STATEMENT FOR THE RECORD

Submitted to the
Senate Finance Committee

Health Care: Issues Impacting Cost and Coverage

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America’s Health Insurance Plans (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 appreciate the committee’s interest in examining both health care costs and the availability of high quality, affordable coverage options. These issues are particularly important in the individual health insurance market, where consumers are facing significant challenges due, at least in part, to uncertainty about government policies for the Affordable Care Act’s (ACA) Health Insurance Exchanges.

Our members are strongly committed to advancing solutions that address these immediate, short-term challenges while also supporting long-term reforms that are needed to help ensure a stable, competitive market that delivers real choice, high quality, and affordable care. To contribute to the discussion at today’s hearing, our statement focuses on four priorities: (1) making coverage more affordable by bringing down the cost of care; (2) legislative solutions that could be enacted right now to provide relief to consumers, reduce uncertainty, and address the immediate challenges in the individual market; (3) regulatory steps to promote a stable market in the short term; and (4) principles for longer-term improvements in our nation’s health care system.

Make 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. The affordability crisis poses a serious challenge to the U.S. health care system – not only for consumers, but also for employers and government programs. Bold steps are needed to meet this challenge. From out-of-control drug prices to bureaucratic regulations to outdated payment models, we need effective solutions that bring down the cost of health care to U.S. health systems, thus reducing the overall cost of care for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. Below we highlight numerous areas where we see opportunities for decelerating the growth in overall health care costs:

- **Competition, Transparency, and Consumer Engagement:** Encouraging competitive market forces and more market-oriented regulatory systems and promoting greater transparency – with respect to information on price, quality, and value – to support greater consumer engagement in health care decisions;

- **Wellness, Prevention, and Care Coordination:** Moving beyond the sick-care paradigm to focus more strongly on wellness and prevention and increasing the integration and coordination of programs (e.g., Medicare, Medicaid) to address the burden of chronic disease;
• **Greater Options for Care Management**: Creating a broader range of options for wellness, acute care, chronic condition management, and end-of-life care – with greater discretion for individuals and families in selecting health care providers and sites of care;

• **Paying for Value**: Accelerating the move away from volume and toward value by adopting value-based payment approaches that demonstrate their effectiveness in improving both quality and affordability;

• **Leveraging Data and Technology**: Investing in data- and technology-driven innovations to reduce costs, enhance quality, and improve outcomes, including expanding the use of remote monitoring, at-home solutions, telehealth, and other innovative approaches to health care delivery;

• **Additional Options**: Promoting an adequate and diverse health care workforce; reducing and resolving medical malpractice disputes; and supporting initiatives at the state-level to meet quality- and cost-related goals.

In addition, any discussion about health care costs must include a strong focus on pharmaceutical costs and the need for market-based solutions to ensure that consumers have access to affordable medications. A March 2017 analysis by AHIP’s Center for Policy and Research concluded that 22 cents of every dollar spent on health insurance premiums goes to pay for prescription drugs – outpacing the amount spent on physician services, inpatient hospital services, and outpatient hospital services.¹ Prescription drug prices are out of control, and this is a direct consequence of pharmaceutical companies taking advantage of a broken market for its own gain. When drug companies are effectively granted extraordinary protections through the patent system or market exclusivity protections in federal law, they can set any price they choose – and raise prices at any time for any reason. To put it simply, they have a monopoly on medications. And the result is that everyone pays more, from patients, businesses and taxpayers to hospitals, doctors, and pharmacists.

As the committee explores strategies for reducing prescription drug prices, we urge you to consider our recommendations for effective, market-based solutions in three areas:

• **Delivering Real Competition**: Promote a robust biosimilars market and ensure that providers and patients have unbiased information about the benefits of biosimilars; provide the necessary resources for the Food and Drug Administration (FDA) to clear the backlog of generic drug applications, particularly for classes of drugs with no or limited generic competition; prohibit anti-competitive tactics such as “pay for delay” settlements and “product hopping”; preserve the Inter Partes Review (IPR) process through the U.S. Patent

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¹ “Prescription Drugs Are Largest Single Expense of Consumer Premium Dollars.” AHIP, March 2, 2017. [https://www.ahip.org/health-care-dollar/](https://www.ahip.org/health-care-dollar/). This AHIP estimate understates the actual impact of prescription drugs on insurance premiums, as drugs administered in hospital inpatient settings were excluded.
and Trademark Office; require brand manufacturers to share information and scientific samples to promote the development of generic drugs; and ensure that the Orphan Drug Act’s incentives are used by those developing medicines to treat rare diseases – not as a gateway to premium pricing and blockbuster sales beyond orphan indications.

