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Matthew Eyles
President & Chief Executive Officer

July 30, 2021

The Honorable Frank Pallone, Jr.
Chair, House Committee on Energy and
Commerce
Washington, DC

The Honorable Patty Murray
Chair, Senate Committee on Health,
Education, Labor & Pensions (HELP)
Washington, DC

Dear Chairs Murray and Pallone:

On behalf of AHIP, thank you for the opportunity to offer comments on ways to achieve universal, high-quality coverage. We agree and believe that all Americans should have both high-quality and affordable health insurance coverage choices. We do not believe – and facts do not support – that a public health insurance option would produce that outcome. Instead, a federal public option would ultimately deliver higher taxes and fewer choices. It would harm the people who like and rely on the coverage they have today and the providers that serve them. We urge you to advance policies that build on what works by strengthening the Affordable Care Act (ACA) to lower health care costs, increase coverage choices, and encourage competition and innovation to make coverage more affordable and accessible for everyone.

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to making health care better and coverage more affordable and accessible for everyone. We believe that when people get covered and get and stay healthy, we all do better. The best way to do that is to expand on the market-based solutions and public-private partnerships that are proven successes.

Approximately 300 million Americans – more than 90% – have health insurance coverage today. They are served through different markets specifically designed for their needs, including through employer-provided coverage, the individual market, Medicare, Medicaid and other public programs. The vast majority of people are served by health insurance providers that compete vigorously to offer the most cost-effective, high-quality products possible.

We share your goal of getting covered the remaining 30 million uninsured Americans. It is more than a goal – it is a top priority. The Congressional Budget Office estimates that 20 million of these individuals are already eligible for subsidized Medicaid, exchange premium tax credits or employer coverage, and this estimate was prior to the recent expansion of premium tax credit eligibility included in the American Rescue Plan Act (ARPA).¹ Spending time and resources designing and implementing an unproven and impractical federal public option will not suddenly close the coverage gap, but rather would exacerbate many of the problems of high costs and limited consumer choices outlined in the request for information. A public option sidesteps the root causes of why millions remain uninsured, both a lack of awareness about coverage options

¹ <https://www.cbo.gov/publication/56504>

and the high cost of delivering medical care and prescription drugs. Instead, it would rely on government rate setting and fee-for-service reimbursement. Further, a federal public option will divert attention away from much-needed health care reforms that have strong bipartisan support today.

Americans continue to demonstrate they want solutions that build on the existing health care system, including the ACA. In a June 2021 Kaiser Family Foundation tracking poll, 53% of American adults held a favorable view of the law, up from 33% in November 2013. Conversely, only 1 in 3 American adults (35%) view the ACA negatively, down from an all-time high of 53% in July 2014.² Support for coverage options and patient protections enacted as part of the ACA has continued to grow with the recent strengthening of the ACA in ARPA. As we discuss later in our letter, continuation of the APRA tax credit expansion being discussed as part of budget reconciliation represents an immediate opportunity to make long-term progress on coverage gaps and represents real savings for consumers.³

Our response also addresses how to achieve universal and affordable coverage by addressing the root issues of affordability and access and that do not require the creation of a federal public option. The apparatus to do this already exists, ushered in by the ACA and making a real difference for people today, rather than an untested public option upending coverage for most with limited potential to expand coverage. Last year, the No Surprises Act was a hard-fought success aimed at both protecting consumers from out of network bills they could not afford and curtailing the high prices charged by certain medical specialists but more needs to be done.

Every day, health insurance providers help their customers navigate an often-confusing system and advocate on their behalf for essential care and lower prices. However, swift action is necessary to address one fundamental issue – the underlying cost of health care – which will in turn make coverage more affordable for everyone. The underlying costs of both medical services and prescription drugs continue to grow. Cost is the biggest barrier to coverage, and that challenge cannot be fully solved without focusing on the prices of care itself. We can take steps to increase health care competition and drive better value in health care spending. This requires zeroing in on the increasingly indefensible rates charged by too many health care providers and facilities, such as hospitals and standalone emergency rooms, and as highlighted in the recent Competition Executive Order, by promoting greater competition in all aspects of health care including prescription drugs.

