



Stabilizing the Individual Health Insurance Market

by

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**for the
Senate Committee on Health, Education, Labor and Pensions**

February 1, 2017

I. Introduction

Chairman Alexander, Ranking Member Murray and members of the committee, I am Marilyn Tavenner, President and CEO of America's Health Insurance Plans (AHIP). AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. The coverage and benefits that our members offer 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 every consumer.

We appreciate this opportunity to testify about the actions that are needed to stabilize the individual health insurance market. It is clear that certain parts of the Affordable Care Act (ACA) have not worked as well as intended, especially for individuals who purchase coverage on their own. This year, many consumers face fewer health plan choices and significant increases in average premiums. These increases have been driven by underlying growth in medical and prescription drug costs as well as the sunset of the transitional reinsurance program. In addition, we know how bureaucratic rules, requirements, and red tape have complicated the market. Ineffective regulations have raised costs and limited choices for consumers leaving hard-working Americans struggling to make ends meet. We have witnessed firsthand how higher costs are a barrier to access and the sustainability of the delivery system – and we are committed to working with you to fix this.

At the same time, the ACA has succeeded in expanding coverage to 20 million Americans and the percentage of Americans without health insurance has dropped to historical lows—down from 16.0% in 2010 to 8.6% in 2016.¹ These gains have been achieved through the expansion of Medicaid as well as through the coverage offered in the ACA exchange marketplace.

Our members have long supported an approach to health care that brings as many people as possible into the system. Broad coverage improves the availability and affordability of health insurance coverage options. While the challenges of providing broad access to affordable choices remain significant, we are strong believers in private-sector solutions. Health insurance plans have a proven track record of providing more affordable, high quality, efficient choices. As just one example, America's seniors and disabled persons in the Medicare Advantage and Part D programs have benefited tremendously from innovations advanced by our members. Our plans deliver better value, better services, and better results for beneficiaries and taxpayers alike.

¹ Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-March 2016. <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf>

Health insurance plans also provide coverage to 70 percent of all Medicaid beneficiaries. These plans promote better care coordination for patients with chronic conditions, improve health outcomes, and maximize efficient use of public funds.

Together we have an opportunity to deliver the same level of success in the individual market. We have an opportunity to improve the individual market for years to come, so that consumers have access to quality, affordable coverage that best meets their specific needs. I am here today to offer our recommendations for short-term solutions that can deliver long-term benefits for consumers: lower costs, more choices, and better quality care. An effective transition can deliver a strong, stable market that will help ensure public confidence, encourage them to participate in the market, and increase the health care access and financial security that the American people deserve. I will focus on two key priorities:

- The immediate policy steps that can help deliver an effective transition and continuous coverage.
- The long-term principles for lasting improvements that can deliver real choice, high quality, and access to affordable care in the individual market.

II. Immediate Steps for Stabilizing the Individual Market

As the American people think about the care and coverage they want and need, they are looking for strong signals that the individual health insurance market will remain viable this year, next year and for the duration of any transition period. There are several steps that can be taken to ensure that Americans have quality coverage options as policymakers and industry collaborate to build an improved, sustainable health care system.

First and foremost, we need to ensure that consumers have quality coverage options. This market continues to face challenges, and additional market uncertainty will likely exacerbate these challenges. But strong signals of certainty can help stabilize the market, avoiding even higher costs and fewer choices. Specifically, we recommend:

- **Continuing to provide subsidies such as the advanced premium tax credits (APTC) and cost-sharing reduction (CSR) payments in their entirety.** The absence of this funding would further deteriorate an already unstable market and hurt the millions of consumers who depend on these programs for their coverage.

- **Making full federal reinsurance payments for 2016.** This funding is important for plans to effectively cover the needs of high-need patients, including those with chronic conditions.

While these policies are critically important, they by themselves are not sufficient to ensure a stable and workable transition for consumers and patients. This is especially the case if the requirement to have insurance or pay a tax penalty is eliminated this year without workable alternatives to promote continuous coverage and market stability. As long as current market rules that prohibit the exclusion of pre-existing conditions, require guaranteed issue of insurance policies and impose community rating requirements on insurers remain in place, there is a corresponding need for incentives for people to purchase and keep continuous coverage.

