees’ use of health care services are essential in maintaining quality, affordable coverage.

We fully support extending favorable tax treatment to those without access to employer-based coverage who purchase health insurance in the non-group market, without diminishing the tax benefits for employer-sponsored coverage. We also believe that income-based premium subsidies will significantly improve the affordability of health coverage for all low-income individuals who either obtain coverage through their employer or in the non-group insurance market. This will respond to those who are concerned that the current employee tax exclusion for health coverage is more generous for taxpayers in higher tax brackets than those in lower brackets. Income-based premium subsidies will result in direct financial support to lower-income individuals for the cost of their health coverage, as opposed to less direct strategies such as changing current tax preferences for employer-sponsored coverage to either a standard deduction or a refundable tax credit.

Recommendations:

- R Maintain the ability of employers to deduct their expenses for health coverage to employees.** For employers, it is essential that they be permitted to continue to deduct their expenses for sponsoring and contributing to employee health coverage for income tax purposes. In addition, employers should not be required to include these expenses for payroll tax purposes.
- R Retain the employee tax exclusion for health coverage obtained through employment.** For employees, the cost of health care coverage paid on their behalf by employers should continue to be excluded for both income and payroll tax purposes and these amounts should not be capped or eliminated.
- R Allow employees to pay their share of health insurance premiums on a pre-tax basis.** Employees should also continue to have the ability to pay their share of health care premiums and other qualified medical expenses on a pre-tax basis through cafeteria plans.
- R Provide comparable tax preferences for coverage purchased in the individual insurance market.** For individuals who do not have access to coverage under an employer plan, health coverage in the individual insurance market should be subject to favorable tax treatment, comparable to the rules that currently apply to coverage for self-employed individuals.

Prescription #10: Enable Employers and Employees to Develop Retiree Health Care Solutions.

The decline in employer-sponsored retiree health benefits has been the result of several factors, including the pressure caused by the rate of increase in health

care costs, the challenge of competing in a national and global marketplace where companies in the same industry may have significantly lower or no retiree benefits,

and a change in accounting rules requiring employers to account for their long term and mostly unfunded retiree health care liabilities on their balance sheets. These factors have caused employers to seek ways to reduce their exposure to these increasing benefit liabilities and have frequently resulted in retiree health coverage being capped or even eliminated, particularly for new hires. Despite these challenges, many employers continue to look for more sustainable solutions to help employees meet their retiree health care needs.

Unlike coverage for active workers, employers and employees lack tax-favored funding vehicles to enable them to contribute for future retiree health care coverage. The availability of tax-favored solutions for pre-funding retiree health benefits would encourage greater employer and employee participation in programs to finance these future benefit needs. According to a 2006 Kaiser Family Foundation/Hewitt Associates survey, 75 percent of employers reported that they did not pre-fund their retiree health programs.¹³ Nearly half of those employers thought that better solutions were needed for retirees, starting with establishing tax-favored funding opportunities for retiree health benefits.

Overall health care reform will also improve the availability of quality, affordable health coverage for retirees,

especially early retirees who leave employment and may need to find health coverage for the first time on their own. However, these overall improvements in our health care system should be accompanied by policy solutions tailored to retirees, particularly policies that encourage better use of employer-based plans through sensible and constructive changes in tax policy.

Recommendations:

- R Improve tax preferences for retiree health insurance to make coverage more affordable.** Retirees should be able to take an above-the-line deduction for health insurance premiums.
- R Provide employers and employees with better options for funding retiree health care needs.** Improvements should be made to existing retirement savings vehicles to provide employers and employees a range of options to better meet retiree health care needs. These options should include:
 - permitting pre-tax payments of retiree health premiums from a defined benefit or defined contribution retirement plan;
 - permitting employees age 50 or older to designate a limited amount of their 401(k) catch-up contributions to a retiree medical

- sub-account for future pre-tax payments for retiree health coverage;
- lowering the health savings account (HSA) catch-up contribution age from 55 to 50 and permitting tax-free distributions from these accounts for retiree health premiums before age 65 ; and
- allowing employers to pre-fund retiree health costs using Voluntary Employees' Beneficiary Associations (VEBAs) under rules that permit contributions to be based on reasonable projections of future increases in retiree health costs and not taxing VEBA earnings, provided that reserves do not exceed the maximum amount permitted. Current law applies similar favorable contribution and tax rules only in the case of collectively bargained VEBAs.

Conclusion

Our vision of health reform is rooted in our confidence that most Americans welcome and expect employers to continue to play a central role in our health care system as sponsors of health coverage, innovative purchasers and strong allies in improving the quality and affordability of health care.

We welcome the challenge of working on practical solutions to transform the nation's health care system by building on what is working well in our employer-based health care system while creating new solutions for those who purchase

coverage on their own or are eligible for coverage under a public program. Lasting reform will only succeed in covering all Americans by also slowing the growth rate in health costs to a sustainable level and improving health quality. Here too, employers will play an essential role in helping to meet these challenges. We are committed to working together with Congress and other key stakeholders to reach beyond the broad consensus that health care reform is needed and we believe that our 10 prescriptions for health care reform provide a workable pathway to achieve it.

NOTES

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