We stand ready to partner with you to expand affordable coverage to those Americans who remain uninsured. And we stand ready to work with you to address underlying cost drivers and market distortions that are driving premium increases – prescription drug pricing and anti-competitive practices, vertical provider consolidation across the health care system, third party payments driving patients to higher-cost drugs and settings of care, and overly restrictive market rules inhibiting private market innovation and value-based insurance design. In the pages that

² KFF Health Tracking Poll: The Public's Views on the ACA. June 3, 2021 (survey conducted in May 2021).

<https://www.kff.org/interactive/kff-health-tracking-poll-the-publics-views-on-the-aca/>

³ <https://www.ahip.org/new-study-without-extension-of-arpa-benefits-americans-could-face-higher-premiums-in-exchanges/>

follow, we offer actionable policy solutions and explain how we are doing our part to address these issues.

Sincerely,

A handwritten signature in cursive script that reads "Matthew Eyles".

Matthew Eyles
President & Chief Executive Officer

Attachment

The Essential Role of Private Health Insurance Coverage

People in the United States have more personal choices than anywhere else in the world when it comes to coverage, doctors, and treatments. Upending the competitive private health insurance market through the offering of a government-run health insurance plan with artificially deflated premiums based on government price setting is not the answer. Would a public option have to comply with the same standards that private health insurers have to meet – for example, licensure, solvency protection, accreditation, etc.? How would the public be best served if a government-run plan option leads to fewer coverage options and more limited access to providers for most Americans?

Today, more than 200 million Americans receive their health care coverage through high-quality innovative plans offered in the commercial health insurance market (individual and group) where people are highly satisfied with their coverage. Health insurance providers representing a range of business models provide options to Americans seeking different types of comprehensive health coverage. As the individual market continues to stabilize and grow, more American consumers benefit from a range of plan types available for free or at affordable costs.

Americans have options to choose from health plans that best meet their needs and their budget. For those purchasing coverage on their own, that would include plans offered by large, national carriers, as well as plans available from local and regional providers and community-affiliated plans. For those enrolled in Medicaid coverage, more than two-thirds of Medicaid beneficiaries in 40 states and territories are served by Managed Care Organizations designed and administered by private health insurance providers.⁴ Millions are served by health plans that act as a bridge between Medicaid and individual market coverage, with a unique mission to deliver access to care for low-income individuals and people living with disabilities.

For the majority of Americans covered by employer-provided insurance, plans compete to offer tailored benefit packages that meet the needs of that particular business and their employee population. Employees and their families, as well as individuals purchasing on their own, have options that may include a Health Savings Account-eligible plan with a lower premium and tax-free savings opportunities, a Health Maintenance Organization (HMO) plan that can help address complex health needs, or the flexibility of a Preferred Provider Organization (PPO) or Point of Service (POS) plan. A key feature of all of these plans, whether safety net, individual market, or employer-provided coverage is they all compete against each other on a level playing field and are regulated under the same terms.

⁴ <https://data.medicaid.gov/Enrollment/2018-Managed-Care-Enrollment-Summary/gn4b-7d7q/data>

More than 183 million Americans are protected by employer-provided health insurance coverage.⁵ And across the country, tens of millions invest in supplemental coverage, like dental, vision, and disability income protection. Over the last 18 months, as the COVID-19 pandemic impacted everyone, American families and workers across the country depended on their coverage. The private market stepped up and quickly responded by waiving cost-sharing on COVID-19 testing, treatment, and vaccines, and took steps to aid employers in maintaining coverage.^{6,7} The pandemic only magnified the importance of employer-provided coverage – a survey of employees conducted earlier this year for AHIP by Locust Street Group found more than three-quarters of employees (76%) feel their coverage would protect them from the majority of their medical costs in an emergency.⁸ For those workers who lost their health insurance, Congress recognized the critical role of COBRA by providing subsidized employer-provided coverage to bridge coverage gaps.

