

Marilyn Tavenner
President &
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May 23, 2017

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Building
Washington, D.C. 20510

Dear Chairman Hatch:

On behalf of America's Health Insurance Plans (AHIP), this letter is in response to your request for comments and recommendations on issues surrounding the health reform legislation that you are developing with your Senate colleagues. We appreciate your leadership in this debate and your commitment to receiving input from a broad range of stakeholders as the Senate considers how to advance patient-centered health reforms.

AHIP is the national association whose members provide coverage for health care and related services to about 200 million Americans. 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.

Today, the Medicaid program provides coverage to almost 70 million Americans, and more than 50 million beneficiaries (over 70 percent) receive coverage through private Medicaid health plans. The individual market delivers private coverage to approximately 20 million people – about half buying coverage through state and/or federal exchanges with federal premium and/or cost sharing reduction (CSR) assistance for those eligible and the other half purchasing coverage “off exchange” with no financial assistance. While differing in relative size, the individual market and Medicaid are in fact closely related given the populations they serve. For example, many people with Medicaid are employed but do not have employer-sponsored coverage. As they move up the economic ladder, they may lose eligibility for Medicaid and thus need affordable coverage in the individual market. Conversely, if their incomes fall again due to loss of employment, income, or other reasons, Medicaid acts as an important safety net. As a starting point, it is therefore important to note that policy changes affecting Medicaid beneficiaries will have implications for the individual market and vice-versa.

AHIP also recognizes that recent legislative efforts have largely set aside the employer-sponsored and Medicare markets, acknowledging that they work well to advance the health, well-being, and financial security of more than 200 million Americans. However, the individual market clearly faces immediate and significant challenges, especially for the 2018 plan year.



Some of these challenges are the result of the structural issues and policy decisions during the initial years of Affordable Care Act (ACA) operations. Others are directly related to the uncertainties that health plans face with respect to CSR funding and potential non-enforcement of the individual requirement to purchase coverage. Despite these challenges, our members are committed to market-based approaches and believe in public-private partnerships that improve affordability, value and access for every consumer.

We look forward to working with you and all policymakers on practical solutions as the Senate works on health reform legislation. We offer policy recommendations in the following areas:

- **Short-Term Individual Market Stability:** These recommendations include the immediate policy steps that could help promote a stable individual market.
- **Transition Period:** As policymakers evaluate changes to the market, these recommendations would ensure a stable, sustainable transition to a reformed individual market or Medicaid program.
- **Medicaid Beneficiary Needs, Funding and Flexibility:** Any Medicaid policy changes should ensure the program continues to meet the health needs of beneficiaries, provide adequate funding, and enhance state flexibility.
- **Long-Term Market Priorities:** Our health care reform recommendations include lasting improvements that can deliver real choice, high-quality, and access to affordable coverage options and care to individuals and families.

I. Immediate Steps for Stabilizing the Individual Market

The American Health Care Act (AHCA) included a number of important provisions that would help stabilize the individual market in the short term. Consumers who buy their own coverage in the individual market should have affordable access to high-quality coverage options, and the AHCA took positive steps in that direction – creating a significant Patient and State Stability Fund, eliminating ACA taxes, enhancing tax credits for younger consumers, and recognizing the importance of continuous coverage.

While those AHCA provisions are critical, health plans are making 2018 business decisions and finalizing plan products and offerings right now. The timeline for implementing changes to 2018 products is short and constrained by impending federal and state filing deadlines. For health plans that intend to participate in the federally-facilitated Marketplace (FFM), the deadline to submit their initial qualified health plan (QHP) applications to CMS is June 21, which is only four weeks away. However, in several states, deadlines to file products and rates have already passed while deadlines loom in eleven other states.



As a first step toward repairing the current instability and uncertainty in the individual market, changing the trajectory of higher premiums and costs, and having fewer, if any, coverage choices available to consumers, we recommend:

