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John R. Graham
Acting Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted electronically via CompetitionRFI@hhs.gov

Re: Promoting Healthcare Choice and Competition Across the United States—AHIP Comments

Dear Mr. Graham:

America's Health Insurance Plans (AHIP) appreciates the opportunity to provide comments in response to the Request for Information (RFI) from the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE) on Promoting Healthcare Choice and Competition Across the United States, published on December 26, 2017.

AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public/private partnerships that improve affordability, value, access and well-being for consumers.

We support the administration's goal to increase choice and competition across healthcare markets. Americans deserve good health coverage choices. Good coverage options help people manage their health to reduce the chances that they will have a major health problem later. Good options also protect Americans from having an injury or illness devastate them or their families financially.

Our recommendations focus on promoting the kinds of quality coverage options Americans want, options that:

- **Improve affordability** by addressing the rising costs of care and prescription drugs;

- **Improve patient satisfaction and value** by removing regulatory barriers that hinder the ability of health insurance providers to improve and expand the ways in which care is delivered;

- **Promote meaningful consumer choices that provide health and financial security** rather than approaches that splinter health insurance markets and/or expose American families to substantial risks when someone gets sick or has a serious medical condition; and

- **Provide consistent, stable, timely regulatory policies** that create a level playing field, both across and within market segments, and implement policies with adequate lead time for insurance providers and other stakeholders to incorporate them into business and operational plans.

Additional detail is provided in the attachment. We would welcome the opportunity to discuss our recommendations with you and others on the ASPE team.

Sincerely,

Matthew Eyles

Matthew Eyles
Senior Executive Vice President & Chief Operating Officer

Detailed Recommendations

(1) Address the Cost of Care

Health insurance premiums are driven by the underlying cost of medical treatments, services and products covered by the plan. These costs are typically a function of both the unit cost (i.e., price) of treatments and services and the amount (i.e., quantity) of services utilized. As the cost of services such as doctor's visits, emergency care and prescription drugs rises—often substantially from year to year or even quarter to quarter in the case of drug prices—the cost of health insurance premiums must necessarily follow and increase. Insurance providers may be hesitant to enter and/or remain in markets where they cannot offer the level of coverage people expect at a price they can afford. Policies that decrease competition among providers, including physicians, hospitals and health systems, directly cause higher premiums and make it difficult for insurance providers to offer affordable coverage that employers or individual consumers want.

A. Provider Consolidation and Acquisition

Provider-related costs account for about 60% of total premium costs covered by health plans.[1] Consumers benefit when health care providers compete to offer lower costs, higher quality services, and innovative approaches to delivering care. Empirical studies demonstrate that provider consolidation diminishes competition and results in higher prices and costs for consumers, reduces incentives for innovation and care improvement, and sometimes diminishes quality.

AHIP and its members have repeatedly emphasized that the actual *price* of care must be addressed in any efforts to make health care markets more competitive. Multiple research studies have found that consolidation in provider markets results in higher health care costs for consumers and employers. For example, a recent AHIP study showed that:

- Physician prices increased, on average, by 14 percent for medical groups acquired by hospital systems.

- Hospital mergers in already concentrated markets may result in hospital price increases of as much as 20 percent without any corresponding improvement in the quality of care.

- Local hospital ownership and multi-hospital health system ownership of provider groups resulted in per patient expenditures that were 10 percent to 20 percent higher than for patients seen at independently owned groups. [2]

[1] AHIP Infographic, Where Does Your Premium Dollar Go?, March 2017.
[2] AHIP Data Brief, Impact of Hospital Consolidation on Health Insurance Premiums, June 2015.

Several states and their residents have seen the impact of provider consolidation first hand:[3]

- In Georgia, insurance premiums were 35 percent to 52 percent higher in highly consolidated hospital markets compared to premiums for plans offered to residents in markets having less provider consolidation.

- In Missouri, people living in highly consolidated hospital markets paid 31 percent to 46 percent more than those in regions of the state with greater levels of hospital competition.

- In Ohio, premiums were 9 percent to 13 percent higher in the least competitive hospital markets compared to premiums in more competitive markets.