One path towards reducing the number of uninsured Americans is to increase the number who have access to affordable employer provided coverage. When more companies are able to offer coverage and give every employee more affordable options, a greater share of Americans will enjoy coverage that has been the gold standard for comprehensive health benefits and consumer satisfaction. Furthermore, private sector innovation can continue to flourish while producing a substantial return on investment for the taxpayer. A recent working paper for the National Bureau of Economic Research found the net annual social value of employer provided health coverage at \$1.5 trillion.⁹ That figure includes the private value of the coverage – what an individual family gains from having coverage – and the external value – what that same family gains from other Americans having access to employer coverage. By growing the number who have employer coverage while increasing the affordability of individual market coverage and strengthening Medicaid and Medicare offerings, every American can have access to affordable, comprehensive coverage through pathways they already know and have been proven effective while generating substantial benefits for society that in turn grow more businesses that offer employer coverage.

Here is a sampling of the many ways that health insurance providers support their enrollees:

- ***Addressing Socioeconomic Needs of the Community and Improving Health Equity***— Health insurance providers in partnership with local health care and social service providers, communities, and other partners rallied together to build new service delivery

⁵ US Census, Health Insurance Coverage in the United States: 2019. Available at:

<https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf>

⁶ <https://www.ahip.org/health-insurance-providers-respond-to-coronavirus-covid-19/>

⁷ <https://www.commonwealthfund.org/blog/2021/update-how-many-americans-have-lost-jobs-employer-health-coverage-during-pandemic>

⁸ <https://www.ahip.org/new-survey-employer-provided-health-coverage-is-delivering-real-value-for-consumers-during-the-pandemic/>

⁹ https://www.nber.org/system/files/working_papers/w28590/w28590.pdf

models to deliver critical resources to people experiencing greater needs during the COVID-19 pandemic. Examples include building new food distribution models, securing emergency temporary housing, promoting access to essential resources, providing access to needed transportation to COVID-19 testing, and reaching out to at-risk individuals.¹⁰

- ***Responding to the Opioid Crisis***—In addition to our response to the COVID-19 pandemic, health insurance providers responded in force to the nation’s health crises, including the impact of the opioid crisis. Our members embraced a comprehensive approach that includes evidence-based treatments for pain management, more cautious opioid prescribing, careful patient monitoring, and more. By combining effective education, prevention, comprehensive behavioral health care for those suffering from substance use disorders, and evidence-based care, such as medication-assisted treatment, health insurance providers continue to make real progress in eradicating addiction and improving the health and well-being of families and communities.
- ***Integrating Behavioral Health Care***—Besides offering behavioral health benefits on par with medical and surgical benefits, insurance providers are working to seamlessly coordinate and integrate care to promote a more holistic approach. Insurance providers have demonstrated strong leadership in pioneering innovative programs to meet the health care needs of individuals with mental health and substance use disorders, often through partnerships with behavioral health care organizations. These programs are designed to raise patient awareness of the importance and availability of behavioral health care, encourage discussions with providers, and focus on proactive identification of behavioral health needs. Leveraging evidence-based criteria helps guide coverage decisions and ensures proven quality metrics are used to track and improve patient outcomes.
- ***Supporting Telehealth as a New Mode of Care Delivery***—Health insurance providers have led in the exponential growth in telehealth – a safe and affordable way to seek care when and where people need it. While telehealth use prior to the pandemic had been growing, the COVID-19 crisis led to a significant increase in its use as a safe and convenient way for people to access needed care. Before the pandemic, 96% of large employers (500 or more employees) provided access to telehealth for their workers.¹¹ A study published in the *Journal of the American Medical Association* found that telemedicine visits increased at an average compound growth rate of 52% per year from

¹⁰ AHIP, Health Insurance Providers Are Innovating to Address Socioeconomic Needs during COVID-19 and Beyond. <https://www.ahip.org/wp-content/uploads/Socioeconomic-Needs-Innovation-Brief.pdf>, June 2020.

¹¹AHIP, Telehealth: Connecting Consumers to Care Everywhere. https://www.ahip.org/wp-content/uploads/IB_Telehealth-031219.pdf, March 2019

2005 to 2014¹² and a report from Frost & Sullivan projected seven-fold growth in telehealth by 2025.¹³

- ***Support for Care Management***—Health insurance providers are committed to providing high-quality, affordable plans that protect families' health and wellness. That starts with empowering people to take control of their health with routine check-ups, screenings, and preventive care at little to no cost. Through easy access to health advocates and care managers, health insurance providers help people get better when they're sick and stay healthy when they're well.¹⁴