- **Fund Cost Sharing Reductions:** Funding for CSRs that benefit low and modest-income consumers (under 250 percent of the federal poverty level (FPL)) should be guaranteed and continue without interruptions at least through 2019. If health plans lack certainty about continued CSR funding, the only operational alternative is to incorporate CSR costs into premiums, which translates into an estimated 15-20 percent premium increase for *all* consumers in the individual market and higher costs to taxpayers. Even more important, without CSR funding certainty, it will lead to fewer, if any, plan choices for millions of consumers.
- **Establish Market Stabilization Program:** A market stabilization program with substantial funding should be established. This program should be focused on a reinsurance approach and other market stabilizing purposes that would *reduce* premiums in the individual market while providing flexibility for states to determine how best to help their citizens. For instance, a reinsurance program with \$15 billion in annual funding could reduce premiums by 15% or more and simultaneously lower federal spending on premium assistance.
- **Enhance Credits for Younger Individuals:** Policy changes should include an additional age-adjustment factor to encourage enrollment by younger Americans during the transition period, as they are under-represented in the risk pool. More specifically, additional funding should be directed toward individuals aged 18-34.
- **Repeal or Suspend Taxes that Increase Costs:** Provisions that add to the cost of health insurance coverage should be repealed or suspended, such as the health insurer fee. Without congressional action, the health insurer fee, which was suspended for 2017, will return in 2018. As previous studies have estimated, reimposing this tax in 2018 will increase premiums by more than 3 percent.
- **Include Continuous Coverage Provisions:** If the tax penalties associated with the individual requirement are eliminated, any new legislation must include alternatives to incentivize continuous coverage.

Finally, it cannot be overemphasized that, as changes and reforms to the individual market are considered as part of a broader package, the timeline is extremely short to advance these crucial steps to improve stability and affordability for consumers in the individual market and have a positive impact on 2018 premiums.



II. Ensuring a Stable Transition to a Reformed Individual Market or Medicaid Program

As the Senate considers health reform legislation that would affect tens of millions of consumers involving a large section of the U.S. healthcare system and multiple stakeholders, we believe that an important principle is that any proposal should ensure an effective transition period of appropriate duration. This will promote public confidence and allow adequate time for stakeholders (e.g., states) to make adjustments, encourage participation in the market, and increase health care access and financial security.

For the individual market, the AHCA provided a transition period in which the existing market framework was largely maintained for plan years 2018 and 2019. This transition period is important, as new rules must be promulgated, and health plans need time to create new products, gain approval from state regulators, and introduce them in the marketplace.

If changes are made to the eligibility criteria for Medicaid, Congress should extend the timeline for such changes to ensure that beneficiaries and states are given adequate time to plan and adjust – and more time for the individual market to stabilize to ensure people continue to have access to coverage. State Medicaid programs need adequate resources and flexibility to administer an efficient, effective program that helps beneficiaries improve their health. But, state flexibility should be granted consistent with the principles of state self-determination and state control over the Medicaid program rather than primarily to realize potential budget savings.

III. Meeting the Health Needs of Beneficiaries, Providing Adequate Funding and State Flexibility for the Medicaid Program

As noted earlier, Medicaid provides health coverage to more than 70 million Americans, and the vast majority (more than 50 million) receive their coverage through private Medicaid health plans. We want to work with the Senate to ensure the continued strength of the Medicaid program. We believe the opportunity exists to enhance the role of Medicaid health plans in providing patient-centered and coordinated care, delivering high quality and better health outcomes for beneficiaries, and moving our healthcare system more rapidly toward value-based payments and away from fee-for-service reimbursement.

During its first decades, Medicaid was almost exclusively a fee-for-service system with payments that often undercompensated providers for actual costs. As a result, Medicaid had fragmented care, inconsistent access to providers and services, a lack of accountability, and little emphasis on improving quality and controlling costs. In many corners, this perception still exists even though Medicaid has evolved in many important aspects.

For many years, states have partnered with private Medicaid health plans to significantly change much of the Medicaid landscape. Consequently, Medicaid health plans have become vital to the operation of the program and the dominant approach to provide coverage, enrolling more than 70 percent of all Medicaid beneficiaries. States have shifted to Medicaid health plans because the



results are clear: lower costs with better health outcomes and more predictable impacts on state budgets. By offering integrated health care delivery, conducting outreach and health education efforts, and managing chronic conditions through patient-centric disease management programs, Medicaid health plans are improving care and services while also reducing costs.¹

As the Senate considers changes to Medicaid and the millions of beneficiaries covered by the program, we believe that it is important to keep some core key principles in mind:

