HEALTH BENEFITS INSTITUTE

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Submitted electronically

Dear Chairman Pallone and Chairwoman Murray,

We at the Health Benefits Institute thank you for the opportunity to discuss the merits of the public option. The Institute has championed the goal of expanding affordable health insurance coverage through promoting consumer choice and competition while still maintaining key standards that protect consumers. The Health Benefits Institute (HBI) is a policy organization supported by agents, brokers, insurers, employers, benefit platforms and others seeking to protect the ability of consumers to make their own health care financing choices. We support policies that expand consumer choice and control, promote industry standards, educate consumers on their options and foster high quality health outcomes through transparency in health care prices, quality, and the financing mechanisms used to pay for care.

The goal of universal coverage is one that is shared by the Institute. Indeed, we have proposed numerous solutions over the years to the problems of both rising health care costs and rising health insurance premiums that impede that goal. These include efforts to help control escalating hospital costs, solutions that expand access and lower drug costs, changes to existing government programs that make them work better for patients, and new efforts to assist employers who provide most Americans with their health coverage. We do not support a so-called public option because we don't believe this government-designed program can work. Furthermore, the evidence is on our side.

A Government-Run Health Plan Creates an Unlevel Playing Field

Any public option created and run by government or a quasi-governmental agency has inherent legal advantages, and never meets the same standards required of industry. There is no sense that the government-run plan must abide by the same rules and regulations as an insurance carrier. Specifically, we suggest any public option should be required to comply with all state rules, and file all rates and forms for the insurance department for approval. The public option should be subject to the same statutory accounting rules as insurers, the same network adequacy rules (for use of any networks), must provide access to coverage for consumers who travel out-of-state and must be required to meet the same minimum loss ratio standards.

Insurers are required to meet minimum capital requirements, and in many cases retain reinsurance to ensure financial solvency. To protect taxpayers, any public option should be subject to the same rules.

Prior Efforts to Create a Public Option Have Failed

The Affordable Care Act included several attempts at creating "public options" including the creation of co-operative health plans or co-ops, multi-state plans run by the Office of Management and Budget, and finally the creation of the CLASS Act to help with long-term care expenses.

After millions of dollars and numerous lawsuits, most of the federally funded co-ops have either become insolvent or ceased to operate as a co-op. Multi-state plans – intended to interject national competition into local markets – were failures from the outset. Of course, the long-forgotten CLASS Act, which was supposed to be a public option for long-term care, was repealed before it was operationalized.

In short, all the federal public options in the ACA have flopped. The programs cost taxpayer money, destabilized insurance markets, and led to higher overall insurance prices as insurers were negatively impacted. We believe the imposition of a new public option scheme would be similarly detrimental to the overall health insurance marketplace and result in increased premiums.

Efforts in the states have fared no better. Many state insurance codes included requirements to offer "basic and standard" plans starting in the late 1980's and early 1990's. Even prior to the passage of the ACA, the plans were not popular with the public and enrollment was anemic, at best. More recently, Washington state (Colorado and Nevada passed similar laws this year) has passed and implemented their Cascade Care program. The program includes standardized plan designs and a rigid Medicare-based reference price for insurance plans participating in the program. Despite the advantage in set medical costs, Cascade Care plans were actually more expensive than plans designed and offered by private insurers at commercial reimbursement rates. In response, this year Washington state passed new changes to the program to limit competition with Cascade Care plans.

Public Option is the Wrong Problem, Wrong Solution

The ACA has done nothing to control underlying medical costs. A recent study for the North Dakota Department of Insurance[1] found high medical costs are helping to drive high premiums. Other contributing factors of note include:

1. Health insurance is already subject to significant and appropriate rate review process.

[1] As highlighted above: https://www.insurance.nd.gov/sites/www/files/documents/Communications/Reports/20210108%20ND%20Legislative%20Management%20Interim%20Healthcare%20Study-FINAL.pdf.

2. Health insurers are subject to the Affordable Care Act's minimum loss ratio. This means that medical expenses must comprise at least 80% of the insurer premiums.
3. Providers are in a favorable bargaining position. Network adequacy, and the essential health benefits provide much needed consumer protections, but the standards also ensure some one-sided contracting in some states without a dynamic competitive provider and insurer market.

To be clear, we're not saying high health insurance premiums in the United States are not a problem. We believe insurers can be part of the solution: any proposal should instead focus on giving insurers the tools necessary to lower health care costs before implementing any proposed public option.

Any Public Option Should be Subject to Financial, Actuarial, and Market Conduct Examinations

Consumers have few protections from a government-run health plan. While plans are created with the best of intent, when rules and regulations are not imposed on government plans, poor consumer outcomes may follow. Indeed, in a number of cases in my role as Deputy Insurance Commissioner in Wisconsin, we had to step in on behalf of consumers who had specific problems with the federal exchange. In one case, we had to issue an order on an insurer to prevent the exchange from forcing the insurer to withdraw additional premiums without notice from consumer accounts.

These issues make it paramount that the any public option be regularly audited like an insurance company. A comprehensive financial examination should be completed at least once every 5 years. All rate filings of the authority should be made public upon filing, and the state should consider a public hearing. In addition, an actuarial audit should be completed to ensure rates are consistent with sound actuarial principals.

Artificially Lowering Provider Reimbursements May Not Lead to Lower Overall Health Care Costs

Health care costs are not just based on the cost of service, but also on number of services received and the intensity of the service. Increasingly, there is evidence that both the number of services, the location of the service (i.e. hospital vs. outpatient), and intensity of the service vary with the level of reimbursement. Lower reimbursement rates have often led to consumers receiving more services (on average) and at higher intensity levels.

Increasingly, insurers have been able to use the contracting process to ensure consumers receive the best care available. In some cases, this means that insurers are willing to pay more for nominal services to ensure medical providers use best practices, for example requiring specific monitoring criteria in diabetes patients or providing earlier treatment by a physical therapist for chronic back pain.

It is also important to note that insurers seek to create high value networks through contracting. These networks provide a competitive advantage and ensure that their patients are receiving high value care. Credentialing and other efforts allow insurers to

guarantee that patients only receive high quality medical care. While standard, lower prices may temporarily lower health care costs, there should be concern about the long-term impact.

Finally, doctors and hospitals respond to appropriate incentives. By artificially lowering the price of medical care, it is likely doctors and hospitals will no longer offer certain kinds of low profit services to patients. In the long run, it may lead to fewer medical providers offering care.

Thank you again for providing an opportunity to comment on the public option. Please do not hesitate to contact me if you have further questions at jpwieske@thehealthbenefitsinstitute.org or (920) 784-4486.

Sincerely

JP Wieske
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