Lowering the Costs of Care and Prescription Drugs

Every American should be able to access affordable, comprehensive coverage regardless of their income, health status, or pre-existing condition. Solid majorities of Americans rate the coverage (69%) and quality (80%) of the health care they personally receive as "excellent" or "good."¹⁵

We applaud your recent leadership on surprise medical billing, an issue that has devastating effects on patients in numerous ways, including some who were afraid to go to the emergency room over concerns that they would receive an extremely high out-of-network bill. We strongly supported the goal of the No Surprises Act to prevent providers from balance billing patients when visiting an out-of-network emergency room or receiving treatment from an out-of-network provider at an in-network hospital in situations where they had no choice in their provider. **With surprise billing on its way to being eliminated next year, we urge your Committees to focus on the rising costs of prescription drugs and hospital costs.** The President's recent Executive Order on Competition highlighted these same issues.¹⁶

Prescription drug costs and hospital costs are the largest portion of health plan premium spending. Research shows that 81.6 cents of every premium dollar in the commercial market goes directly to prescription drugs and medical services, with prescription drugs making up the biggest expense component at 21.5 cents out of every dollar spent. Another major driver of medical spending is payments to hospitals: 19 cents of every commercial premium dollar is used to pay for in-patient hospital costs, while 19.8 cents is used to pay for out-patient hospital costs.¹⁷

¹² <https://jamanetwork.com/journals/jama/fullarticle/2716547>

¹³ <https://ww2.frost.com/news/press-releases/telehealth-to-experience-massive-growth-with-covid-19-pandemic-says-frost-sullivan/>

¹⁴ For example: <https://www.aetna.com/services/care-management.html>, <https://www.cigna.com/health-care-providers/resources/case-management>, and <https://www.humana.com/provider/medical-resources/clinical/health-programs/chronic-care-programs>

¹⁵ <https://news.gallup.com/poll/245195/americans-rate-healthcare-quite-positively.aspx>

¹⁶ 86 FR 36987

¹⁷ https://www.ahip.org/wp-content/uploads/AHIP_HealthCareDollar-2021.pdf

Our members stand ready and eager to work with policymakers and other stakeholders to make coverage more affordable. We must do so in ways that bring all health care stakeholders together and build on markets that are working for millions of Americans today.

Swift action is needed to:

- ***End anti-competitive practices by prescription drug manufacturers***— Some pharmaceutical manufacturers have not been content with the government’s grant of a near exclusive period to sell their product under the patent system and FDA licensing. Instead, these manufacturers have attempted to contort these systems to continue charging above-market prices to consumers long after the expiration of the original patent was granted for their innovation. Such gamesmanship has tremendous costs—in dollars, in access, and in health. We strongly support additional enforcement by Federal agencies (Department of Justice and Federal Trade Commission) to prevent and remedy such gamesmanship by pharmaceutical manufacturers, including product hopping and reverse payment settlements (*i.e.*, pay for delay). Developing innovative treatments should be encouraged by the patent and licensing process, whereas legal efforts to exploit loopholes that unfairly extend the exclusivity periods should not be rewarded.
- ***Curtail the use of prescription drug coupons***—Congress should end the practice of manufacturers steering patients to higher-cost drugs through the use of drug coupons and patient assistance programs and instead help lower drug prices for all. Coupons, and other forms of direct or indirect drug manufacturer assistance to patients, are only available to carefully selected patients for a very limited period of time, sidestepping the problem — the high price of the drug. In fact, the HHS Office of Inspector General finds coupons used in government programs to be a violation of the anti-kickback statute as they “induce the purchase of Federal health care program items or services”—that is, the drug manufacturer offering the coupon is directly benefiting from its use at the expense of taxpayers. Until drug makers address sky-high prescription drug prices, these coupons will continue to make health care unaffordable for everyone.
- ***Address the wave of disruptive, anti-competitive vertical consolidation among health care providers***—For many decades, consumers have borne, and continue to bear, the cost of the wave of horizontal consolidation in hospital markets. These costs are both literal (higher prices) and more insidious (lower incentives for quality and innovation). Now, consumers are witnessing a second, equally harmful wave of consolidation as hospital systems and others (*e.g.*, private equity) acquire physician practices, reducing competition among physicians and, through control of referrals, in hospital markets. Enforcement is needed to prevent such anticompetitive consolidation and creative

approaches are needed to address the harm from the consolidation that has already occurred.