Federal antitrust agencies have challenged some mergers of hospitals and provider systems. Yet, a great deal of provider consolidation has occurred (often unreported and/or invisible to regulators for multiple reasons). Now, regions that previously had many independent physicians, physician groups, and hospitals are increasingly dominated by one or two dominant entities. In 2009, hospital ownership was already "highly concentrated" in more than 80 percent of 335 areas studied. Hospital mergers and acquisitions have continued at a rapid pace since that study, with 87 mergers documented in 2017 by the end of September. [4]

This accelerated trend in provider consolidation results in real harm to consumers from higher prices, reduced incentives to improve quality, and diminished innovation. If a provider transaction or series of transactions will lead to harm to consumers, it should be challenged. If a transaction, or a series of transactions, has already harmed consumers, the harmful effects should be addressed through enforcement, regulation, or removing regulatory enhancements to market power.

Recommendations:

- **Challenge anticompetitive provider consolidation.** More resources must be devoted to stopping anticompetitive provider consolidation before it happens.

- **Gather and analyze data on the consumer impacts of practice acquisition of small health care providers that do not currently trigger review by the Federal Trade Commission (FTC)**.

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[3] Ibid
[4] Kaufman, Hall & Associates, LLC, Hospital Merger and Acquisition Activity on a Pace to Potentially Exceed 2016, According to Kaufman Hall Analysis, October 17, 2017.

- **Pursue retrospective merger challenges and conduct challenges.** Agencies should challenge provider mergers retrospectively when there is a demonstrated record of harm and should pursue conduct cases when dominant providers have misused their market power.

- **Do not implement regulations that enhance or protect provider market power**. The agencies should advocate against policies, at the state and federal level, such as provider collective bargaining statutes, any willing provider statutes, certificates of need, certificates of public advantage, restrictions on telemedicine, and restrictions on retail clinics that protect or enhance provider market power.

B. Provider Networks

We agree with policymakers that companies should be encouraged to offer innovative ways to improve the care quality and patient satisfaction. Because we cannot predict what groundbreaking new ways to deliver and receive care will be invented, network adequacy requirements should be flexible enough not only to allow for options that may now be unfathomable but to encourage their development.

Building and managing provider networks are some of the most effective ways insurance providers can lower costs and ensure patients get high quality care. By agreeing to be in a health plan's network, providers can typically expect more patients—which positions them to offer their services at lower prices. Those lower prices, in turn, lead to lower premiums and out-of-pocket costs for consumers. Insurance providers also increasingly use networks to collaborate with providers to improve the quality of care for patients, provide patients with better information about their health and out-of-pocket costs, and change the way insurance providers pay doctors to reward higher quality care.

Federal agencies have long recognized that policies like any willing provider laws undermine insurance providers' ability to use networks to improve quality and affordability, and therefore they are not in the best interest of consumers. FTC staff have expressed concerns that any willing provider laws have harmful downstream consequences by making it unreasonably difficult for insurance providers to negotiate for lower prices, reducing incentives for plans to invest in plan designs and complex negotiations; and limiting competition by restricting the ability of insurance companies to offer consumers different plans, with varying levels of coverage, cost, and choice.[5]

[5] Id. See e.g., FTC Staff Comment to the Hon. Nelie Pou Concerning New Jersey A.B. A-310 to Regulate Contractual Relationships Between Pharmacy Benefit Managers and Health Benefit Plans (Apr. 2007), available at http://www.ftc.gov/be/V060019.pdf; FTC Staff Comment to the Hon. Terry G. Kilgore Concerning Virginia House Bill No. 945 to Regulate the Contractual Relationship Between Pharmacy Benefit Managers and Both Health Benefit Plans and Pharmacies (Oct. 2, 2006), available at http://www.ftc.gov/be/V060018.pdf; Letter from FTC Staff to Patrick C. Lynch, Rhode Island Attorney General, and the Hon. Juan M. Pichardo, Rhode Island State Senate (Apr. 8, 2004), available at http://www.ftc.gov/os/2004/04/ribills.pdf.

