WellPoint's Response to White House Blog

White House Assertions regarding WellPoint's Analysis	WellPoint's Response
WellPoint did not take young adults and premium credits into account	WellPoint took into account premium subsidies available within the exchange by Federal Poverty Level (which is not limited by age and would include young adults) in pages 2-4 of its analyses
WellPoint ignored the "young invincibles" policy proposed in the Senate Finance Committee proposal	WellPoint includes language specific to the "young invincibles" program as early as page 2 of the analyses
WellPoint overlooked the proposals related to reinsurance	The WellPoint analyses contain several references to the impact of reinsurance (for example, see pages 2 through 4 and page 8 of the Indiana analysis)
WellPoint disregarded health insurance exchange proposals	WellPoint includes reference of an exchange and the impact of the exchange on premiums throughout the analyses (for example, see page 17 of the Indiana analysis)
WellPoint reached the opposite conclusion of the CBO as to the benefits of health insurance reform	WellPoint analyzed the impact of health reform on premiums. The CBO has yet to produce a complete analysis of the impact of health reform on premiums; however, WellPoint did take into consideration many of the studies that have been done regarding the impacts on health insurance reform for determining how to do the modeling for these analyses
WellPoint's assumption that the entirety of taxes and fees will be passed onto the consumer is erroneous	WellPoint assumed that the taxes and fees would be passed onto the consumer – a conclusion similar to that of the CBO as evidenced by the testimony by Dr. Elmendorf to the Senate Finance Committee
Unlike in the WellPoint analysis, any impact from taxes and fees will be offset by an increase in membership resulting from health reform	Taxing coverage to pay for coverage is simply redistributing income and does not address health care costs
Unlike in the WellPoint analysis, even if taxes and fees are passed onto consumers this will be more than offset by the reduction in uncompensated care which will be attributable to increased subsidies and cost containment mechanisms	WellPoint assumes that higher premiums related to increased taxes and fees will actually make coverage less affordable and will not provide the offset in terms of a reduction in uncompensated care

WellPoint Response: The WHITE HOUSE Blog, *Reality Check: WellPoint Analysis Continues the Misinformation Campaign*, Posted by Jesse Lee on October 23, 2009 at 12:20 PM EDT http://www.whitehouse.gov/blog/Reality-Check-WellPoint-Analysis-Continues-the-Misinformation-Campaign

Recently WellPoint released analyses on the premium impact of proposed health care reform legislation in the fourteen states in which it operates as the local Blue plan.[1] While the analyses focus on the underlying cost of the premium, there are also elements of reform that would offset a portion of those costs from lower-income individuals and certain employers by providing premium assistance[2] and tax credits.[3] Additionally, in our analyses we include those elements that may result in a lower post-subsidy premium cost.[4] We examined the impact of the subsidy as a way of reducing the impact of reform and presented the data by federal poverty level.[5]

This document reflects the work of WellPoint actuaries and contains supplementary information in the appendix detailing their assumptions.[6] Because of the detail within the document, we encouraged readers to thoroughly review the entire document, including the appendix, before drawing any conclusions.

WellPoint remains steadfast in our commitment to a sustainable health system and therefore continue to be supportive of health care reform. As a company we share concern for our members and desire to protect them from higher health care costs. We believe sustainable health care reform is that which controls costs, increases access and promotes quality outcomes. It was our sincere hope that our analyses provide additional state-specific information regarding the states that WellPoint does business in to assist elected officials in those states in evaluating the various proposals before Congress and their impacts, both intended and unintended.

After the release of our analyses, the White House posted on the *White House Blog* a number of false allegations. The blog entry alleged that:

> WellPoint's study consciously ignores: special policies for young adults including premium credits and a special "young invincibles" plan; reinsurance to lower the cost of catastrophic care; and the benefits of creating a new health exchange,

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[1] Stats and Facts: Impact of Health Care Reform on Premiums. http://www.wellpoint.com/newsroom/stats_facts.asp

[2] The analysis referenced in this document is specific to Indiana. http://www.wellpoint.com/pdf/Indiana%20Premium%20Impacts%20Analysis.pdf. We completed similar analyses with varying results for all of the fourteen states in which we operate as the local Blue Plan. http://www.wellpoint.com/newsroom/stats_facts.asp. Similar references to those mentioned in this document can be found in all of the analyses for each of the states.

[3] Ibid. at pages 1, 5 - 7, and 11 - 14 (Appendix).

[4] Ibid. at pp. 1 - 3.

[5] Ibid. at pp. 2 – 4..

[6] Ibid. at pp. 8-17.

> which the non-partisan CBO [Congressional Budget Office] says will reduce premiums.[7]

Additionally, the blog implied that the results of the WellPoint analyses were erroneous, stating that "if you take a flawed methodology and break it down state by state, you still end up with a flawed result."

