May 22, 2009

The Honorable Max Baucus  
Chairman  
Committee on Finance  
United States Senate  
Washington, DC  20510

The Honorable Charles Grassley  
Ranking Member  
Committee on Finance  
United States Senate  
Washington, DC  20510

Dear Chairman Baucus and Ranking Member Grassley:

The U.S. Chamber of Commerce, the world’s largest business federation representing more than three million businesses and organizations of every size, sector, and region, thanks you for your work toward overhauling America’s health care delivery system. The Chamber has reviewed the document, “Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans,” and would like to offer our thoughts as detailed in the attached document.

The Chamber is committed to working with Congress to find policy solutions that work for business as Congress engages in a comprehensive overhaul of the health system. We support the processes established by the Senate Finance and HELP Committees and continue to hope for a bipartisan bill that is supported by a broad array of stakeholders.

The Chamber thanks you for this opportunity to share its thoughts about expanding health insurance coverage and looks forward to working with you to enact meaningful reform that will lower costs, increase quality, and expand coverage.

Sincerely,

R. Bruce Josten

Cc: The Members of the Senate Committee on Finance

Attachment
Section I: Insurance Market Reforms

Federal Rating Rules
The Chamber believes very strongly in implementing insurance market reforms for both the individual and small group markets. These groups are getting hit the worst with skyrocketing increases in their health care costs. The Chamber feels that there is need for certain federal reforms, as the states (in some cases) have exacerbated the situation. One concern is that the options in this paper leave the definition of “small business” up to the states. That type of variation has been troubling in the past. Further, allowing states to have varied definitions of “groups of one” and other issues is troubling. The Chamber is concerned that the new federal rating requirements would be put into place immediately for the “micro” businesses, but the rest of the small group would be phased-in over 3-10 years.

If these rating reforms and guaranteed issue are applied to the individual, micro-group, and small business markets, there would be no need for a government-run plan, as consumers would have many options.

Health Insurance Exchange
The Chamber has concerns that only micro-businesses would be allowed in the exchange at first. The 10-50 group also needs significant help and would benefit from being able to enter the exchange. The Chamber is concerned that the employer contribution would have to be pegged to only one benefit level. It is also unclear how premium assessments would be calculated to subsidize operation of the exchange – they would need to be indexed responsibly.

States should have a minimal role in running the exchange(s). If an individual wishes to purchase coverage through the exchange, that person should be permitted to purchase from an out-of-state carrier.

Grandfathered Plans
The Chamber needs further clarification on what plans are deemed “grandfathered.” If minor changes are made to the design of the plan, is it no longer considered grandfathered? Are grandfathered plans deemed to satisfy the level of coverage needed to avoid any applicable pay-or-play taxes or fees? Grandfathered plans should be deemed to meet all the requirements of any employer mandates, individual mandates, and minimum coverage requirements. Further, organizations that have set up successful pooling operations and group plans for numerous small employers or self-employed individuals should be allowed to continue with their successful projects.

Section II: Making Coverage Affordable

Benefit Options
This document lays out an extremely prescriptive plan design and does not leave much room for innovation or benefit design that would encourage individual responsibility. Using tools such as medical management, care coordination, and case management helps to control costs. This is not going to be an “affordable” plan for many Americans; this mandates that all insurance be gold-plated “Cadillac” plans. Many scholars already say that tens of millions of Americans are
currently over-insured, and this classification of benefits standards would certainly exacerbate the situation.

Individuals above the income levels qualifying them for a subsidy (400 percent of FPL) would still be challenged to afford even the low option plan with an actuarial value of 76 percent. The affordability of the premium for the low income individual not eligible for a premium subsidy would be an increased issue in year 2 if premiums increase as expected 6 to 10 percent. The Chamber recommends that Congress include an option for HSA-qualified high-deductible plan designs which cover preventive care at 100 percent and an agreed-to co-insurance level. A minimum benefit design should be developed by transparent, multi-stakeholder efforts and should only include broad insurance policy matters and not specific decisions related to devices, treatments, procedures, etc.

The minimum required benefit plan represents a potentially significant burden on small employers especially if they are required to offer health coverage or pay an excise tax. The burden of the “pay or play” requirement would inevitably lead to job loss, non-replacement of current positions, and/or transitioning work outside the United States. The benefit levels proposed are richer than typical plans offered in 2009 by plan sponsors.

Clarification is needed as to whether this would “undo” the Mental Health Parity language passed last year.

**Actuarial Calculations**

The use of actuarial equivalence to determine Minimal Credible Coverage (MCC) is an administrative nightmare for employers. It is difficult to place an actuarial value on different benefits – and fair is not always equal. Pegging benefit design to an actuarial standard could lead benefits design to go the way of the defined-benefit retirement plans. The administrative complexity would be too much for some employers. Further, the Chamber urges you to design a plan such that individuals can understand what they are getting, and actuarial numbers do not achieve that.

