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**Matthew Eyles**  
President and CEO

March 1, 2019

The Honorable Lamar Alexander  
Chairman  
Senate Health, Education, Labor, and Pensions Committee  
United States Senate  
428 Dirksen Building  
Washington, D.C. 20510

Dear Chairman Alexander:

On behalf of America's Health Insurance Plans (AHIP), I am writing in response to your request for recommendations on steps that can be taken to provide relief to the American people from rising health care costs. We appreciate your leadership in addressing the challenge of making health care more affordable, and we join you in that commitment.

Providing high-quality, affordable coverage improves the health and wellness of all Americans. Health insurance providers work every day to address the significant cost drivers of chronic disease and poor health; give consumers the power to choose the care and coverage that works best for them; and improve patient care with innovative tools, treatments, and technology.

We agree that underlying health care costs are a financial burden for too many Americans, and that innovative policy solutions and other steps are needed to meet this challenge. As we confront problems ranging from out-of-control drug prices to surprise medical bills to provider consolidation that decreases competition, we need effective solutions that reduce the overall cost of health care for every patient and consumer.

In response to your letter, we are attaching recommendations focusing on three areas where you requested feedback: (1) lowering health care costs; (2) incentivizing care that improves the health and outcomes of patients; and (3) increasing the ability for patients to access information about their care to make informed health care decisions. While reviewing these issues, we outline challenges, opportunities, solutions, and specific recommendations for your consideration.

As the committee explores legislative options to halt rising health care costs, we stand ready to work with you to advance thoughtful solutions that promote affordability while preserving and expanding consumer choice. Thank you for considering our comments and recommendations.

Sincerely,

A handwritten signature in black ink that reads "Matthew Eyles". The signature is written in a cursive, flowing style.

Matthew Eyles  
President and CEO

Enclosure

**Addressing America’s Rising Health Care Costs**  
**AHIP’s Response to Chairman Alexander’s Call for Recommendations**

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**Introduction**

We support the Committee’s efforts to identify solutions to lower the cost of health care, incentivize care that improves the health and outcomes of patients, and increase patient access to information about their care to help them make informed decisions. Too many policy conversations focus on cost-shifting between consumers, health insurance providers and government programs, while ignoring the real problem of high and rising health care prices. The result is that American families, taxpayers and businesses continue to bear the brunt of rising health care prices through out-of-pocket costs, premiums, or taxes paid to fund government programs.

We believe that American consumers, businesses, and taxpayers face an accelerating affordability crisis in health care. While conversations about addressing health care costs are often highly complicated, the reason health care costs are so high in the United States is simple. Providers and drug makers in this country charge higher prices for the same services than are charged in any other country. In 2017, the U.S. spent almost \$10,000 per person on health care –

250 percent more than the OECD median of \$4,000 per person.<sup>1</sup> For Americans and businesses who pay the full cost of their insurance premiums or those employers that are self-insured, these inflated costs are reflected directly in their premiums or their total health care costs.

Solutions that promote affordability can and should be implemented in ways that preserve and expand consumer choice. Americans want a system that allows them to choose the coverage and provider network that's right for their family. Nearly three-quarters of Americans – 72 percent – are satisfied with their current health care coverage.<sup>2</sup> Innovations like telehealth and in-home monitoring devices for people with chronic conditions are proof that we can reduce costs while offering consumers more options, not fewer. We recommend the Committee examine all recommendations received for their impacts on consumer choice and give preference to solutions that preserve or expand opportunities for American families to find high-quality coverage and care that meets their specific needs. We also suggest that consideration be given to balancing global innovation with the ability of the U.S. government and hardworking taxpayers to afford the cost of health care.

Below we identify specific challenges and opportunities and propose solutions.

## **I. Lower Costs and Improve Affordability**

*Affordability is consumers' top concern.* Consumers emphasize the importance of affordability in getting coverage and care. Three in four Americans would prefer the government focus on making health care more affordable ahead of addressing other health care issues.<sup>3</sup> Consumers are concerned about both the cost of premiums and out-of-pocket costs. Policies that shift health care costs from deductibles into premiums do not improve affordability overall. We encourage policymakers to embrace policies that promote affordability by lowering the total cost of care and recommend several below. For a policy to truly advance the cause of affordability, we suggest that it must pass four tests:

1. Does it lower, or at least not increase, patient cost-sharing?
2. Does it lower, or at least not increase, premiums for American families and employers?
3. Does it lower, or at least not increase, taxpayer spending on government programs like Medicare and Medicaid?
4. Does it increase access to health insurance coverage, or at least not increase the number of uninsured Americans?

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<sup>1</sup> OECD was founded by 18 European nations, the United States and Canada and now consists of 36 countries that span the globe. A list of OECD member countries can be found here.

<http://www.oecd.org/about/membersandpartners/#d.en.194378>

<sup>2</sup> AHIP/Morning Consult Poll, <https://www.ahip.org/new-poll-americans-are-focused-on-health-care-affordability-drug-costs-protecting-pre-existing-conditions-in-2019/>

<sup>3</sup> AHIP/Morning Consult Poll

## A. Challenge: Drug Prices are Out of Control and Rising

**Solutions: (1) Promote the use of more cost effective generic and biosimilar drugs over expensive name-brand drugs; and (2) Where a generic or biosimilar isn't available, make the cost and price of drugs transparent to consumers and stakeholders so those who pay for the drugs can make informed decisions.**

Prescription drug prices are out of control and contributing to unsustainable growth in health care costs in the U.S. In addition to straining the health care system, rising drug prices place financial burdens on patients who rely on prescription medicines to treat and manage their chronic conditions. For employer-provided coverage, growth in spending on prescription drugs outpaces spending for inpatient hospital care, and drug spending continues to grow at a faster rate than overall health care spending, making up a greater share of total medical expenses.<sup>4</sup>

### Recommendations

- **Pass the Creating and Restoring Equal Access to Equivalent Samples (CREATES) Act.** CREATES is needed to address abuse of patient safety protocols and ensure widespread availability of generic and biosimilar drugs to promote affordability and lower consumers' out-of-pocket costs. At a hearing on drug prices before the Senate Finance Committee on February 26, 2019, several CEOs of the largest global pharmaceutical companies even expressed support for CREATES.
- **Pass the Preserve Access to Affordable Generics and Biosimilars Act.** This bipartisan legislation would prohibit anti-competitive patent settlements that delay or prevent less expensive generic and biosimilar products from coming to market.
- **Urge the Administration and the Food and Drug Administration (FDA) to enact policies that accelerate generic entry.** The FDA should provide the necessary resources to clear the backlog of generic drug applications, particularly for classes of drugs with no or limited drug competition. "Pay-for-delay" settlements and "product hopping" should be challenged by the Federal Trade Commission (FTC) to address patent abuses and anti-competitive tactics.
- **The Inter Partes Review (IPR) process through the U.S. Patent and Trademark Office should be preserved.** The IPR process plays an important role in invalidating patents that do not represent true innovation and should not have been issued in the first place. Weakening this process would effectively extend the original patent monopoly for pharmaceutical and biological products and result in significantly higher prices for consumers.
- **Urge the Administration and the FDA to enact policies that create a robust market for interchangeable biosimilars.** Biosimilars offer great promise in generating cost savings for consumers. Some of the costliest and most widely used biologics have been on the market for decades without biosimilar competition. The FDA should finalize regulations that promote a robust, competitive market and ensure patients and providers have unbiased information about the benefits of biosimilars. For example, the FDA should provide clarity for all

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<sup>4</sup> *Where Does Your Health Care Dollar Go?*, AHIP. May 22, 2018. <https://www.ahip.org/where-does-your-health-care-dollar-go-ahip-has-the-answer/>

stakeholders and complete the biosimilar approval pathway by finalizing interchangeability policies. Without interchangeable biosimilars, Americans will never realize the truly significant cost savings that are possible due to greater price competition when biosimilar products are interchangeable with their reference product.