WellPoint welcomes a reasonable and honest debate and discussion of the impacts that those purchasing coverage would see post-reform. To that end, we have some serious concerns with the accuracy of the assertions in the White House blog entry. In terms of the direction and general magnitude of the changes that would result from proposed heath reform, WellPoint stands by the results of our analyses with a very high degree of confidence. We would like to take this opportunity to provide a thorough and balanced discussion of the White House assertions and provide feedback to the White House and others that may have some of the same questions and concerns.

Young Adults and Premium Subsidies

The White House blog states "that WellPoint's study consciously ignores: special policies for young adults including premium credits." However, WellPoint's analyses in fact do display the estimated impacts of premium subsidies, including those available in the exchange where eligibility is based on Federal Poverty level.[8] The following chart points out the subsidy impacts:

Federal Poverty Level: Premium Subsidy	Reform Premium after Subsidy	Total Impact after Subsidy
100% - 150%: 90% subsidy	$25	-70%
150% - 200%: 74% subsidy	$66	-22%
200% - 250%: 54% subsidy	$116	38%
250% - 300%: 26% subsidy	$187	121%
300% - 350%: 2% subsidy	$247	193%
350% - 400%: 0% subsidy	$252	199%
400%+: 0% subsidy	$252	199%

Additionally, we provide estimated impacts for premium subsidies available to small businesses in the form of a tax credit,[9] which could also assist with premiums for young adults. The analysis contains language specific to the impacts of the tax credit for varying age groups with varying health status for example:

> Certain businesses may be eligible for a small employer tax credit, which shifts a portion of the premium cost onto taxpayers. The tax credit is limited in several

[7] The WHITE HOUSE Blog, *Reality Check: WellPoint Analysis Continues the Misinformation Campaign*, Posted by Jesse Lee on October 23, 2009 at 12:20 PM EDT http://www.whitehouse.gov/blog/Reality-Check-WellPoint-Analysis-Continues-the-Misinformation-Campaign

[8] Health Care Reform Premium Impact in Indiana at pp. 2 – 4. http://www.wellpoint.com/pdf/Indiana%20Premium%20Impacts%20Analysis.pdf

[9] Ibid. at pp. 5 – 7, and 11 (Appendix).

> ways: employer size, wages of employees, and only for the first two years coverage is purchased through the exchange. The CBO estimates that the small employer tax credit will cost about $23B over 10 years, or $2.3B per year. This amount reflects roughly 2-3 percent of small employer premiums across the U.S. and thus under this assumption will not likely broadly reduce premiums paid by small employers and their employees." [10]

Furthermore, in the appendix we discuss the desire by States to make the tax credit available to the businesses within their states and the potential impact that this could have on the timing of rating changes, stating that:

> We believe it is logical to expect that most states will move very quickly to implement the new rules in their small employer markets as the small employer tax credits will not be available to states until they have fully adopted these new rules. As a result, we found it more reasonable to assume quick implementation of the rating changes, with the thought that a slight delay could occur but that a five-year implementation window was unlikely. [11]

Young Invincibles

The White House blog also asserts that the WellPoint study consciously ignores "a special 'young invincibles' plan."[12]

To the contrary, our analyses clearly acknowledge that "young invincible" policies are contemplated in the Senate Finance Committee mark, and we spell out the fact that the increase attributable to actuarial value would not apply in this case. Our analysis concludes that the "young invincibles" plan seems unlikely to provide any material cost relief for employer-sponsored coverage in the post-reform environment. Our analysis states:

> [T]he Senate Finance Committee proposes to create a "young invincible" plan that will provide another option below the 65 percent minimum actuarial value. However, the plan will only be made available to individuals 25 years or younger. This demographic comprises only about 7 percent of currently insured small employer subscribers in WellPoint markets. As rating reform is put into place and results in significant increases to premiums for younger workers, we anticipate the percentage of subscribers age 25 or younger that are covered by their employer's coverage will drop significantly.[13]

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[10] Ibid. at page 5.
[11] Ibid. at page 11 (Appendix).
[12] The WHITE HOUSE Blog, *Reality Check: WellPoint Analysis Continues the Misinformation Campaign*, Posted by Jesse Lee on October 23, 2009 at 12:20 PM EDT http://www.whitehouse.gov/blog/Reality-Check-WellPoint-Analysis-Continues-the-Misinformation-Campaign
[13] Health Care Reform Premium Impact in Indiana. Page 14

We further take into consideration the population that is included in the "young invincibles" population when we examined the younger/healthier population in our individual market case and note the possible impact of allowing younger individuals to purchase plans with more modest benefits. The note says:

> In the Senate Finance Committee legislation, those 25 and under are eligible to purchase a product with more modest benefits, but this is not available in the Senate HELP or House bills. If this provision is incorporated into the final legislation, those 25 and under will not likely face higher premiums due to richer benefit requirements. [14]

In fact, WellPoint's study shows that market premiums will increase for many demographic groups, not just those we might assume are the "young invincibles." [15] For example, our overall analysis shows that our standard member of average age and average health would also be expected to see his/her premiums increase.[16]

We did not consider only one age group with a single health status, instead we chose to focus on a variety of age and health status combinations for an individual and small-group premium analyses in order to provide a complete picture of the impact of current health reform proposals. The White House chose to single out the "young invincibles" in their response with the implication that the addition of this proposal is a silver bullet for reducing premiums and encouraging young people to purchase coverage. However, we chose to examine the impact of the proposals on many age groups and health statuses, not only the "young invincibles" proposal.