Repealing annual and lifetime caps is also of concern. The Chamber understands and appreciates the goal of trying to limit financial exposure to the employee or individual. However, employers and insurers put caps into place to manage costs. Without any caps, utilization would inevitably increase and important cost-management tools such as case management, disease management, and coordinated care would be disregarded by patients and practitioners. Employers want to ensure their employees are getting the most appropriate and timely care. A better approach would be to create a reinsurance system so that the highest cost claims are shared between all risk pools, thus eliminating the need for such limits.

**Low Income Tax Credit**

The Chamber understands the need to subsidize coverage for those who cannot afford it, however we feel that Congress must first make insurance products more affordable before subsidizing it. This goes back to the benefit design and overly prescriptive benefits package earlier in this section. If individuals making more than $88,000 annually need government money to buy health insurance, the U.S. system is grossly unaffordable, and costs need to be
addressed before engaging in such a massive redistribution of wealth. If this credit is refundable, it should be paid directly to the exchange or insurer; there must be no room for abuse or noncompliance.

**Small Business Tax Credit**
This section should be coordinated with the other credits proposed. Further, because of the tax structure and tactics of most small businesses, they would not be eligible for this credit if it is not refundable. It is also unclear why the credit would phase out at 25 – this could create a disincentive for business to grow.

**Section III: Public Insurance Option**

A public plan would not be needed due to strict rating reforms and banning the use of health status to rate premiums. The Medicare-like plan would lead to significant cost shifting and does not solve the problem of lack of providers that want to take on public plan enrollees. Option B (no public plan) is much better; preserve the free market and competition while also providing people with affordable health care.

The Chamber appreciates the efforts of many in Congress to create a public plan that would be a fair competitor. However, by its very nature a public plan could not compete on a level playing field, and any public plan would necessarily be unfair, uncompetitive, coercive, disruptive, and a threat to Americans’ abilities to keep the plans they have, if they so choose. Therefore, the Chamber urges Congress not to include any of the “compromise” options, including the third-party option, the state-run option, the Schumer/Nichols option, or any other government plan. It is absolutely essential that under no circumstance is a new entitlement program created, or any government program that is permitted to take general revenue transfers, or that operates under a pay-as-you-go mechanism.

**Section IV: Role of Public Programs**

The Chamber agreed to establish a Medicaid floor of 100 percent of the FPL through our deliberations in the Health Reform Dialogue, and believes 150 percent of FPL is too high and is fiscally irresponsible. Further, what is the purpose of expanding Medicaid so high that it overlaps with proposed credits? And, is this an unfunded mandate?

Chamber members are concerned about the “temporary Medicare buy-in” for several reasons: first, the fact that it may not remain temporary. Second, Medicare already has a massive, unfunded liability around $40 trillion that is impossible to address. With this economic outlook, it seems irresponsible to expand the program. The elimination of the disability waiting period would also represent a cost-shift to private insurers. At every opportunity in this legislation, Congress should find ways to redirect money from the public into the private system; government programs should pay, not play.
Section V: Shared Responsibility

The Chamber prefers option B, but has concerns about the level of coverage required to meet the individual mandate. An employer mandate is not needed to increase coverage. Excessive fees and taxes would hurt the economy and cost jobs. The opt-out provision would lead to adverse risks. Option B (no employer mandate) is much better and would help to protect the part of the system that works (although if supporting option B means that the Chamber also supports the individual mandate as described in the options paper, we may have concerns).

Employers will always look at benefits in total. If they are required to pay more on health benefits, they may do so, but would then not be able to be as generous with other benefits – retirement, 401(k) contributions, vision, dental, etc. If Congress adds more to one benefit sector, inevitably it will come from somewhere else.

The use of “total payroll” is inherently problematic as well. Small employers often seriously invest in their businesses, and their own compensation should not be counted in any kind of evaluation of payroll size. In bad economic times, these business owners often significantly invest from their own savings, and this would have to be taken into account as well.

Also of concern is the possibility that increasing government regulation and interference between employers and employees in the sponsoring of health insurance would lead many, if not most employers, to choose to pay rather than play. This would represent a loss to employees who currently benefit from the expertise, hard-bargaining, and advocacy of their employers.

Section VI: Prevention and Wellness

The Chamber supports the commitment to wellness and prevention contained in this document. However, the wellness piece alone will not help drive participation in these programs – the United States needs GINA and HIPAA relief. This wellness credit approach is a first generation “participation” model that qualifies the employer for a tax credit merely by setting up a program with required elements. There are no requirements for employee engagement, measurement of impact on health status and costs of participants and non-participants, and no requirements for promotion or communication. Such a program would serve only to raise awareness and is highly unlikely to have any sustained impact on behavior change or lowering costs. Further, because of the tax structure and tactics of most small businesses, they would not be eligible for this credit if it is not refundable. It is also unclear why the credit would phase out – this also could create an incentive for a business not to grow.

If Congress is serious about promoting wellness and healthy living, they should include safe harbors to protect employers who use wellness programs from HIPAA, GINA, COBRA, and the ADA. Further, wellness programs should be allowed to have stronger incentives for participation – specifically, the 20 percent premium variation limit in HIPAA should be widened to at least 50 percent, and participation in a group health plan should be allowed to be contingent on participation in wellness plan activities.