Network adequacy requirements do serve an important purpose. However, these requirements should not be conflated with any willing provider statutes. The appropriate role of network adequacy requirements is to make sure coverage options include enough providers to offer high-quality care to the people who use that network, not to ensure the inclusion of every provider in the area in every coverage option. To avoid the pitfalls of any willing provider statutes, network adequacy rules should be local, limited, and flexible. Any willing provider-like approaches, regardless of name or form, should be rejected.

Recommendations:

- **Keep network adequacy standards at the state level when possible**. This allows states to promote approaches adequately responsive to local markets, rather than a one-size-fits-all approach.

- **Take the least prescriptive approach necessary to network adequacy requirements to ensure consumer access to high-quality care**. State and federal network adequacy policies should be limited to specific enduring public health goals. They should not arbitrarily impede plan designs that improve affordability or the quality of care, such as tiered networks or high-value plans. They should also be flexible enough to allow plans to include new options in their networks, such as telemedicine and retail clinics.

- **Protect affordability for consumers when faced with "must have" providers.** Entities that are the only providers of highly specialized care in an area have the power to charge exorbitant prices that threaten cost and access goals. In those cases, policymakers should look at the situation holistically and ensure that the provider's terms for participating in the network do not undermine the community's interest in affordable coverage options.

- **Amend the Airline Deregulation Act so states can prevent air ambulance providers from demanding exorbitant prices from patients.** The federal Airline Deregulation Act appears to prevent states from acting to protect their citizens from egregious practices by air ambulance companies. The lack of state oversight for air ambulance companies is a growing source of unnecessary health care costs that drive up premiums. Due to the restrictions imposed by federal law, several states have struggled to implement policies to protect consumers from exorbitant surprise bills from air ambulance companies that can easily exceed $20,000.[6]

- **Modernize network adequacy requirements in Medicare and Medicaid to improve access to telehealth.** CMS should modernize the Medicare Advantage network adequacy

[6] The difficulties many states are facing with air ambulance are described in detail in this 2017 report. Consumers Union, Up in the Air: Inadequate Regulation for Emergency Air Ambulance Transportation, March 2017

criteria and exceptions process to account for innovative care delivery services such as telehealth or other treatment modalities. In addition, the Medicaid Managed Care Final Rule allows states to consider telemedicine options in determining that a Medicaid managed care organization's network is adequate; states should ensure their criteria allow for this option. Telemedicine is playing an important role in improving consumer health, including ensuring access to high quality, cost-effective care in rural areas that may lack an adequate supply of certain kinds of providers. We also recommend two related sets of changes: updating provider licensure laws and other requirements, which in some states create barriers to adoption of telemedicine; and having CMS interpret the use of telehealth as a mode of delivering the basic health care benefits covered under the Medicare fee-for-service (FFS) program, which will expand the ability of Medicare Advantage plans to cover such services.

C. Rising Drug Costs

Spending on prescription drugs continues to grow at a rapid and unsustainable rate. Prescription drug prices are out of control, which is a direct consequence of pharmaceutical companies taking advantage of a broken market for their own financial gain. The lack of competition, transparency, and accountability in the prescription drug market has created extended, price-dictating monopolies that exist nowhere else in the U.S. economy.

When drug companies can extend and abuse the exclusivity provided under patent law or other federal laws, they prevent competitors from entering the market and protect their ability to obtain monopoly prices. The end result is that everyone pays more—from patients, businesses and taxpayers to hospitals, doctors, and pharmacists. Rising prescription drug prices are a barrier in increasing choice and competition in the health coverage options available to Americans.

Recommendations:

- **Identify and address existing challenges that block or slow entry of generics into the market.** Policies that reduce or prevent generic drug competition also result in increased costs for consumers. By ensuring that true competition exists in the form of generic alternatives, consumers and taxpayers can experience lower costs and better affordability for prescription drugs. For example, the FDA should be provided the necessary resources to clear the backlog of generic drug applications, particularly for classes of drugs with no or limited generic competition.