The following chart describes just that:

	Younger/ Healthy	**Average Age/ Average Health**	**Older/ Less Healthy**
Individual	199%	122%	-11% (decrease)
Small Employer	94%	20%	-23% (decrease

However, the notes for this chart explain that this is the "percent increase shown before any adjustment for the increase in medical costs over time."

The "young invincible" notion was included only in the Senate Finance Committee mark-up, which used conceptual language. However, we are willing and readily able to project the premium level of the "young invincibles" plan once that plan is actually defined.

However, as we understand the conceptual language from the Senate Finance Committee markup, those over 25 would be required to buy the higher benefit level which in turn would result in a higher premium.

[14] Ibid. at page 2.
[15] Health Care Reform Premium Impact in Indiana. Page 2 – 6.
[16] Health Care Reform Premium Impact in Indiana. Page 1

Reinsurance

The White House blog entry further contends that the WellPoint study consciously ignored reinsurance to lower the cost of catastrophic care. However, our analyses certainly did address the impact of reinsurance[17] as well as risk pools,[18] stating that:

> The Senate Finance Committee legislation does propose reinsurance to offset a portion of the costs associated with the adverse selection that will result from guarantee issue requirements. However, the reinsurance program is limited to three years, and the total funding is limited to $20B over three years. The impact on premiums in the individual market is anticipated to total well over $150B during this same period. Risk corridors and risk adjustment mechanisms are also proposed but do not add funding to the individual market and thus will not mitigate increased premiums in the aggregate.[19]

Additionally, we believe reinsurance will actually raise premiums overall since insurers will be required to make "separate contributions" that "would fund the administrative expenses of the Non Profit."

Health Exchange

The White House blog also states that the WellPoint study completely ignores "the benefits of creating a new health exchange, which the non-partisan CBO says will reduce premiums." It is important to note that the CBO only estimated the impact of reforms upon health care costs, while the WellPoint study reflects the impacts to premiums.

Again, the WellPoint analyses clearly address this issue and in doing so, we explain that administrative savings attributable to the exchange are likely to be offset by administrative fees that will be charged to insurers to support the exchange. The analyses states:

> While the existence of a health insurance exchange and its impact on premium was considered for this analysis, we believe the assessment to fund the exchange and any resulting lower insurer administrative costs will roughly offset each other.

For example, a review of five WellPoint states determined that the average percent of premium attributable to sales accounts for 4 percent to 6 percent of premium in the small group market. The Massachusetts Connector—the health insurance exchange in

[17] Health Care Reform Premium Impact in Indiana at pp. 2-4, 8.
[18] Health Care Reform Premium Impact in Indiana at pp. 8 – 11, 13, and 16.
[19] Health Care Reform Premium Impact in Indiana. Page 8

Massachusetts—charges an assessment on coverage sold in the exchange that falls within this range to fund its operations—much of which is attributable to sales and marketing.[20]

The health reform proposal in Massachusetts has resulted in higher costs, less consumer choice, longer wait times and has fallen short of providing universal coverage. Consumers in Massachusetts are being forced to buy more expensive coverage. Over 200,000 currently insured individuals are having to "buy-up" coverage because their current coverage does not meet the new Minimum Credible Coverage (MCC) requirements of the law.[i] Reports have indicated that more than 200,000 individuals will have to pay more for their insurance to meet the new benefit requirements. This is because real cost drivers have not been addressed. The cost of coverage in almost all market segments is continuing to increase because the reforms enacted in Massachusetts did not address the underlying factors driving costs: provider price increases and increased utilization.[ii] What the results of the reform to date really show is that, prior to expanding coverage, reforms in the delivery system need to be put in place to improve quality and control costs.[iii]

Taxpayer costs in Massachusetts are millions more than initial estimates. The costs of the reforms have been substantially higher than those originally presented to taxpayers. Proposals are now on the table to increase taxes that will be passed on to consumers because the costs are so much higher than originally projected.[iv] We can expect that without addressing cost through responsible, sustainable health reform, the American taxpayer will also pay increased costs for health reform and the exchange.