• **Ensuring Open and Honest Price Setting:** Require pharmaceutical manufacturers to disclose information regarding the intended launch price, the use of the drug, and direct and indirect research and development costs; examine and address the impact of drug coupons and co-pay card programs (and related charitable foundations) on overall pharmaceutical cost trends; and assess the impacts of the growth in direct-to-consumer (DTC) advertising, particularly broadcast advertising, and evaluate the best approaches for conveying information to consumers.

• **Delivering Value to Patients:** Support private and public efforts to provide information to physicians and their patients on the comparative and cost-effectiveness of different treatments; promote value-based payments in public programs like Medicare for drugs and medical technologies, based on agreed-upon standards for quality and outcomes; and address existing statutory and regulatory requirements (e.g., Medicaid best price rules) that may inhibit the development of pay-for-indication and other value-based strategies in public programs.

**Legislative Solutions Are Needed to Provide Relief to Consumers and Stabilize the Individual Market**

The individual insurance market has been a challenge for many years – both before and after the ACA. Certainty regarding key government policies and other improvements is needed to ensure that the individual market delivers lower costs and more choices.

Just seven weeks from now, November 1 will mark the beginning of the 2018 Open Enrollment Period for coverage offered through the ACA Exchanges. Less than six months from now, health plans will begin the process of building products for the 2019 plan year. As a result, we strongly believe that any legislative stability package considered by Congress must continuously cover at least a two-year period – 2018 and 2019. Otherwise, market uncertainty will persist, and Congress will need to revisit these same exact issues early next year. Below we suggest several steps that can be taken in the short-term to ensure that Americans have real choices of quality, affordable coverage options.

• **Provide funding for cost-sharing reduction (CSR) benefits that help lower-income individuals afford the care they need:** This funding is important in the remaining months of 2017 and through at least the next two years. Nearly 85 percent of consumers who buy coverage through a health care exchange receive tax credits to help them pay their premiums.\(^2\) Well

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over half – and as much as three quarters – of these consumers receive additional assistance to lower their deductibles and cost-sharing for the care they receive. The Congressional Budget Office (CBO) estimates that terminating CSR funding after December 2017 would cause premiums for silver plans to be 20 percent higher in 2018 and 25 percent higher by 2020. This would have the additional consequence of increasing the federal budget deficit by $194 billion from 2017 through 2026.\(^3\)

- **Establish a premium stabilization program to improve market stability:** A federally-funded premium stabilization program would offset some of the costs of patients who have the most complex health conditions and need the most care. This will put downward pressure on premiums and help keep coverage affordable for more healthy people who buy their own coverage. Depending on the size of the program, this could reduce premiums in the individual market by 10 percent or more.\(^4\) There has been broad bipartisan support in Congress for such efforts.

- **Provide relief from burdensome, anti-consumer taxes and fees that raise health care costs:** Eliminating taxes and fees, such as the tax on health insurance, will reduce premiums and promote affordability. Congress provided relief from the health insurance tax for 2017, but it is slated to return next year. A recent Oliver Wyman study estimates that under current law, a total of $267 billion will be assessed and collected as a result of this tax over the next ten years (2018-2027). The same study projects that stopping the tax on consumer health insurance would lower premiums by an average of $158 per member in 2018 in the individual market.\(^5\)

- **Promote innovation and state flexibility:** Many Governors and state insurance commissioners have called for more flexibility and control over their markets. This flexibility can be provided with improvements to the ACA’s Section 1332 waiver process, including shortening the federal review time, creating a fast-track option, and establishing a process to waive the requirement for new state authorization legislation in an emergency. Changes to expedite the Section 1332 waivers should be balanced with requirements for state legislation within two years. Policymakers should maintain guardrails to ensure that 1332 waiver proposals provide coverage that is at least as comprehensive and as affordable for as many people as without the waiver and does not result in separate health insurance markets—one for healthy individuals and another for those with significant health conditions.