- **Promulgate regulations that create and promote a robust safe biosimilars market.** Though biosimilars offer great promise in generating cost savings for consumers, some of the costliest and most widely-used biologics have been on the market for decades without biosimilar competition. It is important to ensure that the FDA, state governments, and other government entities (e.g., state boards of pharmacy) promulgate regulations that promote a

robust biosimilars market or do not inhibit competition. A more detailed list of AHIP recommendations for promoting a robust biosimilars market can be found in our December 2017 comments to the FTC.[7] Such concerns only increase with the growth of biosimilars and it is important that the FTC have the tools and information necessary to challenge pay for delay agreements in this realm as well

- **Require drug pricing transparency.** Nearly all other participants in the health care sector have to be accountable for their prices and actions, and drug manufacturers should not continue to be exempt from that fundamental rule. As part of the FDA approval process, manufacturers should be required to disclose information regarding the intended launch price, the use of the drug, and direct and indirect research and development costs. After approval, manufacturers should provide appropriate transparency into list price increases.

- **Evaluate direct-to-consumer advertising impact.** Nine out of the ten biggest pharmaceutical companies spend nearly twice as much on sales, marketing, and advertising than they spend on research and development. We urge the HHS to assess the impacts of the growth in direct-to-consumer advertising, particularly broadcast advertising, and evaluate the best approaches for conveying information to consumers. As part of this assessment, it is important to examine the impact of direct-to-consumer advertising on physician prescribing behavior and/or its effect on generic drug availability and utilization.

- **Prohibit "product hopping."** Product hopping is a strategy for driving drug company profits. Drug manufacturers withdraw a drug from a market and introduce a newer version with minor changes - thereby preventing the entry of a generic substitute that will cost less. Product hopping has resulted in an insulin drug that has been widely available for the last 90 years, that only has brand-name options costing hundreds of dollars per prescription.

- **Prohibit anti-competitive "pay for delay" settlements.** Drug companies engage in anticompetitive settlements with generic manufacturers that prevent generics from entering the market in a timely manner. The FTC estimated that these agreements are costing consumers $3.5 billion per year and concludes that "'pay for delay' agreements are a 'win-win' for the companies: brand name pharmaceuticals stay high, and the brand and generic share the benefits of the brand's monopoly profits."[8] The Congressional Budget Office estimated that prohibiting these settlements would save the federal government $3 billion over ten years and would accelerate the availability of lower-priced generic drugs.[9]

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[7] AHIP comments regarding "Federal Trade Commission Workshop on Understanding Competition in Prescription Drug Markets: Entry and Supply Chain Dynamics," December 2017.
[8] Federal Trade Commission Staff Study. "Pay-for-Delay: How Drug Company Pay-Offs Cost Consumers Billions," January 2010.
[9] Congressional Budget Office Cost Estimate: S. 2019, Preserve Access to Affordable Generics Act. October 2015.

- **Give insurance providers enough flexibility in managing formularies in Medicare Part D by allowing for one drug per therapeutic class to be covered by a plan.** Though Part D plan sponsors vigorously negotiate with drug companies for the best rebates and discounts for Part D covered brand drugs, policies such as the two drug per class requirement stunts competition in the Part D program and removes important leverage that plans can use to reduce costs for consumers and taxpayers.

- **Provide more flexibility for Medicaid managed care organizations to manage drug formularies.** We urge the federal government and states to remove unreasonable restrictions that prevent insurance providers from managing their own preferred drug lists and using effective medication management techniques available in commercial health coverage and the Medicare program. This would help insurance providers manage drug costs more effectively for states, while still maintaining high standards of access for beneficiaries to necessary drugs.

D. Challenges in Rural Communities

Across product lines, choice and competition challenges are most pronounced in rural areas. Specific challenges to entering health insurance markets in rural areas include: a lack of providers; populations too small to support a robust health insurance market; increasing prevalence of chronic conditions and the opioid epidemic. Policymakers should consider policies to promote choice and competition in rural communities specifically.

Recommendations:

- **Provide exceptions to network adequacy requirements.** State regulators should work with insurance providers to address network issues that make it difficult to offer coverage to rural communities. For example, states should permit insurance providers to offer products in rural areas that cover non-emergency care in the nearest urban area even when the distance to that urban center exceeds typical time and distance standards. States should also expand and enhance options to include telemedicine services in coverage for rural communities.

- **Reduce taxes or create other federal or state tax incentives for companies offering coverage in rural areas.** States can work with insurance providers to provide financial incentives for service areas that are challenging to serve due to small populations or lack of a sufficient health care workforce.