In fact, the CBO analysis of the Senate Finance proposal as amended specifically states that:

> On a preliminary basis, CBO and JCT [the Joint Committee on Taxation] estimate that the proposal's specifications affecting health insurance coverage would result in a net increase in federal deficits of $518 billion over fiscal years 2010 through 2019. That estimate primarily reflects $345 billion in additional federal outlays for Medicaid and CHIP and $461 billion in federal subsidies that would be provided to purchase coverage through the new insurance exchanges and related spending.[21]

[20] Health Care Reform Premium Impact in Indiana. Page 17
http://www.wellpoint.com/pdf/Indiana%20Premium%20Impacts%20Analysis.pdf

[21] Congressional Budget Office, "Preliminary Analysis of the Chairman's Mark for the America's Healthy Future Act, as Amended**,"** Letter to the Honorable Max Baucus. October 7, 2009. Page 5.
http://www.cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus_letter.pdf

And in the more recent estimates of the House proposal the CBO analysis states:

> On a preliminary basis, CBO and JCT estimate that H.R. 3962's provisions affecting health insurance coverage would result in a net increase in federal deficits of $894 billion over fiscal years 2010 through 2019. That estimate primarily reflects $425 billion in net federal outlays for Medicaid and CHIP and $605 billion in federal subsidies that would be provided to purchase coverage through the new insurance exchanges and related spending.[22]

More to the point, the CBO has just stated, in a letter to Senate Finance Committee Chairman Baucus, that it intends upon addressing the question of what impact these proposals might have on health insurance premiums.[23] This is a clear statement that CBO is not even clear on the impacts of the health exchange on premiums, and that CBO has yet to conclude that the health exchange will benefit by reducing premiums.

The CBO also explains that:

> The subsidies reflect the administrative costs of establishing and operating the exchanges. Related spending accounts for $5 billion for high-risk pools, about $3 billion for insurance co-ops, and the net budgetary effects of proposed reinsurance fees and payments.[24]

Additionally, in a recent letter to House Leadership detailing the cost of the Affordable Health Care for America Act, when discussing the number of people who would choose the public option offered in the exchange, the CBO noted:

> That estimate of enrollment reflects CBO's assessment that a public plan paying negotiated rates would attract a broad network of providers but would typically have premiums that are somewhat higher than the average premiums for the private plans in the exchanges. The rates the public plan pays to providers would, on average, probably be comparable to the rates paid by private insurers participating in the exchanges. The public plan would have lower administrative costs than those private plans but would probably engage in less management of utilization by its enrollees and attract a less healthy pool of enrollees. (The effects of that "adverse selection" on the public plan's premiums would be only partially offset by the "risk adjustment" procedures that would apply to all plans operating in the exchanges.)[25]
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> Even so, while the premiums for public option may be higher than a private plan, the evidence is not clear that a health exchange would reduce either cost or

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[22] Ibid.
[23] Congressional Budget Office, "Different Measures for Analyzing Current Proposals to Reform health Care," Letter to the Honorable Max Baucus, October 30, 2009 at page 9. http://www.cbo.gov/ftpdocs/106xx/doc10689/hr3962ClarifyMeasuresBaucusLtr.pdf
[24] Congressional Budget Office, "Preliminary Analysis of the Chairman's Mark for the America's Healthy Future Act, as Amended**,"** Letter to the Honorable Max Baucus. October 7, 2009. Page 5.
[25]Ibid. at page 6

> premium. Exchanges may potentially reduce administrative costs or premiums, but this depends upon their actual structure and rules – details that are yet to be determined.

The CBO estimates for the exchange were limited to the thought that 4 to 5 percent of administrative expense could be removed with the movement to the exchange (for the non-group market). It then assumes that the exchange fee will only be 3 percent, but there is nothing in the legislation that specifies what the exchange fee will be.[26] [27]

White House Gruber Reference

Perhaps most disturbing is an assertion by the White House blog that WellPoint reaches almost exactly the opposite conclusion to the CBO. The blog provides a direct link to a paper by Jonathan Gruber of MIT[28], not the CBO, nor does the blog provide a link to the CBO analysis. While the CBO has not released a detailed analysis of the impacts of all of the health reform proposals on premiums, an initial analysis it has produced, an impact analysis of the Chairman's Mark for the Senate Finance Proposal, the America's Health Future Act, has focused almost entirely on the impact of subsidies on premiums[29] rather than the impact of health reform as a whole on premiums. The CBO letter to Chairman Baucus opens by stating,

> [T]his letter responds to your questions about the subsidies offered through insurance exchanges and enrollees' payments for that coverage under the specifications for the Chairman's mark for proposed health care legislation that were provided by the staff of the Senate Finance Committee on September 15, 2009. It also discusses the factors that affect a comparison of those figures to the amounts that individuals and families would pay, on average, for employment-based coverage or individually purchased policies under current law.[30]

Additionally, because the White House chose to reference the Gruber white paper on reform, we believe it is important to note that reform will result in individual market premiums increasing, not decreasing, as stated in the Gruber paper. The Gruber paper refers to a CBO paper stating that a typical non-group single-coverage plan is projected to

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[26] Preliminary Analysis of the Chairman's Mark for the America's Healthy Future Act, as Amended**,** Letter to the Honorable Max Baucus. October 7, 2009. Table 1, Page 3. http://www.cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus_letter.pdf

[27] Ibid. at page 6.