- **The Health Needs of Beneficiaries Should Come First:** Any changes to Medicaid should keep the health and support needs of the program’s diverse and often vulnerable beneficiary population as the top priority. Medicaid’s primary constituents include children, people with physical or developmental disabilities, older adults with significant impairments, low-income working people without other coverage, and people with serious mental illness. Medicaid beneficiaries are more likely to be in poor health, with many suffering from chronic conditions, as well as managing other related health issues that can adversely affect overall health and well-being. Medicaid beneficiaries therefore require coverage to meet their unique needs, including low or no copayments for preventive benefits, behavioral health services, and acute care; coverage of screening and diagnostic services for children; coverage for behavioral health, chronic care, and disease management services; and home- and community-based services and supports.
- **Adequate Funding to Meet the Unique Needs of Beneficiaries:** Medicaid funding must be adequate to meet the healthcare and service needs of beneficiaries and provide actuarially sound resources to state Medicaid programs and Medicaid health plans. We are concerned that key components of the proposed new funding formulas in the AHCA – such as the base year selection, annual increases tied to the consumer price index for medical care, and applying per capita caps to certain populations – could result in unnecessary disruptions in the coverage and care beneficiaries depend on. For example, Medicaid health plans are at the forefront of providing coverage for and access to behavioral health services and treatment for opioid use disorders, and insufficient funding could jeopardize the progress being made on these important public health fronts. At the same time, AHIP members are committed to reducing cost growth by using value-based care arrangements and other innovative programs to address chronic illnesses, support functional impairments, and better manage the care of the highest-need enrollees.
- **Enhanced State Flexibility to Improve the Program:** Given the important and primary role that states play in program implementation, they are in the best position to understand the unique needs of their populations. States should be given more flexibility to innovate with new approaches that reduce unnecessary administrative burdens, increase effectiveness of care and services, and provide enhanced opportunities to manage costs. While there are aspects of the federal-state partnership funding system



that can also be improved, we believe in focusing on more targeted refinements rather than broad or systemic changes that could threaten the program's stability and shift significant financial risk to states.

- **Additional Key Considerations:** Given the important role of Medicaid in the U.S. healthcare system (and to the broader economy), the Senate should keep some additional key considerations in mind as its work moves forward. As noted earlier, the individual market and Medicaid are closely related given the populations they serve. It will be critical to have a stable individual market that provides adequate tax credits, especially for low-income individuals, if large numbers of beneficiaries are made ineligible for Medicaid and move into the individual market. Finally, Medicaid's vital role in supporting rural hospitals and health care providers as well as other effects on economic activity should be considered.

IV. **Longer-Term Market Priorities to Ensure Affordable Coverage Options**

After a transition period for 2018 and 2019, the AHCA proposes a major restructuring of the individual market in 2020. These changes can largely be organized into two main categories: market reforms and changes to the tax credit. As we look ahead to the possibility of a reformed individual market and other potential changes, we recommend the following key principles:

- **Ensure Access to Coverage for All Americans:** No individuals, including those with pre-existing conditions, should be denied or priced out of coverage because of their health status. While certain modifications to existing rules are needed (e.g., such as greater state flexibility to adopt wider age-bands to make coverage more affordable for younger adults), we believe that core insurance market reforms that guarantee access to affordable coverage for those with pre-existing conditions should be retained, including guaranteed issue, community rating, and barring pre-existing condition exclusions. To ensure that these reforms work effectively, they need to be coupled with adequate tax credits to make coverage affordable and strong incentives for individuals to maintain continuous coverage.
- **Promoting Access to Affordable Coverage through Well-Designed Tax Credits:** It is important that new individual market coverage options be affordable to all consumers. Under the AHCA, some analysts have estimated the value of the flat age-adjusted refundable tax credit in 2020 for enrollees aged 40, aged 50, and aged 60 with incomes at 200 percent FPL would result in annual premiums that are several hundred dollars to several thousand dollars higher than under current law.ⁱⁱ We believe it is important to ensure the tax credit is adequate, especially for those who have lower incomes, are older, and live in areas with high healthcare costs. If the existing flat tax credit structure is employed, this could be accomplished by providing extra assistance to lower-income individuals, providing appropriate age adjustments, reflecting the geographic differences in the cost of care, and



protecting consumers from excessive out-of-pocket costs. Assistance that is annually indexed with medical inflation would help maintain the value of the credit over time.