- **Support state 1332 waivers to address inadequacies/problems in rural areas.** States should develop innovative and state-specific programs to help secure access to health care coverage in rural communities or other hard to serve areas of a state.

(2) Promote a Level Playing Field for High Quality Coverage Options

The keys to promoting choice and competition within a health insurance market are broad-based enrollment and a stable regulatory environment that facilitates a level playing field. More companies will participate in an insurance market if that market attracts a broad mix of consumers. Policies that encourage healthier or younger people to disproportionately leave a market will destabilize that market leading to less competition, reduced choice, and higher premiums.

When considering how to promote choice and competition, we must remember that Americans have common expectations on what health insurance should cover. People expect that things like doctor's visits and trips to urgent care will be covered whether they are related to a new or on-going health issue. Those expectations have been established through the experiences our nation has had over several decades with large group employer-sponsored coverage – where about 155 million people get their coverage today. Public debate related to health insurance is usually focused around products sold directly to individuals and families that are subject to federal laws that define what "individual health insurance" is. When the maximum possible number of people in America are covered by health insurance that meets or exceeds this basic standard, individual health and well-being improves, and health care is more affordable for everyone.

The cost-of-care issues described above must be addressed to increase choice and competition in all insurance markets. In this section we provide additional market-specific recommendations for increasing choice and competition.

A. Individual and Small Group Markets

Approximately 18 million Americans are enrolled in "individual market" coverage that they purchase for themselves. Another 17 million are enrolled in coverage provided by a small employer.[10] Recent concerns about the number of affordable coverage options available in some areas are largely focused on the individual market. CMS reports that in 2018 approximately 2 million consumers enrolled in coverage purchased on an exchange live in a county where only one company offers individual market exchange coverage.[11]

The individual and small group markets are governed by many state and federal rules that apply only to these markets, as well as some rules that apply to large group plans too. Most state and

[10] For health insurance purposes, an employer is defined as a "small group" if they employ fewer than 50 employees in most states. The following states define "small groups" as employers with fewer than 100 employees: California, Colorado, Maryland and New York.
[11] CCIIO, County by County Analysis of Plan Year 2018 Insurer Participation in Health Insurance Exchanges, October 20, 2017.

federal rules and regulations applied to these markets are intended to ensure individuals and small businesses have access to coverage that truly covers comprehensive medical care similar to typical large group employer-sponsored coverage.

Current federal law requires that insurance purchased in the individual or small group market include: coverage for preventive care services; ten categories of essential health benefits (EHBs); and caps on what the enrollees will spend out of their own pocket for covered health care services. Companies must sell an individual market policy to any applicant who lives in the area where the plan is available for purchase regardless of the applicant's health status. For small groups, the insurance company must sell a policy to any business in the plan's service area that qualifies as a "small group." People who buy individual or small group coverage cannot be charged a higher premium because of health conditions they already have.

Several recent policy proposals promote changes to federal law or regulations that would encourage healthy people to abandon the individual and small group markets in pursuit of alternative coverage that does not meet individual or small group health insurance requirements. Recent proposals include but are not limited to: allowing small businesses and sole proprietors to obtain coverage through an association health plan; relaxing limits on short-term limited duration insurance and permitting health care sharing ministries to be eligible for federal financial assistance. These proposals pose a danger of disproportionately redirecting healthy consumers away from the individual and small group markets, which will reduce the number of choices available for the kind of coverage Americans expect.

Recommendations:

- **Preserve distinctions between health insurance products that provide the minimum coverage Americans expect and those that don't.** Americans buying their own coverage expect "health insurance" to cover certain kinds of health services such as doctor's appointments, urgent care and prescriptions even if the care is for a condition they had before they got the insurance. Changes to federal policy should not blur the lines between health insurance products that provide coverage for basic health services regardless of a person's existing health status and those that do not, such as short-term, limited duration insurance (STLDI) or membership in a health care sharing ministry.