[28] Gruber, Jonathan. *The Senate Finance Committee Proposal Lowers Non-Group Premiums*. October 12, 2009. http://www.tnr.com/sites/default/files/Gruber%20SFC%20NonGroup%20Prem%20Analysis.pdf

[29] Congressional Budget Office, "An Analysis of Premiums Under the Chairman's Mark of the America's Healthy Future Act**:** Letter to the Honorable Max Baucus," September 22, 2009. http://www.cbo.gov/ftpdocs/106xx/doc10618/09-22-Analysis_of_Premiums.pdf

[30] An Analysis of Premiums Under the Chairman's Mark of the America's Healthy Future Act**:** Letter to the Honorable Max Baucus. September 22, 2009. http://www.cbo.gov/ftpdocs/106xx/doc10618/09-22-Analysis_of_Premiums.pdf

cost $6,000 in 2016.[31] However, Gruber fails to mention that the same CBO report specifically excludes one very important factor:

> Premiums in the new insurance exchanges would tend to be higher than the average premiums in the current-law individual market—again with other factors held equal—because the new policies would have to cover preexisting medical conditions and could not deny coverage to people with high expected costs for health care. (CBO has not analyzed the magnitude of that effect).[32]

Thus, the Gruber paper excludes a factor (known as guaranteed issue) that WellPoint estimates would add between 20 percent and 80 percent to the cost of premiums under reform,[33] and which the CBO acknowledges would result in increased costs relative to the existing market with all else being constant.[34]

The Gruber paper assumes there is a 5:1 ratio between premiums for 25 and 60 year olds in the existing non-group market.[35] Gruber states:

> The CBO reports that a typical non-group single plan is projected to cost $6,000 in 2016. For the family plan for a family of four, I assume the premium is 2.7 times the single premium, as with group insurance. I assume that there is a 5:1 ratio between premiums for 25 and 60 year olds in the existing non-group market. The CBO also reports that a silver plan (with an actuarial value of 0.70) would cost on average $5,000 in 2016. The Bronze plan has an AV of 0.65, so the price is 93 percent as high. I assume that the premium for a 25 year old is half that amount and for a 60 year old is twice that amount for a total age band of 4:1. For the catastrophic premium, I assume and actuarial value of 0.5. For a family plan, I assume that the premium is 2.7 times the single premium.[36]

In reality, the actual ratio varies by state and insurer and averages in excess of 6:1 for males and 4:1 for females.[37] Ultimately, the Senate Finance proposal requires elimination

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[31] Gruber, Jonathan. *The Senate Finance Committee Proposal Lowers Non-Group Premiums*. October 12, 2009. Page 1.
http://www.tnr.com/sites/default/files/Gruber%20SFC%20NonGroup%20Prem%20Analysis.pdf

[32] An Analysis of Premiums Under the Chairman's Mark of the America's Healthy Future Act: Letter to the Honorable Max Baucus September 22, 2009. Page 6. http://www.cbo.gov/ftpdocs/106xx/doc10618/09-22-Analysis_of_Premiums.pdf

[33] Health Care Reform Premium Impact in Indiana. Page 2
http://www.wellpoint.com/pdf/Indiana%20Premium%20Impacts%20Analysis.pdf

[34] An Analysis of Premiums Under the Chairman's Mark of the America's Healthy Future Act: Letter to the Honorable Max Baucus September 22, 2009. Page 6. http://www.cbo.gov/ftpdocs/106xx/doc10618/09-22-Analysis_of_Premiums.pdf

[35] Gruber, Jonathan. *The Senate Finance Committee Proposal Lowers Non-Group Premiums*. October 12, 2009. Page 1.
http://www.tnr.com/sites/default/files/Gruber%20SFC%20NonGroup%20Prem%20Analysis.pdf

[36] Gruber, Jonathan. *The Senate Finance Committee Proposal Lowers Non-Group Premiums*. October 12, 2009. Page 1.
http://www.tnr.com/sites/default/files/Gruber%20SFC%20NonGroup%20Prem%20Analysis.pdf

[37] Health Care Reform Premium Impact in Indiana. Page 9
http://www.wellpoint.com/pdf/Indiana%20Premium%20Impacts%20Analysis.pdf

of gender rating (in the many states that currently allow it) and compression of age variation.[38] Thus, making an assumption solely around age results in an oversimplified analysis.

The Gruber paper also assumes in each case that family rates will be 2.7 times the single rate. In fact, there is significant variation in this ratio.[39] And, in some cases, family rates are developed by summing the applicable individual rates for each member of the family. In these cases, the resulting ratio can be dramatically higher or lower than the simplistic assumption applied in the paper. Again, this variation will cause actual rates to be significantly higher in some cases and lower in others than those shown in the paper. Thus, this assumption does not reflect reality.