- **Revisit and revise orphan drug incentives through revisions to the Orphan Drug Act.** The Orphan Drug Act incentives are being misapplied. The law’s incentives should only be used by those developing medicines to treat truly rare diseases, not as a gateway to premium pricing and blockbuster sales for additional, non-orphan indications. In cases of rare diseases for which no effective therapy exists, policymakers should ensure that newly approved drugs are priced in accordance with their value and efficacy.
- **Support federal legislation requiring drug manufacturers to publish true research and development (R&D) costs and explain launch list prices and justify subsequent price increases.** Bipartisan legislation, the Fair Accountability and Innovative Research (FAIR) Drug Pricing Act, has been introduced in Congress that would require drug makers to submit a transparency and justification report to the Department of Health and Human Services (HHS) before they increase the price for certain drugs that cost at least \$100 by more than 10 percent in one year or 25 percent over 3 years. An alternative approach could require drug makers to publish list prices and relevant information about their launch list prices as part of the FDA approval process (and price increases for subsequent FDA approval of new indications). Several states – CA, CT, ME, MD, NV, OR, and VT– have already passed laws requiring drug makers to report the reasons behind drug price increases through annual reporting and disclosure requirements, but a single, comprehensive, federal solution is needed.
- **Enact new requirements for Direct-to-Consumer (DTC) Advertising and urge the FTC to strictly enforce existing regulations.** DTC advertising drives consumers to expensive brand name drugs when clinically appropriate, higher-value treatments may be available, which increases premiums for everyone. In addition to FTC enforcement of existing regulations to ensure drug ads are not misleading, new requirements for DTC advertising should include provisions to promote transparency and accuracy, including requiring that the list price be disclosed in all DTC drug advertising in a meaningful manner, as proposed by the Administration and in bipartisan legislation last year.
- **Encourage the use of evidence-based information on the effectiveness and value of treatments to inform decision-making by insurance providers, doctors and patients.** This may include, for example, support of the value framework and methodology used by the Institute for Clinical and Economic Review (ICER), an independent third-party entity with an established transparent process for multi-stakeholder engagement and input. Increased funding is needed to support private and public efforts to provide evidence-based information on the comparative clinical and cost-effectiveness of different treatments, procedures and medications to insurance providers, doctors, and patients. Findings from independent entities conducting comparative effectiveness reviews such as ICER can and should be used to inform decisions around coverage, payment and reimbursement for therapies and drugs.
- **Support the Administration’s proposals to expand the use of clinically appropriate, evidence-based medical management and formulary tools for certain high-cost “protected class” drugs and employ these tools for physician-administered medications**

**covered by Medicare Advantage (MA) plans.** For decades, these strategies and resources have been employed widely by commercial plans, and have applied to most medications covered by Part D. They are proven to help ensure safe, effective care that improves health, reduces costs, and increases value for all Americans. The thoughtful and targeted proposals from the Centers for Medicare and Medicaid Services (CMS) would ensure continued access to prescription drugs through strong beneficiary protections; promote safe, appropriate, and cost-effective use and clinical best practices; reduce overutilization of off-label indications; and enable plans to negotiate lower prices on behalf of Medicare beneficiaries and taxpayers.

- **Urge the Administration to withdraw the proposed rebate rule.** Savings from rebates go directly to consumers, resulting in lower premiums and out-of-pocket costs for millions of hardworking Americans. HHS' well-intentioned but misguided proposal would, by the government's own estimates, significantly increase taxpayer costs and Medicare beneficiary premiums – by an estimated \$200 billion. Focusing on rebates is a distraction from the real issue – the price of drugs that are in the complete control of manufacturers. In fact, the proposal does not provide any tangible assurances that manufacturers will in fact lower their list prices. The Administration should go back to the drawing board and focus on actions that will lower drug prices and hold drug makers accountable for the prices they set.

## **B. Challenge: Increasing Provider Consolidation is Driving Prices Higher**

**Solutions: (1) Strengthen and enforce policies that prevent anti-competitive provider consolidation; (2) Ensure rigorous monitoring of trends in provider consolidation, both pre- and post-consolidation, and take action as necessary; and (3) Better align CMS and other government policies with the goal of reducing the impact of monopoly and monopsony provider market power.**

One major cause of rising costs is provider consolidation – when more and more of a region's doctors and medical experts work for the same hospital or health system. By no surprise, research has found that when hospitals or health systems in a region get bigger and squeeze out competition, prices go up for consumers. That's basic economics.

Increasing provider competition is a complex challenge but a necessary component to addressing broader health care cost and access challenges. Provider markets that lack competition also lack appropriate incentives to restrain prices, innovate in care delivery, and partner with other stakeholders in ways that will benefit patients. Unfortunately, the trend continues to be toward more anticompetitive provider consolidation. The remedy will require both addressing this trend and implementing innovative legislative solutions to address already embedded provider market power.

Provider consolidation is not a new problem – hospitals have undergone multiple waves of consolidation over the past 30 years. Some of this consolidation eliminated the only, or the strongest, competitor to the acquiring hospital. Other consolidation assembled massive hospital systems that are “must have” for any health insurer looking to assemble a network in an area.

Finally, and more recently, physician practices have been consolidating, both through acquisition by hospitals and through mergers between physician groups.

In spite of promises that accompanied many of these transactions, the result, over time, was inevitable: Higher prices as well as lower incentives to compete in other areas such as quality. The Robert Wood Johnson Foundation (RWJF), the Center for Studying Health System Change, the Massachusetts Center for Health Information and Analysis and others have all documented the impact of this consolidation. For example, a RWJF study noted that “[S]tudies that examine consolidation among hospitals that are geographically close to one another consistently find that that consolidation leads to price increases of 40 percent or more.”

While no policy can fully undo the damage of lost competition from these transactions, there are policy steps that could mitigate the harm. Further, preventing further anticompetitive transactions will avoid the tragedy of history repeating itself in a cycle of promised benefits followed by concrete harm from provider consolidation.

## **Recommendations**

- **Ensure that the FTC and the Department of Justice (DOJ) have the resources to prevent anticompetitive provider consolidation.** The best way to protect competition is to prevent its elimination in the first place. The FTC and the DOJ should have both the resources and the mandate to challenge anticompetitive provider consolidation.
- **Request that the FTC engage in a second retrospective review of provider consolidation and utilize the findings of that review to challenge transactions that have led to consumer harm.** The FTC’s retrospective review of hospital consolidation significantly advanced understanding of the actual harm that resulted from such consolidation. The time is ripe for a second retrospective review by the FTC. Given the increasing role of vertical consolidation (e.g., hospital purchases of physician practices), the scope of the FTC’s review should be broadened to all provider consolidation. As part of its examination, the FTC should examine the impact of provider mergers that have received antitrust protection under state Certificates of Public Advantage (COPAs) and formulate policy recommendations based on this review.
- **Ensure that federal programs and the Affordable Care Act (ACA) marketplaces utilize network adequacy standards in a way that is driven by actual consumer needs, not as a disguised form of “any willing provider” policy.** Provider market power can be enhanced directly, through consolidation, or indirectly, through regulations that create or enhance power. This can occur through means such as “any willing provider” legislation or through network adequacy legislation that goes beyond its purpose and instead adds to provider market power. This should be examined and avoided.
- **Require CMS, jointly with the FTC and the DOJ, to engage in a review of its payment and other policies to determine which are likely to have the unintended consequence of leading to provider consolidation.** The federal government’s actions are not limited to those of a market regulator. It is also, through Medicare, Medicaid, and other programs, a market participant. In many ways, it is the most significant market participant. The policies that

apply to these programs have impacts that ripple throughout markets. For example, differences in Medicare payments based on site of service have been identified as a factor in provider consolidation. CMS should, with the assistance of the federal antitrust agencies, review its policies to determine which are or have the potential to harm competition.

