



HEALTH LAW COMMITTEE

STATEMENT OF PRINCIPLES FOR BIPARTISAN DEBATE AND DELIBERATION REGARDING HEALTH CARE REFORM LEGISLATION

INTRODUCTION

The statement of principles that follows was prepared by the Health Law Committee of the New York City Bar Association (“City Bar”). The City Bar is an organization of over 24,000 lawyers and judges dedicated to improving the administration of justice. The City Bar’s Health Law Committee addresses legal issues relating to the rights and welfare of patients and the betterment of our health care system and is comprised of a broad range of attorneys, from law firms to in-house counsel offices, as well as law students interested in pursuing a career in health care law. The members of the Health Law Committee represent clients from virtually all sectors of the health care industry, including not-for-profit and public academic medical centers and health systems, nursing homes, ambulatory care centers, home care agencies and hospice programs; pharmaceutical companies; health and managed care plans; as well as State and City governmental agencies.

The City Bar has undertaken to articulate a set of principles that, we hope, can help shape the terms and tenor of debate and deliberation going forward, and measure the likely success of any proposed health care reform legislation. Adherence to these principles should also help accomplish two important objectives: 1) the public will actually understand and have the opportunity to provide input on any proposed health care reform legislation; and 2) any legislation enacted by Congress will achieve both bipartisan support and the presumed shared goal of greater access to health care and broader coverage among Americans.

The Health Law Committee has distilled five core principles to guide any consideration of health care reform legislation proposed in the future. Apart from the first principle -- Ensuring the Integrity of the Legislative Process -- the remaining principles have in common the concept underpinning the ethics of the medical profession -- “first, do no harm.” That is, whatever the infirmities or shortcomings that beset the current state of health care law, any reform legislation should not undermine the gains already achieved, under the Affordable Care Act (“ACA”) or otherwise, in patients’ access to health care and health insurance coverage, and the means to finance needed care and coverage, while continuing to pursue innovative ways to contain costs and improve care outcomes going forward.

PRINCIPLES

1. Ensuring the Integrity of the Legislative Process.

It is axiomatic, and fundamental to the success of any democracy, that the laws and regulations governing the conduct of businesses as well as provision of government services be enacted through a legislative process that is both transparent and deliberative. Such a process tends to yield a better and fairer outcome for the various groups and constituencies impacted by legislation and, equally important, engenders public confidence in the legislative bodies entrusted to represent them.

For the reasons that follow, any legislation impacting Americans' health insurance coverage or access to care, through Medicaid or the public exchanges, should not be decided in summary fashion or behind closed doors, under the guise of "reconciliation" or otherwise. Nor should reform legislation be drafted in an informational vacuum, without a record developed to support that the action is in furtherance of stated legislative goals.

Adequate Time and Deliberation. Health care, it has been observed, represents one-sixth of the U.S. economy, and is a leading source of employment and economic stability in communities throughout the country. More fundamentally, health insurance and access to health care are matters of grave importance impacting the health and security of millions of Americans: the lack of coverage when illness strikes can deal a devastating blow to individuals and families struggling to stay afloat and healthy. See discussion in Principle 5.

The lack of meaningful health insurance presents, to many Americans, an intractable obstacle to realizing the full potential of the American dream. As such, it is essential that elected representatives devote the full time and attention this issue warrants, commensurate with its gravity and weight to the nation, so that Congress can arrive at a proposal or set of proposals that helps and does not harm their fellow Americans and constituents. At a minimum, neither house of Congress should approve legislation before the Congressional Budget Office ("CBO") has been able to score its impact on health coverage as well as the federal budget. On the other hand, self-imposed limits on debate or other perceived imperatives to fast-track health care reform legislation are incompatible with the heavy responsibility they bear to legislate in the best interests of the American public.

Hearings and Floor Debate. Rather, legislative proposals for health care reform should be the subject of public hearings before the relevant committees and debate on the floor of the House of Representatives and the Senate, so that all representatives have the opportunity not merely to read the bill, but to understand it, and to discuss and debate its merits and ramifications, with public input. Congress should schedule hearings and invite the key stakeholders -- insurers, health care providers, States and municipalities, and consumers and citizens -- to share their concerns and views about the legislation and its impact on their lives and businesses.