We also want to highlight several additional policies and considerations that will help promote a more stable individual market for consumers and families:

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• **Ensure any legislative reforms are extended for an adequate duration:** As Congress considers legislation to stabilize and reform the individual market, these proposals should span at least a two-year period (i.e., through 2019). This would ensure that reforms are in place long enough to promote public confidence and allow adequate time for states and health plans to implement them. It will also avoid the need for Congress to revisit these issues in early 2018.

• **Consider changes to premium tax credit eligibility to level the playing field:** In states that did not expand Medicaid, Americans with incomes below 100 percent of the federal poverty level (FPL) do not receive premium tax credits to help them afford their coverage. These Americans should also have access to premium tax credits.

• **Avoid policies that could further destabilize the individual market:** Policymakers should avoid legislative proposals that would introduce new elements of risk for the individual market. For example, repealing the individual coverage requirement without a strong alternative incentive to maintain continuous coverage would drive up premiums, increase the number of Americans without health insurance coverage, and exacerbate adverse selection and market instability. As noted above, policies that seek to segment insurance markets and narrowly divide risk pools would also contribute to market instability, especially for individuals with greater health care needs. Instead, policies that encourage personal responsibility and help keep coverage accessible, available, and continuous should be promoted.

**Regulatory Steps Also Are Needed, Along With Legislation, to Promote a Stable Market**

The following administrative actions, in tandem with legislative policies, will help promote a more stable individual market in 2018 and beyond:

• **Continue to enforce the individual coverage requirement to promote a balanced risk pool:** Insurance markets are strong and stable when everyone participates – those who need the coverage to access needed care as well as those who purchase coverage in case they need care in the future. If the coverage requirement under current law is not enforced, costs will increase while choices will decrease because fewer younger, healthier individuals will be incentivized to get coverage.

• **Continue to conduct marketing, outreach, and education before and during open enrollment to ensure consumers understand their coverage options and encourage broader participation of healthy individuals:** In addition to broad participation, stable health insurance markets require that consumers enroll for a full plan year and maintain twelve months of coverage, as opposed to enrolling only when they need care. Marketing, outreach, and education are critical to ensure that all consumers are aware of the upcoming open enrollment period, understand the new timeline, and enroll by the deadline. This is especially critical for 2018 open enrollment due to the new earlier deadline to enroll.
• Issue regulations regarding third party payments so health plans are not required to accept premium payments from entities with a financial interest in the enrollment, while improving transparency to allow payments from appropriate charities: Consumers should be enrolled in the health insurance program that best meets their needs, not because it offers higher payments to some providers. Those who are eligible for public programs (e.g., Medicare and Medicaid), which offer additional benefits and services, should not be inappropriately steered into the commercial insurance market and health plans should be permitted to reject third party payments in such situations. Similarly, prescription drug co-pay cards are decreasing overall affordability by promoting greater use of high-priced branded drugs where lower cost generic alternatives may be clinically appropriate.

• Extend prior coverage requirements to all special enrollment period (SEP) qualifying events to minimize inappropriate movement in and out of the individual market risk pool: Prior coverage is currently required for a limited number of qualifying events and is not sufficient to encourage consumers to maintain continuous coverage throughout the plan year. The Secretary should extend this requirement to all SEP qualifying events, with certain exceptions (e.g., newborns) and require state-based marketplaces to implement similar pre-enrollment verification of SEP eligibility.