- **Require CMS to utilize the results of such a review to modify its payment and other policies to reduce the risk of this unanticipated consequence.** CMS should be empowered to utilize the results of this review to modify its payment and other policies to reduce the risk that such policies will harm competition in provider markets.
- **Require federal programs and ACA markets to, as appropriate, allow for innovations in care delivery to replace traditional care delivery in establishing adequate networks in order to reduce the market power of today's provider monopolists.** Innovations involving the use of telemedicine, retail clinics and urgent care centers, practice up to the license of nurse practitioners, and ambulatory service centers have promise in promoting greater competition and lower cost – especially for markets that have been harmed by monopoly provider pricing and practices.

### **C. Challenge: High Rates of Uninsured or Under-Insurance Drive Up Prices**

**Solution: Reduce the number of uninsured and underinsured people in the United States and do not pursue policies that reduce the number of people covered.**

Our health insurance markets function best when the maximum number of people participate. Uninsured people are more likely to forgo lower-cost preventive care and seek care in the emergency room where they cannot be turned away. If those bills go unpaid, and they often do, the cost of providing that care is built into the prices paid by those who are insured, and the prices demanded of those in the individual and group markets in the form of premiums.

A large number of underinsured Americans will present similar problems. If providers are not reimbursed for the treatment they deliver because a pre-existing condition is not covered, that cost will be transferred into the prices of services for those who are covered.

There are specific considerations for promoting a stable market for people who don't have employer coverage and buy their own coverage on the individual health insurance market. A stable individual market requires broad participation of people who are healthy and sick, young and old. It also requires consumers to maintain continuous coverage, as opposed to enrolling only when they need care. Open enrollment provides an annual opportunity for new consumers to enroll in marketplace coverage and allows existing enrollees to reenroll in coverage or choose a different plan that best meets their needs.

Unlike other health insurance markets that have more static populations, such as employer-provided coverage or Medicare, the individual market is subject to frequent changes as consumers move in and out of coverage for various reasons, for example, due to a permanent



move or gaining or losing coverage from another source. Thus, marketing, outreach, and education are critical to ensure all consumers are aware of the open enrollment timelines.

## Recommendations

- **Advance federal legislation that will reduce individual market premiums, so more people can afford insurance.** In November 2018, we released 12 recommendations that will reduce individual market premiums (attached).<sup>5</sup> Some of these recommendations are included elsewhere in this letter (e.g., reduce drug prices). We also recommend the Committee renew its focus on other time-tested solutions such as federal reinsurance.
- **Enact legislation to permanently repeal the Health Insurance Tax (HIT).** Allowing the health insurance tax to resume in 2020 will result in higher premiums for consumers. If the tax is not suspended or repealed, individual market health insurance providers will have to factor in the cost of the health insurance tax for 2020 and the tax will contribute \$184 per covered person annually to the cost of coverage in the individual market. Because the tax is calculated as a percent of premium, the consumers paying the highest premiums already bear the biggest burden.
- **Enact legislation to permanently repeal the 40 Percent Excise Tax (“Cadillac Tax”).** Employers and plan sponsors are already increasing deductibles and other cost-sharing in preparation for the 40 percent excise tax on employer-provided health coverage scheduled to take effect January 1, 2022. These rising deductibles place financial burdens on working families and limit affordable access to care, which in turn can negatively impact long-term health and result in cost increases for everyone. Contrary to the rationale that only overly luxurious plans would be affected, the tax will quickly apply to nearly all employer-provided plans, beginning with those whose underlying costs are more expensive because they cover older Americans, retirees, women, those with chronic health conditions, and higher-cost geographic areas. In the first two years of the tax, 23 percent of plans that trigger the tax will have actuarial values below 70 percent, less than a silver plan on the Marketplace. The tax will penalize millions if it were to take effect, beyond the direct relationship to employers increasing deductibles in advance of the tax taking effect.
- **Encourage CMS to provide an option to states to transfer a portion of the Federally-Facilitated Marketplace user fee to the state to conduct outreach, education, and marketing.** Health insurance providers who participate on the federal exchange are required to pay a user fee of 3.5 percent of premiums (proposed to be reduced to 3 percent for the 2020 plan year). While CMS has not provided transparency into the allocation of these funds, the user fee is intended to be used to support marketing and outreach activities, among other Federal exchange functions. For the 2018 plan year, CMS announced a reduction in the Federal exchange’s marketing and outreach budget (from \$100 million in 2017, or \$11 per enrollee, and \$51 million in 2016, or \$5 per enrollee).
- **Maintain auto reenrollment processes in the exchanges to promote continuous coverage, lower burdens on consumers, and reduce administrative costs.** Auto reenrollment is a core process of the exchanges—as in Medicare and employer-provided

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<sup>5</sup> Also available at: [http://www.ahip.org/wp-content/uploads/2018/11/AHIP\\_AffordabilityWorkgroup-111518.pdf](http://www.ahip.org/wp-content/uploads/2018/11/AHIP_AffordabilityWorkgroup-111518.pdf)

coverage—that makes it easy for eligible consumers to maintain coverage from year-to-year and avoid gaps in coverage that could limit access to medical services and prescription drugs. CMS has indicated that it may eliminate auto reenrollment in the exchanges in future plan years, which could reduce effectuated exchange enrollments by 1 million and result in an increase in premiums of 5.7 percent for people who remain enrolled.<sup>6</sup>

- **Encourage the Administration to avoid policies that are likely to deter qualified individuals from appropriately accessing Medicaid coverage, such as the recently proposed Public Charge rule.** Such policies would have serious negative consequences for public health and the U.S. economy: sicker people, including seniors and children; weaker communities, resulting from sicker populations and weakened hospital systems; weaker American businesses, resulting from a sicker employee base; and higher taxes, as federal and state costs increase for emergency care and premiums go up for everyone.

#### **D. Challenge: Third-Party Premium Payments Raise the Price of Services**

**Solution: Prevent practices by providers and drug makers that raise the price of services or unnecessarily steer patients to high-cost treatments based on the financial interests of the provider or drug maker rather than the best clinical and financial interests of the patient.**

“Third-party payments” for drugs or health care services are made for consumers by outside entities, such as health care providers, drug makers, foundations, or other entities. Concerns about the conflicts of interest created by these payments have generally resulted in the prohibition of these payments in public programs like Medicare and Medicaid.

There has been less clarity regarding the use of these payments in the individual market. Health insurance providers have seen a rise in third-party payments from entities steering Medicare and Medicaid-eligible individuals into the individual market. The third-party organizations steering consumers to the individual market stand to benefit financially through greater reimbursement rates from private health insurance providers.

Steering older and less healthy consumers to the individual market also skews the risk pool to higher-cost individuals, resulting in higher premiums for everyone. Higher and higher premiums are especially challenging for hardworking Americans who pay for their coverage without any financial support. Ensuring consumers are enrolled in appropriate coverage designed to best meet their needs, instead of steering them to coverage that results in financial gain for a third-party providing health care services, will help keep costs lower and contribute to a more stable market.