- **Do not implement policies that promote adverse selection in the individual market.** Any policy that decreases the number of consumers shopping for individual market coverage will decrease the demand for products and as a result decrease the supply (i.e. choice and competition) in that market. Policies that disproportionately draw healthy consumers away from the individual market have an even more devastating effect on choice and competition. This adverse selection drives up premiums and exacerbates affordability issues for people who aren't eligible to buy other kinds of coverage because of an existing health condition.

AHIP will provide detailed comments on our concerns about adverse selection related to association health plans separately in response to the notice of public rule making on "Definition of "Employer" under Section 3(5) of ERISA -- Association Health Plans."

- **Do not promote products that are not comprehensive medical insurance as a substitute for comprehensive medical insurance.** Recent policy proposals have suggested that choice and competition would be improved by allowing insurance companies to promote products that do not cover care for pre-existing conditions or essential health benefits as an alternative to coverage classified as "individual health insurance" under federal law. Consumers who lack coverage that meets this basic definition are exposed to large financial risks if they have an unexpected health issue. A regulatory approach aimed at moving consumers out of the individual market risk pool onto alternative products will not increase options for the kind of health insurance Americans really want. In fact, due to adverse selection, it will have a catastrophic impact on premiums for the kind of coverage Americans want. To this point, AHIP will be providing specific detailed comments in response to the proposed rule on short-term, limited duration insurance that is expected to be issued by CMS shortly.

- **Propose new regulations regarding third party premium payment rules, providing transparency to allow payments from appropriate charities while freeing insurance providers of the requirement to accept premium payments from entities with a financial interest in the enrollment**. People should be enrolled in the health insurance program that best meets their needs, not because it offers higher payments to some providers. People who are eligible for public programs (e.g., Medicare and Medicaid), which offer additional benefits and services, should not be inappropriately steered into the individual insurance market. Further, we recommend that HHS guidance specifically allow insurance providers to reject third party premium payments in such situations. On a related note, HHS should require transparency into the use of drug "coupons" or co-pay cards by requiring manufacturers to report on their use by insurance market.

- **Implement policies that reduce uncertainty in the individual insurance market.** AHIP has commented at length on our recommendations to reduce federal uncertainty that destabilizes the individual health insurance market. Those recommendations include (but are not limited to): establishing a reinsurance program; meeting all government funding obligations related to programs like risk corridors and cost sharing reductions; and providing relief from burdensome taxes. Rather than reiterating those detailed recommendations in this letter, we refer stakeholders to AHIP's September 6, 2017 statement on "Stabilizing the Individual Health Insurance Market" provided to the Senate Committee on Health Education, Labor and Pensions.[12]

[12] AHIP's statement on "Stabilizing the Individual Health Insurance Market" provided to the Senate Committee on Health Education, Labor and Pensions, September 2017

B. Employer Sponsored Insurance – Large Group

Approximately 155 million Americans are enrolled in "large group" coverage that is subsidized, at least in part, by their employer. Participants in large group plans report high satisfaction with their coverage. Enrollment in large group plans is consistently stable, and premium increases have been more manageable and predictable than premium increases in other markets. Large group coverage is impacted by the cost of care issues described above and addressing those issues would mean premium savings for large group plans.

Employer plans have long been the incubators for new coverage options in other markets. Many innovative health coverage features, such value-based insurance design and wellness programs, were designed for and tested by large group plans. Employers have natural incentives to seek out high quality affordable care on behalf of their employees. According to Mercer's National Survey on 2016 Employer Sponsored Health Plans, 89 percent of employees surveyed say their health benefits are as important to them as their salary.[13] Employers also benefit from increased productivity and workplace satisfaction when their employees are healthy. For these reasons, insurance providers and administrators working with employer groups have found employers to be willing partners in developing innovative health coverage products.

Large groups can collaborate with insurance providers and administrators to offer customized innovative coverage in a way that's not possible for individuals and small businesses for several reasons. First, large employers can afford to invest resources towards understanding and influencing their coverage in ways that increase the plan's value to their employees. Second, the large number of enrollees that will be guaranteed to enroll on the plan allows insurance providers and administrators to devote resources to customizing the coverage to the employers' specifications. Third, employers have specific opportunities to make returns on their investments in innovative health coverage in the form of improved employee health and satisfaction. For these reasons, unique opportunities for large employers to drive innovation cannot be easily replicated in other markets in the absence of a bona fide employer relationship.