In addition, in concentrated markets, prices do not flow from competitive market negotiations, but from the outsized leverage that market concentration affords. We are aware of large hospital systems that attempt to leverage their significant market share by requiring contracts with all affiliated facilities and prevent steering patients to lower-cost, higher-quality care. These anti-competitive contract terms in the form of “anti-steering,” “anti-tiering” and “most-favored-nation” contract provisions foster highly inflated costs and limit health insurance provider’s flexibility in network design to promote high-value care. We urge Congress to address the anti-competitive contract terms that disrupt market dynamics and raise the cost of health care services.

- ***Eliminate non-profit schemes that drive patients to higher-cost drugs and settings of care***—We urge your Committees to examine the continued significant economic incentives for certain charities to steer people away from affordable coverage for which they qualify into commercial coverage with higher premiums so that providers who donated receive higher reimbursement for services. Often these incentives are leading to coverage choices that are not in the best interest of the patient.¹⁸ These schemes also result in higher spending on premium tax credits that could fund additional investment in coverage.¹⁹
- ***Recognize the role of health plan medical management***—Innovative new treatments and medicines are being developed and introduced every day. Health insurance providers are providing access to these innovative methods of care, working diligently to ensure that people are getting the right care, at the right time, from the right provider. Medical and utilization management tools, like prior authorization, are key to promoting safe, effective, and smart care for plan enrollees. Variations in treatment can lead to unnecessary, costly, or inappropriate medical treatments that can harm patients. In fact, 65% of physicians themselves have reported that at least 15-30% of medical care is unnecessary.²⁰ Needless medical tests waste billions every year – as much as \$800 billion is wasted annually on excessive testing and treatment.²¹ We highlight this for the Committee as we are seeing states continue to enact legislation that reduces health insurance provider ability to use these tools. This directly limits the ability to ensure

¹⁸ Porter, Katie. Dying on Dialysis: Inside Industry Putting Profits Over Patients. https://porter.house.gov/uploadedfiles/dialysis_staff_report_final.pdf

¹⁹ <https://www.statnews.com/2021/04/29/dialysis-companies-reimbursement-gaming/>

²⁰ Lyu H, Xu T, Brotman D, Mayer-Blackwell B, Cooper M, Daniel M, et al. (2017) Overtreatment in the United States. PLoS ONE 12(9): e0181970. <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0181970>

²¹ <https://pnhp.org/news/institute-of-medicines-best-care-at-lower-cost/>

high-quality and affordable health care, and we urge Congress to recognize the importance of medical and utilization management as part of your affordability goals.

Bolster Support of the Individual Market & Reduce the Uninsured Rate

As of June 2021, 31 million Americans have coverage through the ACA (including the ACA's individual market and Medicaid)—the highest number to date since the ACA's implementation in 2014.²² The individual market is working better over time and remains an affordable, high-quality option for those who do not have access to coverage through work.

The individual market is strong and stable and continues to grow. Competition among health plans continues to increase, which leads to lower premiums. On the Federal exchange through Healthcare.gov, enrollees with access to two or more issuers increased from 71% to 96% in 2021. In 2021, more than three-quarters of enrollees have access to at least three issuers. Research shows that counties with one additional issuer in 2019 experienced a 2.5% reduction in the benchmark premiums (*i.e.*, second lowest cost silver plan) compared to 2018.²³ Average premiums (benchmark plan premiums in healthcare.gov states) decreased 3% from 2020 to 2021, which follows a 4% decrease from 2019 to 2020.²⁴

Gains in coverage through the ongoing special enrollment period (SEP) demonstrate increased investment in outreach, education, and targeted marketing, in combination with the Navigator program are working to increase access to coverage.²⁵ The individual market continues to be an important source of high-quality coverage as Americans learn that coverage is affordable for them or their family. As of June 30, more than 2 million Americans have newly signed up for coverage through the ongoing 2021 Marketplace SEP, including over 1.5 million in the 36 states that rely on Healthcare.gov and more than 600,000 in the 15 State-based Marketplaces.²⁶ We expect these figures will continue to climb through the end of the SEP on August 15.