The Gruber paper focuses solely on premiums net of subsidies as though everyone would be eligible for subsidies.[40] In reality, under the proposals a large portion of the American population would not be eligible for subsidies.[41] While there will be 282 million non-elderly Americans in 2019, 185 million of them will be insured through their employer or enrolled in non-exchange non-group insurance and therefore ineligible to receive subsidies. The CBO estimates that 5 million of the 23 million individuals eligible for the exchange will be unsubsidized, leaving 18 million people eligible for subsidies through the exchange.[42] A better representation would be to display post-reform premiums both with and without subsidies to give a more comprehensive picture. The WellPoint analyses show both the impact to costs before and after the availability of taxpayer assistance in the form of premium subsidies.[43]

Additionally, while the Gruber paper also identifies a specific price for the "young invincible" policy,[44] the details for the policy are not identified in the legislation.[45] This option is also only available to those 25 and under, and others will be required to buy richer benefits.

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[38] America's Healthy Future's Act. October 2, 2009. Page 2. http://finance.senate.gov/sitepages/leg/LEG%202009/100209_Americas_Healthy_Future_Act_AMENDED.pdf

[39] Gruber, Jonathan. *The Senate Finance Committee Proposal Lowers Non-Group Premiums*. October 12, 2009. Page 1. http://www.tnr.com/sites/default/files/Gruber%20SFC%20NonGroup%20Prem%20Analysis.pdf

[40] Ibid. at pp. 1-2.

[41] Preliminary Analysis of the Chairman's Mark for the America's Healthy Future Act, as Amended, Letter to the Honorable Max Baucus. October 7, 2009. Page 14. http://www.cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus_letter.pdf

[42] Ibid.

[43] Health Care Reform Premium Impact in Indiana. at pp. 2 – 4.

[44] Gruber, Jonathan. *The Senate Finance Committee Proposal Lowers Non-Group Premiums*. October 12, 2009. Page 1. http://www.tnr.com/sites/default/files/Gruber%20SFC%20NonGroup%20Prem%20Analysis.pdf

[45] America's Healthy Future Act. October 2, 2009. Page 23. http://finance.senate.gov/sitepages/leg/LEG%202009/100209_Americas_Healthy_Future_Act_AMENDED.pdf

In sum, in the underwritten individual market today, premiums are often available for under $100 per month, depending on the characteristics of the individual. It is simply not reasonable that legislation with the following characteristics will widely result in reduced premiums: (1) requires insurers to offer coverage to individuals with pre-existing conditions; (2) allows individuals to wait to get coverage until services are needed and just pay a small penalty; (3) requires richer benefits; (4) eliminates health status discounts; (5) reduces age discounts; (6) eliminates gender discounts; and (7) applies new taxes to the market. The WellPoint analyses are far more detailed, complete, and use real market data.[46]

Congressional Budget Office

To return to the criticisms of the WellPoint analyses as described by the White House blog, "As a result, WellPoint reaches almost exactly the opposite conclusion that the CBO and other independent health experts have reached about the benefits of health insurance reforms" we have already addressed the link that the White House provided to a non-CBO study. However the CBO:

1. Projects the impact proposed legislation will have on the federal budget and the number of insured/uninsured; it does not project system-wide health care costs or health insurance premiums;
2. has, to date, only released preliminary estimates and has yet to issue a "full text" estimate; and
3. Has drawn criticism for seeming to ignore the impact on the uninsured of the amendment offered by Senator Schumer during the Finance Committee mark-up.

The CBO's exact words were: "In light of those complexities . . .CBO has not modeled all of those factors and is unable to quantify them or calculate the net effects at this time."[47] Also, even in its estimated impacts on the deficit, the CBO notes that those estimates are subject to "substantial uncertainty," but gives no details on what that may mean.[48] In addition, the CMS Office of the Actuary recently estimated that the House bill would increase national health expenditures by about 2 percent.[49] Many independent health policy experts have reached the same conclusion that we have reached – that under

[46] Stats and Facts: Impact of Health Care Reform on Premiums. http://www.wellpoint.com/newsroom/stats_facts.asp

[47] An Analysis of Premiums Under the Chairman's Mark of the America's Healthy Future Act: Letter to the Honorable Max Baucus September 22, 2009. Page 7. http://www.cbo.gov/ftpdocs/106xx/doc10618/09-22-Analysis_of_Premiums.pdf

[48] Preliminary Analysis of the Chairman's Mark for the America's Healthy Future Act, as Amended, Letter to the Honorable Max Baucus. October 7, 2009. Table 1, Page 2. http://www.cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus_letter.pdf

[49] Foster, Richard. *Estimated Financial Effects of the "America's Affordable Health Choices Act of 2009" (H.R. 3200), as Reported by the Ways and Means Committee*. October 21, 2009. Page 3.

the current federal health care reform proposals, insurance premiums and overall health care costs will increase.[50]

Impact of Taxes and Fees

The White House further assumes that:

> The idea that the entire fee will be passed on to consumers is not credible – especially given the policy design. The policy assesses a flat amount per year, paid by companies based on their market share, beginning in 2010. The assumption that these companies will accumulate the amount of these fees and pass them along in a lump sum to enrollees later simply does not make sense.