Drug coupons and copay cards represent another type of third-party payment funded by drug manufacturers. Often, drug makers provide consumers with substantial financial contributions through cash assistance to pay for brand-name drugs, encouraging use of those drugs instead of less expensive generics or therapeutic substitutes. While the consumer receives a reduction in

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<sup>6</sup> Avalere. HHS Proposed Changes Could Reduce ACA Coverage and Increase Premiums. February 18, 2019. <https://avalere.com/press-releases/hhs-proposed-changes-could-reduce-aca-coverage-and-increase-premiums>

their out-of-pocket co-payment, health insurance providers often pay the whole cost of the drug, increasing overall costs and driving up premiums. Drug coupons lead to unnecessary spending that is ultimately passed on to consumers and businesses through higher premiums, high cost sharing for other types of services, or more limited coverage options. Similar to third-party payments, drug coupons are not allowed in Medicare and Medicaid because they represent an inducement under the federal anti-kickback statute.

## **Recommendations**

- **Congress should not expand the list of third-party entities from which health insurance providers must accept premium and cost-sharing payments, as this will raise premiums for everyone in the individual market.** HHS has identified a limited roster of entities from which health insurance providers must accept third-party payments, including Ryan White and HIV/AIDS programs, Indian tribes, and state and local programs. Expanding this list to include other entities would result in higher premiums and decreased affordability for consumers. Furthermore, Congress should prohibit direct and indirect premium payments to entities in which the health care provider has a financial interest.
- **Support regulatory actions to address conditions for coverage for end-stage renal disease third-party payment.** In December 2016, HHS published an interim final rule that outlined a narrow set of circumstances in which third-party payments by dialysis facilities would be allowed. Due to ongoing litigation, the effective date for this rule has been delayed indefinitely. Revised rulemaking should retain requirements for dialysis facilities to meet certain conditions in order to receive reimbursement and clarify that health insurance providers would not be required to accept third-party payments if those conditions are not met.
- **Extend the prohibitions on the use of copay coupons or other discount programs for brand-name drugs already in place in Medicare and Medicaid to the commercial market if there is a less expensive, equally effective alternative drug available.** Congress should take steps to address the increased use of prescription drug coupons and co-pay assistance cards, by prohibiting their use in the commercial health insurance market just as they are prohibited in federal programs.

## **E. Challenge: Fraud Still Costs Billions of Dollars a Year**

**Solution: Support the existing public-private partnership that has already succeeded in preventing billions of dollars of fraud, and extend and include the cost of fraud fighting in the Medical Loss Ratio (MLR) calculations of all programs (not just in Medicare Advantage).**

Recognizing the importance of eliminating unnecessary spending from the health care system to reduce costs and improve affordability, we want to emphasize the value of investments made by health insurance providers in fighting health care fraud. The Federal Bureau of Investigation

(FBI) estimates that health care fraud costs American taxpayers between 3 and 10 percent of what is spent on health care – between \$80 and \$230 billion a year.<sup>7</sup>

The enormous costs of health care fraud are borne by all Americans, and eliminating fraud and abuse is a critical priority for health insurance providers as well as public programs. AHIP members have invested billions of dollars in initiatives to monitor, detect, and eliminate criminal behavior. Many health insurance providers have established their own designated investigation units comprised of highly trained professionals who employ sophisticated analytics that indicate when an investigation is warranted – to prevent, detect and remedy fraudulent and abusive conduct. When they find criminal activity, they work closely with law enforcement – local police, state police, the FBI, and the Drug Enforcement Administration (DEA) – to stop fraud and protect the American people. This work helps ensure that the care paid for is legal and warranted and, more importantly, protects consumers and patients from both physical and financial harm.

Our members' anti-fraud initiatives also include credentialing activities that identify health care providers who are not qualified, not appropriately licensed, or are operating outside the scope of their expertise. Anti-fraud initiatives focus on:

- Identifying usage patterns indicative of substance abuse and implementing drug utilization programs that rely on data analysis and clinical assistance to provide interventions to help members obtain appropriate treatment for substance use disorders;
- Identifying patterns of provider overutilization or situations where health care providers perform, order, or deliver procedures that are not medically necessary or appropriate; and
- Identifying instances of medical identity theft, including assisting victims in correcting false information in their medical records.

These activities are examples of how health insurance providers' fraud fighting, prevention and detection activities have helped protect consumers from harm, identified abusive practices, and acted to curtail them in order to improve safety and improve health outcomes for enrollees.

Recognizing the important role fraud prevention initiatives play in protecting patients and preventing unnecessary spending, these activities – even though categorized as administrative spending – are, in fact, an investment and a highly effective use of our health care dollars.

HHS recognized the value of fraud and abuse prevention and detection, and the need for aggressive actions to address them early in the Medicare Advantage program. HHS also recognized the administrative costs that insurers incur in fraud fighting in the MLR calculation for that program.

While recognized in the Medicare Advantage MLR calculation, these costs are not similarly recognized in the MLR calculations for Medicaid or the ACA market reforms. For example, the MLR methodology in individual, small group and large group comprehensive major medical

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<sup>7</sup> FBI-HealthCare Fraud at [https://www.fbi.gov/about-us/investigate/white\\_collar/health-care-fraud](https://www.fbi.gov/about-us/investigate/white_collar/health-care-fraud)

coverage only allows claims recovered through fraud detection efforts to be added to the incurred claims. This does not recognize the scale of activities and expenses that the plans never recover. Thus, we recommend this solution to assist in promoting even stronger fraud and abuse detection and prevention.

### **Recommendation**

- **Permit health insurance providers offering either Medicaid Managed Care Plans or private market comprehensive major medical health insurance coverage to include the costs of their fraud and abuse prevention, detection, and work with law enforcement in the MLR calculation to be deducted from their administrative expenses.**

The Healthcare Fraud Prevention Partnership (HFPP), of which AHIP is a founding member, is a voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance providers, and health plan associations. These entities and organizations work together to foster proactive approaches to detecting and preventing health care fraud through data and information sharing. The HFPP offers a forum that facilitates the sharing of identifiable federal, state, and public-sector data and best practices with partners from across the health care landscape.

### **Recommendation**

- **Support the passage of legislation to codify the HFPP in its current form and with its current functions.** Such legislation would also establish reporting and planning requirements for the HFPP; require the HFPP to carry out a study of substance use disorder treatment fraud and abuse; and require the HFPP to report on the feasibility of establishing a system to conduct data analysis to provide entities with real-time feedback on potentially fraudulent health care claims.

## **F. Challenge: Surprise Medical Bills Raise Patient Costs**

**Solution: Protect consumers when they seek care at an in-network facility or face an emergency.**

At least 1 in 5 consumers will receive a surprise medical bill. A surprise medical bill occurs when an out-of-network (OON) provider at an in-network facility bills the patient for any amount not reimbursed by the health insurance plan. Insured individuals should have a reasonable expectation that they are financially protected when they have done everything they could do to seek care at in-network facility. Surprise medical billing is also linked to the growing trend among provider groups and some hospitals that have consolidated to a point they can refuse to contract with health insurance providers. This strategy drives up costs for patients and increases the likelihood that patients will receive a surprise medical bill. Most health insurance providers today are covered by OON payment rules that specify how they will determine the

amount to be paid to out-of-network providers for emergency services. However, the ACA does not prohibit providers from billing patients for the remaining balance and sets no limits on the amount a doctor or hospital can bill.