Evidence-Based Proposals. To date, the opposing camps on the health care debate have often invoked shibboleths and slogans -- for instance, "freedom of choice," or the "right to health care" -- to defend their positions or repudiate the opposition's, without ever concretely defining

these concepts, or weighing the real-world implications on lives, businesses or budgets. Continued reliance on platitudes tends only to divide parties even further, harden positions, and frustrate good-faith efforts at effective health care reform.

There now appears to be unanimity between the two political parties that health care is a more complicated issue. As such, it is important that Congress solicit, receive, and consider actual data and analyses, from actuaries, medical professionals, and others with specialized knowledge about health insurance and access to care, about the effectiveness and likely impacts of any proposed legislation, before they actually vote on the legislation.

At a minimum, hearings and debates, together with expert input and CBO scoring, will enable Congress to better understand and assess whether the provisions in any the health care reform legislation will actually accomplish, or undermine, the legislative goals articulated by the bill's sponsors.

No "Cornhusker Kickbacks." At the same time, we urge that the fate of any legislation impacting health care coverage and access to care, so critical to the lives and well-being of Americans, be decided on the merits. In the normal "give and take" of the legislative process, we are aware that a lawmaker or discrete groups of lawmakers may seek or demand changes in the legislation - unrelated to or even at the expense of greater health care insurance and access to care - that are specific to their priorities or agendas. However, in this instance, when the lives and security of Americans are at stake in relation to decisions affecting coverage and access to care, this type of legislative deal-making should not guide the passage of meaningful health care reform.

2. Avoiding Deleterious Impact on Health Care Access and Delivery Systems.

The key goals of health care reform have been and continue to be improving efficiency and access to health care through expanding choices. In order to achieve this reform, the legislation must focus on not only providing an insurance mechanism to pay for the delivery of health care services, but also ensuring that the health care delivery system is stable, is not disrupted, and is available to those who seek care.

The Health Law Committee recommends the legislators consider the following guiding principles.

- Ensure continued or enhanced access to health care to individuals and their families.
- Offer insurance plan options to health care consumers that are both comprehensive in scope and comprehensible to consumers.
- Abide by legislation creation and drafting norms: ensure public and health care industry engagement as part of drafting process.
- Establish clear guidelines for insurance plan coverage to prevent the free market exchange from delivering coverage products that result in a shrinking span of

coverage, rise in self-pay patient population, and erosion of employer based health insurance coverage.

- Establish actuarially sound mechanisms for financing health care and insurance coverage, to ensure that (i) the uninsured population does not increase and (ii) hospitals do not become the “insurer of last resort” bearing additional risk and greater losses for bad debt and charity care without any commensurate increased reimbursement or other compensation.
- Provide effective incentives to our citizens to be insured.
- Fund ongoing innovation and health care delivery transformation efforts to improve both the quality of health care and the efficiency of health care delivery systems.

3. Avoiding Deleterious Impact on State and Local Governments.

States and municipalities not only administer and share the cost of the Medicaid program. They are also on the front lines of the delivery of health care and, in many cases, serve as the “provider of last resort” for Americans struggling financially, and striving to stay healthy and receive needed medical care. Thus, in considering any legislation affecting health care insurance and access to care, Congress should seek to avoid any deleterious impact upon the delivery of health services as well as on the budgets of state and local governments throughout the nation.

What is more, states and localities carry retirement obligations beyond pensions, which are known as other post-employment benefits (“OPEB”). Most OPEB costs are dedicated to health care. Current health care law provides an opportunity for government employers to reduce OPEB liabilities and reduce costs. In particular, it gives flexibility to move former employees, especially those who retired before becoming eligible for Medicare, to state health exchanges. States can change the way they account for future OPEB liabilities. The law permits states to shift prescription drug costs to Medicare and raise drug subsidy discount rates. This has allowed states to pre-fund a portion of future liabilities by establishing Medicare Employer Group Waiver Plans (“EGWPs”).¹

Accordingly, Congress should approach any health care reform judiciously, and seek to avoid imposing any untoward consequences on State and local governments along with their budgets and programs.

4. Avoiding or Preventing Uncertainty in the Rules and Requirements for Health Benefits and Coverage, for Insurers and Individuals Alike.

At the outset, we note that industry and businesses as well as individuals expect, and need, to understand that current statutes and promulgated regulations governing health care and health insurance will be faithfully implemented and enforced, and government programmatic commitments fully funded. Such reliance is critical to planning lives and businesses and,

¹ “State Retiree Health Care Liabilities,” The Pew Charitable Trusts, May 2016, *available at* <http://www.pewtrusts.org/~media/assets/2016/05/stateretireehealthplanspending.pdf>.

specifically to the health insurance industry, setting plan premiums and reserves. Any action to amend existing health insurance or health care laws and regulations should similarly seek to avoid or prevent uncertainty about what the rules and requirements might be going forward, for both insurers and individuals.