- **Implementing Effective Risk Pooling Programs:** Permanent federal funding for state-based risk pool programs, such as reinsurance, would improve risk sharing and risk pools and deliver more market stability. These programs should be focused on reducing premiums and costs in the individual market rather than for broader purposes. Actuaries and policy experts estimate that a permanent program to reimburse plans for high-cost patients—modeled after a health spending reimbursement model, such as reinsurance—would substantially reduce premiums and promote market stability—lowering premiums from 10%-14%.ⁱⁱⁱ To be effective, risk pooling mechanisms should be adequately financed, well-designed, and administratively feasible to implement, so the goals of market stability and lower premiums can be achieved.
- **Encourage Individuals to Purchase and Maintain Continuous Coverage:** Strong, stable markets can be created only through broad participation, including those who are healthy and sick, younger and older groups, and those purchasing coverage to obtain quality care and those who are healthy but want financial security and protection for themselves and their families in case they get sick. Effective incentives are needed to encourage consumers to get and maintain insurance coverage continuously as part of a broader strategy to make coverage more affordable for everyone. Well-designed and effective continuous coverage policies—such as late enrollment penalties or waiting periods—are a critically important element in stabilizing markets, especially if the tax penalties associated with the individual coverage requirement are eliminated, as contemplated under the AHCA.
- **Promote State Innovation and State Flexibility:** We recognize that consumers want coverage options that best meet their individual needs, not one-size-fits-all approaches. We concur with many state insurance commissioners that states should have more flexibility to develop affordable and lower premium individual market plans. States also should have additional flexibility around coverage requirements, state benefit benchmarks, state innovation waivers, risk pool mechanisms, and plan designs that promote innovations in care delivery, such as value-based insurance designs.
- **Expand Consumer Control and Choice:** We support an expansion of Health Savings Accounts (HSAs) to help consumers prepare for the future by accumulating funds that can be used when medical needs arise. Expansion of HSAs will increase affordable coverage options for consumers, and encourage them to take a more active role in making decisions about their care. In addition, other improvements should make HSAs easier to administer and more broadly available.



- **Making Coverage More Affordable by Bringing Down the Cost of Care:** Rising health care 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 health care to U.S. health systems, thus reducing the overall 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.
- **Maintain the Current Treatment of Employer-Sponsored Coverage:** The employer-sponsored market continues to be the largest single source of health coverage in the United States—providing coverage for over 150 million people, or roughly one out of every two Americans with coverage. It is stable, provides robust benefits, and is a leading source of innovation in coverage and benefit design. Moreover, the unique interests of employers in protecting employee health and the enduring relationships between employers and employees promote data driven decisions and efforts to improve health outcomes through novel programs, such as patient-centered medical homes, accountable care arrangements, and wellness programs. Consequently, we believe it is important for the Congress to maintain the current tax treatment of employer-sponsored coverage.
- **Maintain Current Treatment of HIPAA Excepted Benefits:** Today, individuals and families have the option to obtain HIPAA [Health Insurance Portability and Accountability Act of 1996] excepted benefits – for example: dental, vision, and supplemental insurance products such as accident, specified disease or illness, and hospital or other fixed indemnity – in addition to major medical coverage. These products protect consumers and provide additional financial protection in the event of serious illness, injury, or disability. They are typically funded by employees, provide millions of families with valuable financial security, improve access to resources, and support economic well-being in ways that major medical coverage is not designed to do. Congress has already carefully considered the role of such non-comprehensive coverage and carved out such coverage under HIPAA and the ACA as an excepted benefit. These products have been clearly defined in the Internal Revenue Code, ERISA [Employee Retirement and Income Security Act], and the Public Health Service Act for over 20 years. Any legislative action should maintain the current treatment of HIPAA excepted benefits as outside the scope of reforms under consideration by the Congress.

Conclusion

Thank you for considering our views on these important issues. As the legislative process moves forward, we look forward to working with you, Congress and the Administration to further assist in developing specific policies to advance a health care system that delivers affordable coverage for all Americans.

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Sincerely,

A handwritten signature in blue ink that reads "Marilyn B. Tavenner".

Marilyn B. Tavenner
President and CEO

ⁱ America's Health Insurance Plans. The Medicaid Program and Health Plans' Role in Improving Care for Beneficiaries: What You Need to Know. June 2016.

ⁱⁱ Avik Roy. How to Make Ryancare Premiums Affordable for the Near Elderly. Mar 19 2017.
<https://freopp.org/how-to-make-ryancare-premiums-affordable-for-the-near-elderly-7425ee209b6b>

ⁱⁱⁱ American Academy of Actuaries. Using High Risk Pools to Cover High-Risk Enrollees. February 2017.
<http://www.actuary.org/content/using-high-risk-pools-cover-high-risk-enrollees>