Our members have strongly supported an approach to health reform that brings everyone into the system. Broad coverage can ensure the availability of affordable options. Health insurance only works when everyone is covered: those who utilize insurance to obtain quality care as well as those who are healthy but have insurance to protect them in case they get sick. Both types of consumers must be insured for coverage to remain affordable. The following policies can work to help promote a more stable and workable transition for consumers and families.

- **Using premium tax credits to encourage younger people to get coverage.** There is no question that younger adults are under-represented in the individual market. Recalibrating and reforming the way in which the current APTC subsidy is structured will encourage younger Americans to get covered. This will strengthen the risk pool, expand coverage, and avoid increasing premium costs for everyone. We propose modifying the existing tax credit formula to factor in age bands, based on a 5:1 ratio, thus adjusting the required individual contribution amounts for individuals with incomes between 100 and 400 percent of the federal poverty level (FPL).
- **Creating incentives for people to keep their coverage through the transition.** Absent the establishment of alternative solutions to promote continuous coverage, the elimination of the tax penalties associated with the individual coverage requirement would likely create further market instability, raise costs for insurance, and result in the loss of coverage for millions of Americans. We recommend that continuous coverage requirements be communicated to enrollees this year to encourage enrollment during 2018 open enrollment and to prevent individuals from dropping their coverage. All eligible consumers should be allowed to enroll during 2018 open enrollment regardless of current coverage status without continuous coverage incentives or penalties. Beginning

in the 2018 benefit year, special enrollment period (SEP) enrollees must meet continuous coverage requirements, defined as 12 months of creditable coverage. For individuals without continuous coverage, potential policy options include adopting late enrollment penalties and/or waiting periods similar to Medicare Part D.

- **Establishing transitional risk pools starting in 2017.** A federally funded, transitional risk pool program would offset some of the costs of serving patients who have the most complex health conditions and need the most care—to help promote market stability. Guidelines for how payments will be determined would be established by the Department of Health and Human Services (HHS), and payments would be based on available funding. States could have the option of administering their own risk-pool program, subject to approval by HHS.
- **Providing relief from taxes and fees that hurt consumers.** Eliminating taxes and fees such as the health insurance tax, will reduce premiums and promote affordability. Although Congress has taken action to suspend the health insurance tax for 2017, the most recent estimates from the Congressional Budget Office (CBO) indicate that this tax, if it goes back into effect in 2018, will impose additional costs of \$156 billion over the next decade (2016-2026)². According to an analysis by Oliver Wyman, repealing the HIT would have as much as a three-percent impact on premiums for 2018 – reducing premiums by an average of \$220 per year.³
- **Effectively verifying the eligibility of those signing up for coverage during special enrollment periods, and shortening the 3-month grace period for non-payment of premiums so that it is better aligned with state laws and regulations (e.g. 30-day period).** The market must be fair if it's to be affordable. While most consumers play by the rules, many do not – and that raises costs for everyone. Too many Americans have incentives to game the system by applying for coverage only when they need care. We must eliminate opportunities for fraud if we are to make care more affordable for everyone.
- **Protecting people who are eligible for public programs from being inappropriately steered into the commercial insurance market.** People should be enrolled in programs

² <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline.pdf>

³ Oliver Wyman—Estimated Impact of Suspending the Health Insurance Tax from 2017-2020. December 16, 2015. <https://ahip.org/wp-content/uploads/2015/12/Oliver-Wyman-report-HIT-December-2015.pdf>

that are designed for them. Many people enrolled in Medicare or Medicaid receive additional protections and non-medical services that are not typically available in individual commercial coverage. Inappropriately steering people into a commercial market that does not meet their needs – through third-party payments of premiums and other mechanisms – is inappropriate and unfair to the patient, and creates further imbalance in the risk pool that leads to increased costs for everyone. Patients should have the coverage that best meets their needs, not the financial interest of providers. To that point, the recent district court decision enjoining, on procedural grounds, the new CMS rule requiring patient education of dialysis patients and notice of intent to make third party payments is a setback for patients, consumers, and the stability of the marketplace.

Throughout the discussions on short term solutions and a stable transition, we must provide plans sufficient time to adjust products. Under current federal rules, health plans must file individual and small group exchange products for the 2018 marketplace by May 2017. Health plans should have sufficient time to modify products and pricing to reflect any changes that policymakers may make.