In direct contrast to the White House's assertions, CBO Director Elmendorf testified to the Senate Finance Committee that the fees on insurance companies "would raise insurance premiums by roughly the amount of the money collected."[51] All entities selling insurance of any kind are required by law to project cost into the future in order to establish appropriate premium rates. In the same way that the cost of claims must be projected, the impact of any taxes and assessments must be estimated and included in prospective premium rates.

Secondly, the White House believes that these fees are intended to recapture part of the benefits from larger market share that insurers will receive as a result of the reforms. It believes that no one disputes that insuring nearly 30 million Americans who are not currently insured will increase consumer access to needed healthcare services – which translates into new business for insurers, drug companies, medical device makers and other providers. The White House also believes that this new revenue would far exceed the amount of the new fees – so if you believe that insurers will pass along the new assessment, you would also believe that they will also pass along their new windfall to consumers.[52]

While we all agree that it is vitally important to reduce the number of uninsured and get more Americans enrolled in some form of health insurance, the undeniable logic is that higher premium rates will make insurance less affordable and will lead to more citizens being uninsured.[53] This is a key finding of WellPoint's study and at the heart of the President's and our nation's goal in reforming health care in this country. As currently proposed, health reform is likely to increase the number of insured Americans.

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[50] Health Care Reform Premium Impact in Indiana. Page 1 http://www.wellpoint.com/pdf/Indiana%20Premium%20Impacts%20Analysis.pdf

[51] Testimony of Douglas Elmendorf to the Finance Committee, U.S. Senate, Hearing on September 22, 2009.

[52] The WHITE HOUSE Blog, *Reality Check: WellPoint Analysis Continues the Misinformation Campaign*, Posted by Jesse Lee on October 23, 2009 at 12:20 PM EDT http://www.whitehouse.gov/blog/Reality-Check-WellPoint-Analysis-Continues-the-Misinformation-Campaign

[53] Health Care Reform Premium Impact in Indiana. Page 8. http://www.wellpoint.com/pdf/Indiana%20Premium%20Impacts%20Analysis.pdf

Depending on which proposal gets enacted, this may result in higher membership for private insurance companies. However, this does not necessarily translate into increased revenues for insurance companies. Taxing one person's health insurance coverage to pay for another person's coverage is simply redistributing income and not addressing health care costs. Independent studies conducted by Milliman and others of markets where health plans were required to guarantee issue coverage indicate those markets quickly become dysfunctional.[54] We agree with the President when he said that unless we get everyone into the system, it won't work.

Finally, the White House asserts that

> The fees help improve and expand coverage and thus reduce the $1,000 hidden tax tens of millions of Americans pay for the uncompensated care of the uninsured. Even if you believed that somehow companies would find a way to pass the fees along, they would be more than outweighed by the benefits middle-class families would get from not only hundreds of billions of dollars in health care tax credits but from reducing the hidden tax they currently pay for the uninsured.[55]

Although $6.7 billion is a substantial sum, the reality is that it's a very small portion of the aggregate cost of uncompensated care, and virtually immaterial relative to the cost of covering the uninsured. We know, for instance, that most of the health care reform bill drafts would cost well over $1 trillion to cover just some of the uninsured.[56] The American Hospital Association has expressed concern that under the Senate Finance Committee proposal not enough currently uninsured individuals will become insured to mitigate uncompensated care. As a recent Politico article reported,

> First, the Senate Finance Committee moved forward with a vote on its health care reform bill, even though it violates the deal Chairman Max Baucus cut with hospitals to help fund it. The industry said it agreed to $155 billion in reduced Medicare payments if the bill provided insurance coverage to 97 percent of legal residents. Yet the bill introduced by Baucus, and the one that will be voted on Tuesday, only covers 94 percent of them.[57]

Raising funds by adding to the cost of health insurance, through taxes and fees, clearly won't solve a problem created by the current high cost of health care and, by extension, health insurance.

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[54] Wachenheim, Leigh and Hans Leida; *The Impact of Guaranteed Issue and Rating Reforms on Individual Insurance Markets*. July 10, 2007. Pages 2-3.
[55] The WHITE HOUSE Blog, *Reality Check: WellPoint Analysis Continues the Misinformation Campaign*, Posted by Jesse Lee on October 23, 2009 at 12:20 PM EDT http://www.whitehouse.gov/blog/Reality-Check-WellPoint-Analysis-Continues-the-Misinformation-Campaign
[56] http://www.cbo.gov/
[57] Frates, Chris; 'Health industry holds fire - for now," *Politico*. October 8, 2009. http://www.politico.com/news/stories/1009/28116.html#ixzz0VAmHQ1RR

When it comes to health care reform, we should not just get it done, but we should get it done right. The urgency of the health care crisis in today's economy calls for thoughtful, sustainable solutions. As the nation's leading health benefits company — covering 1 in 9 Americans through WellPoint's affiliated health plans — WellPoint has real-world, proven solutions to share. We not only know how to get health care reform done, but how to get it done right. WellPoint is currently advancing strategies to improve quality, which can help better manage costs and improve insurance coverage, and by working together with the government, employers, and providers, we can build a health care system that is accessible to all and provides quality care for those who need it most.