We have worked with state policymakers to support state legislation that included regulatory guardrails under these circumstances to providers to protect consumers from surprise medical bills. However, state approaches do not help the more than 100 million Americans who receive coverage through a self-funded plan governed by ERISA, products which cannot be regulated by the state Department of Insurance, or people with state-regulated insurance residing in states that have not yet taken action.

Air ambulances generate some of the most egregious surprise bills related to medical emergencies. The Airline Deregulation Act of 1978 prevents states from exercising the same oversight over air ambulances that they exercise for other emergency medical providers. This allows air ambulance providers – who deliver essential emergency medical transportation to patients who have no choice – to uncompetitively price gouge health care consumers and insurance providers alike. Anticompetitive behavior increases the cost of such life-saving transportation and premiums for everyone. Far from unleashing the competitive forces that Congress contemplated would result from deregulation, extending the Airline Deregulation Act to the unique market for these highly-specialized emergency medical transportation providers prevents states from helping to level the playing field, and fosters unfair business practices and consumer harm.

## **Recommendations**

- **Enact federal legislation to protect patients from surprise medical bills.** We support federal legislative action to end surprise medical bills by prohibiting health care providers from billing patients for balances above a benchmark reimbursement amount.
- **Require hospitals to inform patients when care is out-of-network.** Patients have a right to know in advance if a doctor involved in their care is out-of-network and the impact on their financial obligation.
- **Implement a federal policy to protect consumers from surprise medical bills while restraining costs and ensuring quality networks.** Putting patients first means enacting policies that protect consumers from surprise medical bills, while ensuring that those policies do not simultaneously increase premiums or other costs for consumers. This requires reining in out-of-control charges from certain provider specialties so that rates reflect the actual cost of care, rather than price inflation, which will lower premium costs for everyone. Doing so will also maintain incentives for quality providers to contract with health plans to ensure more Americans have a broad choice of providers.
- **Base payments to out-of-network providers on a federal standard.** More than 100 million Americans are enrolled in a self-funded health plan. Protecting them requires a federal standard that reduces complexity while ensuring they cannot be surprise-billed. A federal standard should encourage network participation while restraining costs. We propose requiring out-of-network providers to accept a rate of the greater of the average in-network

rate for that service in the patient's health plan or 125% of the Medicare rate for the service. Some states have existing laws that closely reflect this standard and would not increase costs. Congress should allow states to apply their own standard to fully insured plans so long as the standard does not result in higher payments than the federal standard that would apply to all ERISA plans.

- **Update federal statute to allow states to regulate air ambulance providers to prevent egregious bills.** Many states have attempted to take action to protect consumers from excessive air ambulance bills, which cost \$50,199 on average in 2016, only to find their efforts stymied in the court due to barriers imposed by federal statute. Congress should update the Airline Deregulation Act of 1978 to allow states to regulate their markets or expressly prohibit surprise medical billing by air ambulance providers through federal law.

## II. Incentivize High-Quality Care

*High-quality, evidence-based care is critical to reducing costs.* In recent years, health insurance providers have partnered with doctors and hospitals on the journey from volume-to-value, working to transform our system from one that pays health care providers more when *more* care is provided to a system that pays more when *higher-quality, more cost-effective* care is provided while improving the patient experience.

Reducing harmful and unnecessary care is a key goal. Studies estimate that roughly one-third of health care costs are associated with waste in the system. By focusing on quality measurement, aligned financial incentives, and appropriate medical management that drives the system toward evidence-based care, health insurance providers work collaboratively with clinicians to reduce unnecessary care that diminishes the patient experience, can cause harm, and drives up costs.

Toward this shared goal, health insurance providers have invested in advanced analytics to better identify the needs of consumers and opportunities for care improvement to health care providers. A patient's health plan has a much broader view of the patient's care than any individual provider, but the lack of true interoperability hinders plans' ability to disseminate important information to providers and to provide a consolidated view of health information to plan enrollees. Improving interoperability would enable health insurance providers to better coordinate care for their enrollees and reduce unnecessary costs.

### A. Challenge: Lack of Interoperability Impedes Quality Measurement and Improvement

**Solutions: (1) Promote alignment of quality measures between public and private payers; and (2) Ensure the Administration implements policies that make it easier to collect, report, and receive feedback on quality measures.**

Health insurance providers are at the forefront of efforts to develop and implement performance measures that reward the delivery of high quality, evidence-based health care services. While

robust measurement programs are in place, our member plans have identified two overarching obstacles in gathering the data needed for the quality measures: a lack of electronic health record (EHR) interoperability and overly burdensome processes for health care providers to capture data for quality measures.

Ideally, new information technology is meant to enable efforts such as behavioral health integration and care coordination. However, the clinicians with whom our members contract report that EHRs often create additional administrative work, crowd out patient care, and do not deliver true interoperability. Many health insurance providers provide portals for health care providers within value-based arrangements with robust data to assist with adherence to the evidence base, care coordination, and quality improvement efforts. However, health care providers must log-in and out of the various portals based on each patient's coverage. It is imperative that EHRs are structured to easily collect and transmit quality measurement information, as well as support real-time clinical decision-making without overburdening health care providers. This will return provider time to patient care, improve outcomes, and reduce both medical and administrative costs.

For this to happen, however, EHRs must be able to speak the same language as the providers' systems, the plan's systems and that of other stakeholders to share information from multiple locations on one physician's computer screen instantaneously. Moreover, it requires EHRs to be configured in an easy-to-use manner that naturally collects the information needed for quality measurement as part of a normal visit, and at the same time embeds actionable information to improve care. Certified EHR Technology (CEHRT) should empower value-based payers to insert actionable clinical information into a patient record so health care providers can be alerted to potentially helpful information at the point of care. Furthermore, CEHRT should be better configured to more easily collect quality measurement information.

A specific example of both a policy and interoperability barrier to high-quality care is the inability of health insurance providers to connect electronically with prescription drug monitoring programs (PDMPs). Health insurance providers have an important role to play in addressing the financial and human costs of substance addiction. Health insurance providers provide resources and care navigation assistance to enrollees suffering from substance abuse disorder and help curb inappropriate prescribing through their payment and medical management policies. State and federal policies should be updated to support health insurance providers playing this role.

Virtually no states allow health insurance providers and pharmacy benefit managers (PBMs) to access state PDMPs in order to have a more complete picture of their members' controlled substances prescriptions, hampering efforts by plans and PBMs to assist. This information would allow health plans to target assistance to particular health care providers with an opportunity to improve prescribing patterns and specific patients for whom care management and other services are needed. Health insurance providers are committed to protecting the security and privacy of this information, and to using it solely to improve care for members.



To further reduce the burden associated with quality measurement, more work must be done to develop electronically specified measures (ones that can be derived from the EHR rather than a nurse scouring a paper chart) and advance the public-private alignment of such measures. AHIP leads the work of the Core Quality Measures Collaborative (CQMC) in partnership with CMS and the National Quality Forum as its operational home. This group is a broad-based coalition of health care leaders, including health insurance providers, medical associations, consumer groups, and employer groups. Its members work together to identify core measure sets – succinct groups of high value, evidence-based, and patient-focused measures for consistent use across a broad set of programs – but only a few are electronically based. Through promotion of the core measure sets, the CQMC aims to promote quality measure alignment across public and private payers, reduce provider measure reporting burden, offer consumers actionable information about provider performance, and improve care quality and health outcomes.