Policymakers should continue recognizing that there are good reasons for federal and state requirements for large group coverage to differ from requirements for individual or small group coverage.

Recommendations:

- **Pursue policies that encourage workplace wellness programs.** Allow meaningful incentives for plan participants that participate in employer-sponsored wellness and condition

[13] Mercer, Mercer National Survey of Employer-Sponsored Health Plans 2016, April 2017.

management programs and reduce administrative burden for employers that offer those programs.

- **Allow greater incorporation of innovative large group plan features into products sold in the individual and small group.** State and federal regulations for the individual and small group markets should be flexible enough to allow state regulators to waive certain requirements for individual and small group market products when the product includes an innovative feature that has been proven effective in large group plans.

C. Medicare

Approximately one third of Medicare beneficiaries – nearly 20 million individuals - have chosen to enroll in a Medicare Advantage plan and the popularity and number of beneficiary plan choices continues to grow. Medicare Advantage plans lead the way in innovative, patient-centered care. Furthermore, plans provide health and financial security by limiting out-of-pocket costs and work to address the needs of low-income and vulnerable individuals. The program fosters beneficiary choice and promotes competition both between Medicare Advantage and Medicare fee-for-service (FFS) and amongst plans. The following recommendations would serve to encourage even greater competition and more consumer choice.

Recommendations:

- **Enhance the Medicare Plan Finder to allow improved comparison of Medicare Advantage plans and FFS.** The Medicare Plan Finder allows Medicare beneficiaries to compare Medicare Advantage and Part D options where they reside, but the site remains difficult for beneficiaries and family members to navigate. CMS should improve Plan Finder to enable beneficiaries to more completely compare Medicare Advantage plans with the FFS option.

- **Require beneficiaries to actively choose between Medicare Advantage and FFS at initial enrollment.** When first enrolling in Medicare, individuals are not required to make an active choice between FFS Medicare and Medicare Advantage and beneficiaries who do not make an active choice are auto-enrolled in FFS Medicare. Individuals should be required to make an active selection into Medicare Advantage or FFS when first enrolling in Medicare.

- **Recognize Medicare Advantage as an advanced alternative payment model.** CMS should move forward with the demonstration discussed in the final rule for Year 2 of the Quality Payment Program established by the Medicare Access and CHIP Reauthorization Act of 2015 and allow physicians that participate in value-based arrangements with Medicare Advantage plans to see the same payment benefits as physicians participating in one of the CMS designated Advanced Alternative Payment Models.

D. Medicaid

More than 70 percent of the nation's 74 million Medicaid beneficiaries receive some or all of their care from a Medicaid health plan. Insurance providers develop strong provider networks that offer improved access to high quality primary and preventive care services for Medicaid beneficiaries, together with improved care coordination. These strengths allow insurance providers to help states control escalating program costs and achieve high value for their Medicaid dollars. However, certain state and federal policies create unintentional barriers to controlling costs, promoting access to care and assuring adequate competition in Medicaid markets. The following recommendations would begin to address some of these challenges:

Recommendations:

- **Facilitate access to Home and Community-Based Services (HCBS) through revisiting state certificate of need (CON) laws and providing sufficient funding for providers.** At the state level, these laws may create barriers to competition and the introduction of lower cost alternatives to traditional care. For example, CON laws in one state were identified as a barrier to the expansion of home and community-based services as an alternative to institutional long-term nursing care. Home health agencies were unable to expand into new counties because nursing homes operating in those counties were given standing in the CON review process to object to new market entrants. Additionally, the supply of HCBS providers especially personal care attendants, is an issue in many states, given historically low rates of pay and the demanding nature of these jobs. We urge continued support for adequate funding of Medicaid, which is necessary to support sufficient rates for HCBS providers.

- **Create a level playing field between Medicaid Managed Care and FFS Medicaid.** We recommend CMS remove regulatory barriers and disincentives faced by states wishing to move their Medicaid program to managed care. For example, modernize the upper payment limits calculation formula to account for: 1) utilization and services from all eligible providers, whether paid through FFS or by Medicaid managed care plans; and 2) state-directed pass-through payments specified in managed care contracts. In addition, scheduled phase-outs of pass-through payments not tied to utilization should be applied in FFS programs on the same schedule as in managed care.