²² New HHS Data Show More Americans than Ever Have Health Coverage through the Affordable Care Act. June 5, 2021. <https://www.hhs.gov/about/news/2021/06/05/new-hhs-data-show-more-americans-than-ever-have-health-coverage-through-affordable-care-act.html>

²³ Increasing Competition on the Exchanges to Improve Consumer Choice and Affordability. <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Issuer-Participation-in-the-Marketplace.pdf>

²⁴ CMS. Increasing Competition on the Exchanges to Improve Consumer Choice and Affordability. <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Issuer-Participation-in-the-Marketplace.pdf>

²⁵ 2021 Special Enrollment Period in response to the COVID-19 Emergency. January 28, 2021. <https://www.cms.gov/newsroom/fact-sheets/2021-special-enrollment-period-response-covid-19-emergency>

²⁶ CMS. Health Care Sign Ups Surpass 2 million During 2021 Special Enrollment Period Ahead of Aug. 15 Deadline. July 14, 2021. <https://www.cms.gov/newsroom/press-releases/health-care-sign-ups-surpass-2-million-during-2021-special-enrollment-period-ahead-aug-15-deadline>

While many improvements have been made, Congress has an opportunity to build upon the coverage gains under the ACA and ARPA by making these enhanced tax credits permanent. This action will:

- Ensure people up to 150% of the federal poverty level (FPL) can continue to get \$0 silver premiums with significantly reduced cost-sharing.
- Ensure people with incomes up to 400% FPL can continue to get more premium assistance through more generous subsidies.
- Permanently eliminate the 400% FPL subsidy-eligible cliff so that all Americans can receive help and will be required to pay no more than 8.5% of income toward the benchmark plan.

People like their private health coverage – whether purchased on their own or through their employer. Making the ARPA tax credit expansion permanent would go a long way toward making Americans even more satisfied.

To reduce the number of Americans without health insurance coverage, Congress should support policy solutions that enroll the remaining uninsured in Medicaid or subsidy-eligible coverage to build on and improve the coverage gains as a result of the ACA. As of the first half of 2020, 30 million non-elderly adults were uninsured -- about 11% of the total United States under 65 population, down from 18 percent in 2010.²⁷ Most of this population is eligible for existing coverage either through Medicaid or in the individual market. It is critically important to understand who are the uninsured in order to develop policy solutions targeted at that program and to avoid eroding other sources of private coverage that so many Americans like and want to keep. The Congressional Budget Office (CBO) estimates of the 30 million uninsured people 20 million have access to subsidized Medicaid, the ACA marketplace, or employer coverage. The vast majority of the uninsured can be covered through existing coverage options without creating a government mandated public option and triggering a range of negative costs and consequences.

Since implementation of the ACA, all 50 states have seen reductions in their uninsured rates, with the greatest coverage gains in the 37 states that expanded Medicaid. People who are uninsured are disproportionately Black or Latino, young adults, have low incomes, or live in states that have not expanded Medicaid. States that haven't expanded Medicaid have much higher rates of uninsured (17%) than those that have (9%).

For people who need coverage but aren't eligible for help in the individual market, we support ending the "family glitch" and covering those who live in states that haven't expanded Medicaid. We support permitting dependents of those enrolled in employer-provided coverage to receive tax credits if their coverage options are not affordable. For those who earn

²⁷ ASPE. Trends in the U.S. Uninsured Population, 2010-2020. February 11, 2021.
<https://aspe.hhs.gov/system/files/pdf/265041/trends-in-the-us-uninsured.pdf>

too little to qualify for premium tax credits (because their household income is below the poverty line and they live in states that have not expanded Medicaid), **we urge Congress to close the Medicaid coverage gap to ensure impacted people can enroll in high-quality individual market coverage.**

Finally, young adults remain uninsured at higher rates than their older peers. We recommend Congress remove barriers to affordable coverage for the uninsured by addressing age inequity without harming older enrollees. In addition to ARPA subsidy enhancements, we recommend an additional age-rating curve to premium subsidies that is applied to premium. This creates a strong incentive for younger Americans to enroll in coverage. Younger enrollees are often expected to pay more than the value of the coverage, explaining why the largest group of uninsured is subsidy-eligible. Correcting this age inequity is low-cost, high-impact, and helps address the racial coverage gap, as Hispanic, mixed-race, and Black uninsured are more likely to be younger and more likely to have to pay more for coverage.²⁸