## **Recommendations**

- **Ensure the 21st Century Cures Act is implemented quickly, and as Congress intended, to accelerate interoperability and ensure doctors and health insurance providers can easily share critical information to improve care coordination.**
- **Monitor the 21st Century Cures Act requirement to minimize the burden of EHRs on health care providers by ensuring recommendations to improve clinical functionality and presentation of clinical data in EHRs are implemented sufficiently by the HHS Office of the National Coordinator for Health Information Technology (ONC).**
- **Require states to allow all health insurance providers easy access to PDMPs for patient safety and care coordination purposes through machine readable formats.**
- **Fund the development of electronically specified quality measures that are derived from information collected as part of a physician’s natural workflow, as well as continued participation by CMS in the public-private Core Quality Measures Collaborative.**

## **B. Opportunity: Promote High-Value Networks**

**Solution: Continue to support innovative payment models and identify opportunities for alignment between public and private value-based payment arrangements.**

Insurance providers are deeply committed to moving the health care system from one that rewards volume to one that rewards value. Last year, AHIP again teamed up with the Health Care Payment Learning and Action Network (LAN) to conduct an annual member survey of Alternative Payment Model (APM) adoption. The [report](#) highlighted that the MA program continues to lead the way in value-based care, with 50 percent of MA provider payments in APM contracts, the highest percentage across all payer types studied (including Medicare fee-for-service). Value-based contracts between MA plans and providers groups have been found to

improve utilization, such as increasing office and preventive visits and decreasing emergency department and inpatient hospital admissions, while increasing survival rates.<sup>8</sup>

As part of this transformation, plans are building out high-value networks across the country by investing in physician practices' readiness to take on risk. Plans are providing seed money, data, technology, and other resources to physicians to transform their practices. By structuring payment in a way that financially rewards physicians for high-quality care and encourages them to innovate, we see the total cost of care decline with even higher quality. This investment is also important in withstanding the trend of physicians affiliating with health systems. By cultivating these physician practices, we can avoid consolidation in the market that is proven to increase prices.

In addition, in many geographies with high MA enrollment, spending in the FFS program goes down as health care providers adopt practice patterns and care guidelines that “spill over” into their care of beneficiaries who remain in Medicare FFS. Moreover, many of the providers with whom our members have APM arrangements also serve Medicare FFS patients through Medicare APM contracts (e.g., Medicare Shared Savings Program). Commercial insurance companies also recognize that aligning payment models and incentives, both cost and quality, across payers serves to create synergies that advance the respective programs further and faster, improve quality of care for members, and ease providers' administrative burden.

As part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress provided a 5 percent bonus payment to eligible clinicians to join the movement away from FFS toward value-based payment models in Medicare. Eligibility for that bonus is based on an escalating minimum amount of the clinician's revenue flowing through such programs. Currently the 5 percent bonus will sunset after 2024, creating a major disincentive for providers to move into APMs and take on risk. Furthermore, eligible clinicians participating in APMs within MA can be at a disadvantage because there is an underlying threshold that requires at least 25 percent of revenue flowing through Medicare FFS Advanced APMs before the MA participation can be counted toward eligibility for the bonus. Additionally, the APM bonus threshold under MACRA should be reconsidered. As designed, with thresholds escalating up to 75 percent of revenue, it is likely that even a Next Generation Accountable Care Organization in a full downside risk arrangement would not be eligible for the bonus – sending a counterproductive signal to downside risk-taking providers.

CMS and the Office of the Inspector General (OIG) recently released tandem requests for information seeking feedback on modernizing the Physician Self-Referral and Anti-Kickback laws to facilitate value-based care. These laws are specific to health care providers practicing within federal programs, but there are potential spill-over effects on the commercial markets. While there are a number of specific exceptions for certain financial relationships within health care, we believe additional, targeted simplifications and modernizations to the current legal

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<sup>8</sup> Mandal, Alope K., Tagomori, Gene K., Felix, Randell V., Howell, Scott C. Value-based contracting innovated Medicare Advantage healthcare delivery and improved survival. *American Journal of Managed Care* 23(2): e41-e49. February 2017

framework are needed to reduce provider burden and, in turn, encourage greater participation in value-based care and alternative payment arrangements across multiple payers while still keeping in place the law's overarching protections against fraud and abuse in the Medicare program. We look forward to proposed rules from CMS and the OIG and believe those agencies are able to make sufficient change within the current statute and within demonstration programs to better encourage care coordination within the new care delivery system.

## **Recommendations**

- **Protect against provider consolidation and higher prices by continuing to invest in Medicare Advantage and Alternative Payment Models.**
- **Monitor the impact of the recent regulatory changes to the Medicare Shared Savings Program (MSSP) to ensure robust participation continues.**
- **Extend the 5 percent payment bonus for Advanced APM participation included in MACRA, remove the underlying 25 percent Medicare FFS revenue threshold, and consider revising the minimum revenue threshold escalation levels.**
- **Encourage CMS to implement more multi-payer models in a collaborative fashion.**
- **Support CMS and the OIG's use of their existing authority to modernize the Physician Self-Referral and Anti-Kickback regulations to support the adoption of value-based arrangements.**

### **C. Opportunity: Health Insurance Providers are Promoting Safe, Effective, Affordable Care**

**Solution: Maintain flexibility to use medical management to support safe, appropriate, and affordable care.**

Significant gaps have long existed between evidence-based practices and the care actually being delivered to patients and there continues to be wide variations in practice with little to no correlation between spending and quality.<sup>9,10</sup> The Institute of Medicine has estimated that needless medical tests waste billions of dollars every year – between \$200-\$800 billion wasted annually on excessive testing and treatment.<sup>11</sup>

The private sector has long recognized the value of medical management in promoting safe, effective, and affordable care for consumers. Health plans employ a variety of tools referred to collectively as “medical management” to help health care providers and consumers understand how to best access high quality, high value treatment options under the patient's specific

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<sup>9</sup> Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century. Institute of Medicine, Committee on Quality of Health Care in America. Academy Press, 2001 and To Err is Human: Building a Safer Health System. Institute of Medicine. Committee on Quality of Health Care in America. National Academy Press, 1999.

<sup>10</sup> Variation in Health Care Spending: Target Decision Making, Not Geography. Institute of Medicine. July 24, 2013

<sup>11</sup> Best care at lower cost: the path to continuously learning health care in America. Institute of Medicine. September 6, 2012

insurance policy. Medical management, which includes using evidence-based standards and tools like medical necessity, prior authorization, concurrent and retrospective review, and step therapy, among others, helps ensure that consumers receive optimal care based on well-established standards of efficacy and safety and reduces spending on unnecessary or ineffective care. Some examples of how medical management supports better care for patients include:

- Encouraging recommended, but underutilized, preventive services like cancer screenings, statins, and immunizations.
- Ensuring that opioid prescribing adheres to federal recommendations designed to prevent addiction and abuse.
- Protecting patients from unnecessary exposure to potentially harmful radiation from inappropriate diagnostic imaging, such as CT scans for headaches.
- Encouraging the use of equally effective, more affordable generic medications.
- Helping to ensure that care is delivered by high value, experienced providers and facilities, such as centers of excellence.
- Supporting use of medications for indications where there is evidence of safe and appropriate use.