Various health insurance senior executives, state insurance regulators, representatives of the National Association of Insurance Commissioners, and health care economists have asserted publicly that uncertainty has been the greatest cause of health insurers' withdrawal from the individual market to date. Annual rate filings for state exchange based insurance products are required to be made in accordance with the rules and regulations of the specific states where such insurance products are sold. Generally, these filings are required to be made well in advance of the calendar year end, and 2018 premium rates will need to be finalized in August. Not knowing what will happen to the exchanges where their products are sold, who the products may be sold to, what subsidies, if any, will be provided and accordingly, which rates to file, creates uncertainty.

Insurance companies do not like uncertainty. As a practical matter, insurers are simply not prepared to offer a class of products where there is no reasonable likelihood of ascertaining the underwriting outcomes. In the current environment, it is difficult, if not impossible, to file appropriate rates in light of market uncertainty. Given the choice between uncertainty of outcomes and withdrawing from the individual, exchange-based markets, many insurers have chosen to withdraw. Those that choose to stay in the market try to hedge against the uncertainty by filing for substantially higher rates, which has led to the dramatic escalation in premiums decried by some politicians (a fact that is not fully understood by the press or the public).

Moreover, current law prohibits an insurer from reentering an insurance market for at least five years once that insurer has withdrawn. This has the effect of compounding the consequences of uncertainty.

In addition to a narrowing of product offerings due to insurance market uncertainty, legislative measures that weaken incentives to purchase insurance are likely to result in an actuarial skewing of medical loss ratios, thus making it likely that premiums for an older, sicker insured population will rise significantly, as younger, healthier individuals no longer feel compelled to procure or maintain insurance through exchange based policies.

The transformation of Medicaid health care delivery from fee-for-service to managed care or value based models continues to progress. Thus, any proposal to change the level or formula for funding Medicaid should not impair the ability of health plans to deliver mandated services and maintain adequate capital reserves. Over the mid and longer term, those insurers that rely solely on Medicaid managed care, Child Health Plus and Family Health Plus, such as prepaid health services plans, may be forced out of business or to convert to, or affiliate with, another type of managed care organization and expand into other product lines, such as commercial insurance. Those options too may not be viable, though for different reasons, such as an inability to compete with national and "Blue" plans due to, e.g., an inability to provide networks in multiple states to large accounts.

5. Avoiding Loss or Erosion of Health Insurance Coverage.

Any loss or erosion of the level of insurance coverage achieved under current law would likely have serious, harmful consequences for many affected individuals and their families. Accordingly, the Health Law Committee submits that any health care reform legislation should not cause any such loss or erosion of coverage.

The lack of health care insurance presents a profound threat to the health and well-being of the uninsured and their families. The uninsured often do not obtain needed medical care due to its prohibitive cost. Moreover, uninsured individuals are more likely to defer routine and preventive care for their health problems or chronic conditions. When they do seek care and are forced to pay, the resulting medical debt for many can trigger financial setbacks, including a loss of credit, foreclosure, and personal bankruptcy.

The deleterious impact of inadequate insurance extends beyond those directly impacted by the prospect or the burden of unaffordable medical costs. Among other things, the costs of medical care delivered to the uninsured often become the bad debt or uncompensated care of hospitals and other health care providers already straining under reimbursement limits. Moreover, the uninsured frequently delay seeking medical care and only access the health care system when their underlying medical problems become acute, resulting in more expensive, and often avoidable, emergency care and hospitalizations, the cost of which, as noted, is ultimately borne by the health care systems - and taxpayers. Thus, maintaining or improving the extent of health insurance coverage is a critical component to any health care reform legislation so as to avoid or abate those bad outcomes, for both individuals and society at large.

Finally, any reform of health care insurance should strive to make health care coverage readily accessible, comprehensive in scope, and comprehensible to individual consumers, both when they are seeking to purchase insurance on the exchange and availing themselves of the plan's coverage. It is insufficient to offer plans that do not insure against the unexpected illness or medical need -- the very purpose of insurance -- or whose terms of coverage cannot be understood by Americans at the critical moment when the need for coverage arises.

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August 2017