E. Selling Insurance across State Lines

Selling individual and small group health insurance across state lines has been proposed by some stakeholders as a solution to competition, choice and affordability issues in those markets. While the federal law already allows health insurance to be sold across state lines through the creation of inter-state compacts, the option has not been largely embraced by states or pursued by insurance companies.

As long as Americans expect their coverage to pay for them to see a doctor near where they live or work, the affordability issues stemming from the actual cost-of-care are inherently local and cannot be circumvented by changing the location where the policy was sold. Proposals suggesting that affordability issues can be easily addressed by doubling down on federal permission to sell insurance across state lines completely overlook the central challenge to providing greater choice and competition in health coverage – the cost of the care that is covered where the consumer lives.

Recommendations:

- **Reject policies to promote the sale of insurance across state lines.** Promote greater flexibility for states to regulate their insurance markets and reject policy proposals that diminish state authority over their own markets. Avoid pre-emption of state laws and regulations, especially those designed to address states' issues and health care costs, and to increase access to affordable options and insurance.

- **Do not repeal the McCarren-Ferguson anti-trust exemption.** The McCarren-Ferguson anti-trust exemption does not prevent the sale of insurance across state lines as has been suggested by some stakeholders. Repealing the exemption would increase health care costs and stymie collaboration by states and insurance companies to find state-specific solutions.

F. Financial Health and Wellness Products

There are many health-related insurance products that complement comprehensive medical coverage by promoting wellness and/or protecting enrollees against financial risks that are not addressed by comprehensive medical coverage. Consumers consistently express very high satisfaction with these products.[14]

Policy makers recognized that there are several health-related insurance products that are distinct from comprehensive medical coverage and that should not be subject to the same requirements as that type of coverage when they drafted the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Congress expressly excepted an array of benefits from HIPAA's new federal requirements for health insurance. These "HIPAA-excepted benefits" include: dental coverage; vision coverage; disability income protection; long-term care coverage; Medicare supplemental coverage; and supplemental coverage (e.g., critical illness, specified disease, and hospital indemnity coverage).

[14]AHIP, Every Family Deserves Financial Health and Wellness Protection, August 2017.

In recent years, requirements that are meant to apply to major medical coverage have occasionally been erroneously applied to these products. To ensure these popular options continue to be available to consumers, policy makers should take on-going care to make sure requirements intended to apply to comprehensive medical coverage are not applied to these excepted benefits.

Recommendations:

- **Ensure that future rulemaking maintains a bright line distinction is between HIPAA Excepted Benefits and comprehensive medical coverage.**

- **Conduct a review of federal rules impacting pediatric dental and vision coverages to remove unnecessary administrative burdens that drive up costs for consumers.**

- **Make changes to conform the regulations for group hospital indemnity and fixed indemnity to the requirements for individual market hospital indemnity and fixed indemnity.** The statutory provisions defining excepted benefits have remained unchanged since HIPAA, but recent regulatory and sub-regulatory guidance under the ACA have created confusion and potential uncertainty, given current differences between the rules for HIPAA excepted benefits in the group versus individual markets.[15]

[15]Current regulations permit hospital indemnity and other fixed indemnity excepted benefits sold in the individual market to pay benefits on a per period and/or per service basis (e.g., $100 per day of hospitalization; $50 per doctor visit). However, prior FAQs (ACA FAQ Set 11, Q 7 (Jan. 24, 2013), FAQ Set 18, Q11 (Jan. 9, 2014)) indicate that in the group market such benefits can only be paid on a per period basis. The prior Administration proposed a change in the group market regulations to follow up on the FAQs. While the prior Administration ultimately decided not to change the regulations based on comments received, confusion remains given the FAQs and the differences between the regulations in the group and individual market. Conforming the group market rules to the individual market rules would be more consistent with the statute than the current group market rules, would eliminate confusion between the group and individual market (particularly for individuals who move between markets), and continue the traditional role of states in regulating these products.