Medical management features are a critical part of discouraging harmful or unnecessary care in many public programs as well. In addition to using a medical necessity standard, traditional Medicare has used prior authorization for certain durable medical equipment that are frequently subject to unnecessary utilization and is in the process of implementing a prior authorization program for advanced diagnostic imaging. Traditional Medicare has also implemented a number of prior authorization demonstration programs for specific services and has been encouraged by the Government Accountability Office (GAO) and the Medicare Payment Advisory Commission (MedPAC) to more broadly adopt this tool. In fact, a recent report by GAO recommended that the Medicare program continue prior authorization efforts to reduce spending, citing their analysis that estimated savings from CMS prior authorization demonstrations through March 2017 could be as high as \$1.1 to 1.9 billion. Numerous state Medicaid programs use prior authorization for long-acting opioids and, more recently, CMS has increased flexibility to use prior authorization and step therapy in the Medicare Part D program and enabled MA plans to use step therapy for Part B medications.

### **Recommendation**

- **Support flexibility to use medical management tools in both the private and public sectors.**

### **D. Challenge: Incentivizing High-Value Care Pre-Deductible is Prohibited for HSA Plans**

**Solution: Enable consumers who use HSAs to obtain high value care pre-deductible to avoid more costly care later.**

Millions of Americans currently use Health Savings Accounts (HSA) to save pre-tax dollars for future health care expenses. HSA funds are not subject to income taxation and using these funds to pay for expenses allows for consumer dollars to go farther, increasing affordability.

Currently, there are strict limits on what health policies can be paired with an HSA, including a minimum deductible amount and a prohibition on plan coverage of services before an enrollee has met their deductible, except for services or visits that are solely preventive. Allowing more individual market plans to be eligible for pairing with an HSA will give more Americans the ability to save for near-term and long-term health expenses without paying taxes on those savings. Additionally, giving health insurance providers the flexibility to offer coverage of certain high-value services, treatments, or medications necessary to treat chronic health conditions before an enrollee has met their deductible will allow millions of Americans in HSA-eligible plans to better afford essential services that may prevent costly emergencies in the future.

### **Recommendation**

- **Expand the criteria for health plans to be HSA-eligible, to include all catastrophic and bronze plans in the individual and small group markets and to include all plans with a similar actuarial value to a bronze plan in the large group market.** Both catastrophic and bronze plans typically include high deductibles that allow for more affordable premiums, but limit overall affordability when it comes to accessing medical care. One way to give consumers a tax-advantaged means of preparing for future medical costs and having funds to access care is to permit those consumers to save in an HSA. Section 223 of the Internal Revenue Code places strict limits on which plans may be HSA-eligible. A federal bill that would accomplish this (HR 6311) was approved by the House in July 2018.

### **III. Give Consumers the Information they Need**

*Americans want to be able to choose care that meets their specific needs.* We are pleased to see the Committee requested comments specifically about ways to increase the ability for patients to access information about their care to make informed decisions. Consumer engagement is a critical tool in transforming the health care system. They can, and should, be active purchasers of value-based care, but consumers need the tools to do so. While EHRs are now pervasive, we have yet to reach the point where patients have easy access to their own personal health information embedded in the EHRs.

Health insurance providers invest significant resources in making cost and quality information available to consumers to help them make informed choices for themselves and their families. AHIP strongly supports making quality information available to consumers on publicly administered platforms such as the Medicare Plan Finder. Plans also make information available through their own patient portals, mobile apps, call centers etc. As noted above, AHIP also is working with the physician community to reduce the number of measures used to provide a

clearer signal of what good care is to help patients to make choices, physicians to improve care, and plans to pay for value. AHIP also regularly partners with other stakeholders, such as the Health Financial Management Association, on recommendations for price transparency, including ways to make cost information more accessible.<sup>12</sup> AHIP and our member health insurance providers are eager to work with policymakers and other stakeholders to make it easier for Americans to access cost and quality information that will help them make health care decisions.

#### **A. Challenge: Consumers Don't Have Centralized Access to Their Health Information**

##### **Solution: Improve interoperability to enable better consumer access to personal health information.**

The potential of centralized individual health records to prevent medical errors, some of which can be fatal, and reduce unnecessary costly repeat procedures and tests has long been recognized. Patients also want to be able to access their health records and to easily share information from one health care provider to another.

The meaningful use policies implemented under the HITECH Act have increased the use of EHRs substantially. Despite these gains, most consumers still do not have centralized EHRs where they can easily access all the health care information that's most important to them and seamlessly communicate with all their providers. The lack of interoperability between various health records also presents a major obstacle to health insurance providers, clinicians, and other innovators with ambitious visions for using data to improve care, lower costs, and customize consumer experiences based on their preferences and medical history.

AHIP and our members support seamless access to health information by health care providers and patients to make better choices about care and treatment. Health insurance providers are committed to establishing new, innovative ways to integrate and share data with consumers and doctors. This improves care coordination and leads to better outcomes and higher patient satisfaction. As noted above, our member health insurance providers are also taking a consumer-centric approach to making readily available consumer portals, mobile apps and other technologies to communicate information to consumers where and when they need it.

HHS recently issued two proposed rules to support seamless and secure access, exchange, and use of electronic health information. The rules, issued by CMS and ONC, are meant to increase choice and competition while fostering innovation that promotes patient access to and control over their health information. We, too, support these goals and will provide suggestions on how to promote consumer-friendly solutions that enable the kind of care consumers want and need in a relevant and usable format, without risking patient privacy or creating unnecessary operational complexity.

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<sup>12</sup> Price Transparency in Health Care Report from the HFMA Transparency Task Force, Healthcare Financial Management Association. 2014.

As policymakers make forays into interoperability in the commercial health insurance markets, we recommend that lessons being learned as part of Medicare initiatives be leveraged to protect patient privacy and simplify implementation. As part of CMS' Blue Button 2.0 Initiative, the agency is vetting more than two thousand application developers to determine appropriateness for accessing Medicare data for consumer security and privacy. CMS should serve as a beta site for such consumer-directed access and share findings with private payers to inform their efforts. This would spur innovation rather than each payer duplicating efforts and drawing funds away from further innovation. Moreover, it is key that Medicare serve as an example, but not dictate how the private sector should implement such programs. The commercial markets are known for being nimbler and should not be hindered by government regulations that codify not only which technologies will be used, but which version. It would be a mistake to risk slowing innovation in such a fast-moving part of the economy.

### **Recommendations**

- **Protect patients' privacy and promote market innovation by urging CMS to develop a voluntary, multi-payer pilot project before national implementation of the private plan Blue Button initiative.**
- **Discourage ONC from codifying specific technical requirements that hinder the industry from being agile as technology and consumer needs evolve.**

### **B. Challenge: Consumers Don't Have Consistent Access to Usable Quality and Price Information**

**Solution: Ensure health care providers engage patients about financial obligations during the shared decision-making process and educate patients about quality information available in choosing where to get care or which plan to select.**

As noted above, health insurance providers invest in numerous methods to share cost and quality information with members. Patient portals commonly include relevant information on the quality of different health care providers to assist in choosing where to seek care. Moreover, plans are using this quality information to build high-value physician networks. In terms of shopping based on costs, the most relevant information for consumers is their expected out-of-pocket costs in the form of deductibles, copays and coinsurance. They want to know what their specific financial liability will be in advance of a health care service being rendered. The data points needed to answer this question are: (1) what are the specific services that will be provided; (2) at what prices will the services be provided; and (3) what are the patient's health insurance benefits and how do they apply to these specific services at the provider(s) being considered?

Health insurance providers have been working to provide consumers with better information about their likely out-of-pocket costs and, when applicable, information on lower cost options. The Catalyst for Payment Reform's 2014 National Scorecard on Payment Reform reported that

97 percent of health plans offer or support a cost calculator tool.<sup>13</sup> In addition, an AHIP survey of health insurance providers with price transparency tools found that they use a variety of consumer-friendly methods such as messaging on plan portals, outreach through employers, digital communications—including email, social media, and text messaging—and postal mail to make their enrollees aware of available price transparency tools.