• Prevent enrollment or reenrollment of Medicare enrollees in qualified health plans (QHPs) through the exchanges: While individuals enrolled in Medicare are not eligible to receive subsidies, they are currently not prevented from enrolling in coverage, or renewing coverage, through the exchanges. Inappropriate enrollment of Medicare-eligible beneficiaries in the individual market results in higher premiums for all individuals enrolled in the individual market. It also means Medicare beneficiaries could be paying for unnecessary or duplicative coverage and receiving tax credits for which they are not eligible and must repay upon filing taxes. The exchange should prevent enrollment or reenrollment of individuals enrolled in or eligible for Medicare and conduct periodic checks to identify current QHP enrollees who become eligible for or enroll in Medicare. This would ensure that consumers enroll in the program that is designed to meet their needs and avoid inappropriate payment of tax credits for ineligible enrollees.

• Change the rules around individual market dental coverage to ensure a streamlined shopping experience for consumers: The ACA requires coverage offered in the individual market to provide essential health benefits, including pediatric oral health benefits. Currently, families shopping in the Exchange for a dental benefit have several coverage choices and options between stand-alone dental plans and qualified health plans that embed this dental benefit, but this is not the case when shopping outside of the Exchange. To level the playing field for stand-alone dental plans with pediatric benefits, the same rules should be applied to Exchange plans and off-Exchange plans.
Principles for Longer-Term Improvements to Ensure a Stable, Competitive Market

Looking beyond the immediate and urgent priority of stabilizing the individual market, additional steps are needed to ensure a stable, competitive market that delivers real choice, high quality, and affordable care. When Congress resumes the debate on long-term health reform, we ask you to consider the following key principles.

1. **Bring down the cost of care and coverage**: As we discussed earlier, bold steps are needed to 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. **Preserve a strong Medicaid program**: The individual market and Medicaid are closely related with respect to the partial overlap in the populations they serve. For example, many low-wage employees do not have access to employer-sponsored coverage and need help accessing affordable coverage; if their incomes fall due to loss of employment or other reasons, Medicaid becomes an important safety net. Conversely, individuals with Medicaid who move up the economic ladder may lose eligibility and need affordable coverage in the individual market. Given how the two markets interact with respect to a diverse and often vulnerable population, Congress should ensure that federal policies are designed to ensure both the long-term stability and affordability of the individual market and continued strength and long-term sustainability of the Medicaid program, which delivers real value to more than 70 million Americans. This includes providing states with adequate resources to administer an efficient, effective program that helps beneficiaries improve their health.

3. **Guarantee 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. As modifications to existing insurance reforms are considered – e.g. such as greater state flexibility to adopt wider age-bands to make coverage more affordable to younger adults – those with pre-existing conditions should continue to be protected. To ensure coverage is more affordable for everyone, these protections must be coupled with strong incentives for individuals to maintain continuous coverage.

4. **Implement 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. The permanent risk pooling and mitigation programs in the Medicare prescription drug benefit (Part D) are another example that have been proven to work and promoted that program’s success and high rates of beneficiary satisfaction.

5. **Expand 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
consumers can accumulate savings for the future, buy affordable coverage today, and take a more active role in making decisions about their care.

6. **Promote state innovation and appropriate state flexibility:** Consumers do not want one-size-fits-all approaches. That is why states should have more flexibility to develop affordable and lower premium individual market plans. Building upon any initial steps taken in the current short-term stabilization effort, the longer-term debate should focus on giving states additional flexibility around coverage requirements, state benchmarks, 1332 waivers, premium payment grace periods, 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 with pre-existing conditions or greater health needs and their coverage.

7. **Preserve, protect, and expand employer-sponsored coverage:** Employer-sponsored health benefits are essential to the American economy. This system serves as a bedrock of stability and encourages employers to offer robust health plans with low deductibles while allowing workers the freedom and flexibility to invest more money in their families and communities. The current tax treatment of employer-sponsored health benefits should not change. Strengthening and supporting employer-sponsored health benefits, rather than eroding or taxing them, should be a priority of the Congress.

**Conclusion**

We thank the committee for considering our recommendations on these critically important issues. While the individual health insurance market faces significant challenges, we are committed to helping advance solutions that deliver short-term stability and long-term improvement. We look forward to continuing to work with Congress in a good faith and bipartisan manner to improve and protect the health and financial security of consumers, families, businesses, communities and the nation.