We believe that an essential ingredient for practical and sustainable health care reform is improving quality, which can help manage costs. There are many opportunities to improve health care in this country as we are far from having a system that provides the right care at the right place at the right time. Building on six principles, WellPoint has identified solutions that will deliver better health care while helping to reduce costs:

- Promote evidence-based medicine; determine real-world outcomes
- Advance health care quality by disseminating information throughout he system
- Focus on prevention and manage chronic illness
- Improve effective use of drug therapies to prevent and manage illness
- Promote strategies to reduce medical errors and adverse drug events
- Reduce costs through eliminating fraud, reducing costs related to litigation, and improving administration

Unfortunately, we do not believe that any of the current proposals meet the goals of increasing quality while bending the cost curve. As our analyses show, the various reform proposals instead only serve to exacerbate the problems that currently exist within the system while adding billions and trillions of dollars to the deficit that can only be paid for through increased taxes on an already overburdened health care system.

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[i] As costs go up (because richer benefits are required to meet the mandate requirements and the reform is not doing an adequate enough job of controlling costs), it will become more difficult for residents to purchase coverage. Thus more people will likely qualify for affordability waivers or subsidies. The same will hold true for employers who will drop coverage because of the economy. As more people lose access to employer-sponsored insurance, the more likely they are to be eligible for subsidies or hardship waivers.

Ultimately, as more people require subsides, the more difficult it will be for the reform to be sustainable over the long-term. It will also become more difficult for the state to enforce the mandate as coverage becomes further out of reach for people.

[ii] Massachusetts health reform has not emphasized cost containment, which is a necessary component of sustainable health reform. While the Connector Board has limited rate increases for coverage available through the Connector, this will not be sustainable over the long term if medical costs in the market are not addressed, especially given that Massachusetts has historically had the highest per capita personal health care expenditures of any state, largely driven by the prevalence of costly teaching hospitals in the Commonwealth. The Connector's Executive Director has stated that unless health care costs are brought under

control, “hospital rate setting may be needed.” Health care remains expensive, and as the National Association of Health Underwriters noted in their November 2008 update on Massachusetts Health Care Reform, “the reform will collapse under its own weight” if mechanisms for combating health care inflation are not put into place.

Endnotes

[iii] While Massachusetts has indeed increased coverage for its residents, controlling costs and improving quality have *not* been key areas of focus or areas of success, components which must be part of any holistically successful and sustainable health reform. Disease management and prevention have also not yet been key areas of focus or success for the Massachusetts program, which are critical elements for curtailing system costs (and thereby enabling successful and sustainable reform). While the Massachusetts Health Care Quality and Cost Council was formed in 2006, pursuant to the Massachusetts Health Care Reform Act [“to develop and coordinate the implementation of health care quality improvement goals intended to lower or contain the growth in health care costs while improving the quality of care…”], the Council has not yet taken aggressive action in these areas.

Additionally, any success Massachusetts has had in increasing coverage must be viewed within the context of the favorable pre-reform position the state was in, compared with other states considering health reform programs. Specifically, Massachusetts began their reform program with a low number of uninsured (~7%), readily available dollars (Medicaid, uncompensated care, DSH, etc.), and existing guarantee issue and adjusted community rating requirements within its individual market.

If you measure success only by looking at increased coverage for Massachusetts residents, the reform has made notable strides. Specifically, between June 2006 and March 2008, the program increased the number of Massachusetts residents with insurance by 439,000, and the Urban Institute estimates that the percentage of Massachusetts adults without insurance decreased from 13% down to 7% from 2006 to 2007. However, it should be noted that the majority of newly insured are in Medicaid or subsidized products. Thus it appears that generous subsidies have played the largest role in reducing the number of uninsured -- not the creation of a Connector, the establishment of an individual mandate and employer requirements, or the merger of the individual and small group markets.

[iv] The program has been more expensive than anticipated due to higher than expected enrollment in the Commonwealth Care program (for those with low-incomes who are eligible for subsidies). The cost for FY08 was originally budgeted at $472 million; a supplemental budget request brought that amount to $625 million. Governor Patrick included $869 million for Commonwealth Care in his budget for 2009 although the final costs could be closer to $1.1 billion. Additionally, as the National Association of Health Underwriters noted in their November update on Massachusetts Health Care Reform, when you look at costs of all programs which are part of Massachusetts Health Reform, combined, estimated FY 2009 costs could approach *$2.25 billion* (with approximately half of these dollars coming from Medicaid).