Solutions to reach the goal of universal coverage must specifically target the uninsured and underinsured populations and not disrupt the coverage held by everyone else. Experience shows that additional investment in outreach and education will be necessary. Nationwide, 22% of nonelderly people who are uninsured are Hispanic or Latino, and 12% of people who are uninsured are Black. This population saw the steepest gains in coverage in 2014 and 2015 (due to Medicaid expansion) but continue to have the highest rates of uninsured.

To support more people being covered, recently 18 organizations released a menu for extending and strengthening health care coverage to make it more affordable, widespread, equitable, secure, and valuable to individuals and families. Additional long-term improvements to Medicaid, the individual market and CHIP are discussed as well as steps to ease the process of enrolling and staying in coverage.²⁹ **A focused national effort to enroll those who are currently uninsured in existing coverage options will have the added benefit of making coverage more affordable for everyone.**

Improve Flexibility in Cost Sharing

We are also eager to work together to ensure cost-sharing is not a barrier to preventive and other high-value care for those with chronic conditions. **We support changes to the Internal Revenue Code to permit Health Savings Account (HSA) eligible plans the ability the cover items or services to treat or prevent the exacerbation of chronic health conditions as first-dollar coverage, so that the deductible would not apply to that care.** Currently, more than 32 million Americans are covered by High Deductible Health Plans (HDHP) that can be paired with

²⁸ Foster, Heather, Murray, Margaret. A Sensible Solution: How The Affordable Care Act Can Insure More Young Invincibles. Health Affairs. June 9, 2021. <https://www.healthaffairs.org/doi/10.1377/hblog20210604.467869/full/>

²⁹ https://familiesusa.org/wp-content/uploads/2021/07/COV-2021-177_CSCC_v2.pdf

HSAs, the majority of whom have at least one diagnosed chronic condition. Current law greatly restricts what HDHPs may cover for an enrollee prior to satisfying their deductible.

This change in law has the potential to greatly increase adherence to medication and other treatment where cost has previously been a barrier, promoting high-value care that has been demonstrated to yield cost savings while improving health outcomes, benefiting patients, employers, and the federal government alike. By improving access and affordability for millions living with conditions ranging from asthma and heart disease to diabetes and depression, this policy change would quickly make health care more affordable for millions while improving health equity and long-term health outcomes.

Health Plan Leadership to Shift to Value-Based Care

Health insurance providers continue to ensure coverage is affordable by delivering access to high-quality health insurance plans and continually innovating to improve the benefits offered. Other widespread actions such as value-based arrangements, reference pricing, and centers of excellence are in place to reduce input costs and unit prices of health care. These new models seek to move the health care system toward better achieving the Triple Aim®: improving the individual experience of care; advancing the health of populations; and reducing the per capita costs of care for populations. The private market has championed this movement, making great strides to develop and implement care delivery and alternative payment models (APM) that promote high-quality, equitable, and cost-efficient care.

Health insurance providers are committed to reducing cost growth by using value-based care arrangements and other innovative programs and technologies to promote well-being, address chronic illnesses, support functional impairments, and better manage the care of their members. This commitment is demonstrated through data gathered through a survey by the Health Care Payment Learning & Action Network (LAN), a public-private partnership, showing thirty percent of health care payments from commercial market plans were tied to a value-based payment model in 2018.³⁰ Moreover, when asked about the future of APMs, 90% of respondents indicated that APM activity will increase, with no health insurance providers indicating it would decrease, showing a clear consensus that the industry will continue to develop and implement APMs.³¹ Survey responders also selected “payer interest/readiness” as the top facilitator for APM adoption, further corroborating their broad support and commitment to payment reform going forward.

³⁰ Health Care Payment Learning & Action Network (HCP-LAN), APM Measurement Effort. <https://hcp-lan.org/apm-measurement-effort/2019-apm/#1479737966515-d822014b-3f98>

³¹ APM Measurement: LAN Insights Into APM Adoption (2018). <http://hcp-lan.org/workproducts/apm-discussion-2018.pdf>