III. Principles for the Development of Long-Term Reforms to the Individual Market

As stated above, the most immediate need is to deliver an effective transition that ensures continuous coverage. We can achieve that goal by working together to develop and deliver smart solutions. The solutions outlined here will allow us to build a strong, stable individual market that serves our citizens well. As Congress and the Administration debate long-term reforms for strengthening the individual market, we have identified several key principles for ensuring a stable, competitive market that delivers real choice, high quality, and affordable care.

1. **Bringing down the cost of care and coverage.** Rising healthcare costs have been a financial burden for too many families for too long. From out of control drug prices to bureaucratic regulations to outdated payment models, we need effective solutions that bring down the cost of care for families. More market competition, better coordination, using evidence-based medicine, and prioritizing value can deliver the affordable coverage and quality care that every American deserves.
2. **Guaranteeing access to coverage for all Americans—including those with pre-existing conditions.** No individual should be denied or priced out of coverage because of their health status. However, with this as a principle, modifications to existing insurance reforms are needed—e.g. such as greater state flexibility to adopt wider age-bands to make

coverage more affordable to younger adults—while retaining core insurance reform elements that guarantee access to coverage for those with pre-existing conditions. However, in order to ensure these reforms work effectively, they would need to be coupled with strong incentives for individuals to maintain continuous coverage.

3. **Promoting public policies that encourage individuals to purchase and maintain continuous coverage.** Strong, stable markets are the result of everyone having coverage – those who utilize insurance to obtain quality care and those who are healthy but have insurance to protect themselves in case they get sick. We need effective incentives to encourage consumers to get and keep insurance so coverage can be affordable for everyone.
4. **Implementing more effective risk pooling programs.** An improved and reformed risk-adjustment program and permanent federal funding for state-based risk pool programs, such as reinsurance, will improve risk sharing and deliver more market stability.
5. **Assuring adequate and well-designed tax credits to promote access to affordable coverage.** Any new coverage options will be meaningless if consumers cannot afford them. Those who live paycheck to paycheck and struggle to make ends meet should have more generous tax credits and be protected from excessive out-of-pocket costs. Assistance that is annually indexed with medical inflation will help even further.
6. **Expanding consumer control and choice.** Consumers and patients need more control over their health care. Nearly 20 million Americans have Health Savings Accounts (HSAs) because they deliver affordable coverage and more consumer control. We need to expand HSAs so they can accumulate savings for the future, enable them to buy affordable coverage today, and encourage them to take a more active role in making decisions about their care.
7. **Promoting state innovation and state flexibility.** Consumers do not want one-size-fits-all approaches. That’s why states should have more flexibility to develop affordable and lower premium individual market plans. States should also have additional flexibility around coverage requirements; state benchmarks; 1332 waivers; risk pool mechanisms; and plan designs that promote innovations in care delivery, such as value-based insurance designs. We caution, however, that state flexibility should not come at the expense of consumers and their coverage.

These principles reflect our members’ priorities for long-term improvements to the individual market. As specific legislation is developed in the coming weeks and months, we will offer

more detailed recommendations for strengthening the individual health insurance market and more specific guidance on legislative proposals.

IV. Conclusion

AHIP and the health plans we represent look forward to working with the committee, members of Congress on a bi-partisan basis, and the administration as it works to improve health care for all Americans. We can achieve this by working together in a good faith and bi-partisan manner to fix critical problems while preserving the expanded coverage and enhanced affordability of coverage for millions of patients and families. Thank you again for the opportunity to work with you on these important issues.

Appendix: Considerations to Support Implementing a Better, More Effective Market

We are committed to making healthcare work for every American. As policymakers develop and debate the long-term solutions to improve the individual market, the following considerations are important factors to guide new solutions:

- Allow time to develop new products. Health plans need at least 18 months to create new products, gain approval from state regulators, and introduce them in the marketplace.
- Question whether new rules are needed. New rules will require time for draft rulemaking notices, comment periods, final rulemaking and timing for implementation.
- Understand that states may need to repeal current statutes tied to current federal law or enact any necessary changes.
- Allow time for consumers to become informed and educated on changes and options. This includes changes to the purchasing process and any new requirements related to getting and staying covered.
- Make changes effective at the start of a new benefit year. Mid-year changes to rules and regulations may lead to more confusion in the market, creating unnecessary disruption for consumers and businesses alike.

- Engage the states as a key stakeholder. Every consumer is different – and every state is different. States should have a voice in deciding what is best for their people, and letting the people decide what is best for themselves. By granting states more flexibility to serve their citizens, reforms can encourage innovations that deliver better quality and lower costs.