However, plans can only provide estimates for common services, and despite these efforts, consumer uptake of these tools appears to be slow. Health care providers are the ones who know what specific services will be provided and at what price. While the health insurance provider can certainly speak to a patient’s benefits, providers are also able to easily and electronically determine a patient’s benefits, coinsurance structure, and where the patient is in their deductible. To truly engage patients in shared decision-making, providers need to be able to furnish patients with estimates of their out-of-pocket costs in advance of services, similar to the estimates provided by dentists, auto mechanics, and veterinarians.

In addition, individuals choosing among traditional Medicare or Medicare Advantage as well as selecting Part D plans are unable to easily compare their options due to limitations with the online tool CMS makes available – the Medicare Plan Finder. A recent assessment of this tool has identified a range of flaws and necessary improvements to facilitate better transparency and more informed patient engagement in the Medicare plan selection process.<sup>14</sup>

## **Recommendations**

- **Encourage health care providers to educate patients about the availability of relevant cost information, including expected out-of-pocket costs from insurers before services are rendered or referrals are made.**
- **Encourage providers to use electronic transaction sets to access information about the patient’s benefit structure and what remains of the deductible, and then share it directly with the patient.**
- **Encourage providers to work directly with health plans to develop an estimate by sharing expected services, and charges where applicable, with the plan.**
- **Dedicate funding to improve the Medicare Plan Finder, or develop an alternative, based on comprehensive recommendations reflecting the consensus of CMS staff, plans, beneficiary advocates, providers, and other stakeholders.**

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<sup>13</sup> National Scorecard on Payment Reform. Catalyst for Payment Reform. 2014.

<sup>14</sup> Clear Choices Campaign and National Council on Aging. Modernizing Medicare Plan Finder: Evaluating and improving Medicare’s online comparison shopping experience. April 2018. Available at: <https://static1.squarespace.com/static/547e0e88e4b0d4a9ddc29e99/t/5aeb24b6352f53cf7ab94656/1525359803050/C+2018+MedicarePF+Report+5.3.18+FINAL.pdf>



### **C. Opportunity: Support Patients and Health Care Providers Making Informed Decisions Based on Cost and Quality**

**Solution: Reauthorize the Patient-Centered Research Outcomes Institute (PCORI), allow for the consideration of cost-effectiveness in PCORI research, and establish an accelerated process for setting the research agenda and funding studies.**

Before comparing options based on provider quality and the cost of care, consumers want – and deserve – to know that the treatment options they are considering are safe and effective. Providing consumers with information that’s meaningful to them to compare treatment options has been very challenging.

PCORI was authorized as part of the Affordable Care Act. Its purpose is to assist patients, clinicians, purchasers, and policymakers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases and other health conditions can effectively be prevented, diagnosed, treated, monitored, and managed through research and evidence that considers variations in patient subpopulations, and the dissemination of findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness. In contrast with ICER which we discussed above (see Section I.A.), PCORI’s authorizing legislation under the ACA prohibited the organization from including cost or cost-effectiveness in its research which has been a significant constraint.

AHIP and our health plan members continue to believe in the critical importance of comparative effectiveness research (CER) to inform stakeholders’ medical policy decisions. PCORI’s original authorization expires on September 30, 2019. PCORI serves as a trustworthy source of critical CER, filling gaps in existing health care research. However, the cost of PCORI is not insignificant for payers, and at this point it is difficult to measure the success of PCORI’s output as most of the funded studies are not yet completed. As a result, we are not comfortable with a full reauthorization. However, a one- or two-year extension would likely not provide sufficient time to demonstrate the true value, since the first significant wave of studies is expected to be released in 2020. In addition, with State and Federal rate submission deadlines starting in May 2019 for the 2020 plan year, it is important that insurers know their PCORI-related costs in time to include them in their rate submissions. As such, we would ask that Congress consider these important factors when taking up legislation reauthorizing PCORI.

#### **Recommendations**

- **Reauthorize PCORI for a three-year period and allow PCORI to consider cost-effectiveness in its research.** PCORI’s long-term clinical outcomes data can be key to estimating cost and value, but currently PCORI’s hands are tied from producing these types of critical findings. Independent research on which treatment options yield the best value for patients is crucial to informing health plans on which coverage choices will improve the health and well-being of their members while also protecting members from unnecessary financial burdens.

- **Require PCORI to establish an accelerated, evidence-based process for setting the research agenda and funding studies.** CER is valuable but often requires four to five years to complete, limiting health insurance providers' ability to factor the findings into their decision-making. An accelerated process for setting the research agenda and funding studies should consider gaps in comparative evidence on clinical effectiveness and appropriateness. This change would also support more short-term research that would both help provide more timely answers to key research questions and help PCORI be nimbler in how it guides future research.

# 12 Solutions to Lower Premiums for Hardworking Americans Who Buy Their Own Coverage



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# Improving America's Health Care System: 12 Solutions to Lower Premiums for Hardworking Americans Who Buy Their Own Coverage

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## Introduction

Every American should be able to get affordable, comprehensive coverage - regardless of their income, health status, or pre-existing conditions. But hardworking Americans who buy their coverage on the individual market are increasingly finding their premiums are out of reach if they don't qualify for premium subsidies. This population includes families with an income that is more than 400 percent of the federal poverty level (\$47,520 for an individual or \$97,200 for a family of four).<sup>1</sup>

Consumers and policymakers at the federal and state levels want solutions. In this paper, we provide several recommendations for actions state and federal policymakers can take to make premiums more affordable. Our recommendations address three issues that drive up premiums for these families:

1. The out-of-control cost of health care services and prescription drugs.
2. Families making over 400 percent of the federal poverty level are the only segment of the American population that don't receive some help with their insurance premiums.
3. Too few healthy people participate in the individual market to balance out the risk.

State and federal policymakers and regulators can take action now to improve premium affordability. Some of these recommendations can be implemented very quickly through regulation, while others require state or federal legislation. While this paper focuses on improving out-of-pocket premium affordability for those who don't qualify for federal support, many of these recommendations will drive down premiums for everyone, reducing the total cost of subsidies and the financial burden they place on taxpayers.

## Describing the Challenge

For the 2017 plan year, around 5 million Americans bought comprehensive health coverage without assistance from tax credits, subsidies, or employer contributions that reduce the costs of their premiums.<sup>2</sup> These hardworking Americans include entrepreneurs, those who have retired before qualifying for Medicare, and workers who do not qualify for employer-provided coverage. This includes 2 percent of those insured in the United States. The Centers for Medicare & Medicaid Services (CMS) reports from 2017 to 2018, the average monthly exchange premium for this market increased from \$471 to \$597.<sup>3</sup> The average premium for the least expensive bronze plan for a single 40-year-old rose from \$329 to \$394 from 2017 to 2018.<sup>4</sup> Increasing health care costs hit these Americans hardest. It's time we brought them some relief.



Evidence is emerging that individual market premiums are becoming more stable.<sup>5</sup> But in some regions, premiums are too high for many Americans. When families can't afford premiums for comprehensive coverage, some decide to purchase leaner coverage— or even go without coverage at all. That can put their health and financial security at risk.

## How are Premiums Set?

To overcome the challenges, it's important to know how premiums are set. The vast majority of dollars spent on premiums go to cover the cost of health care – for example, doctor appointments, hospital visits, and prescription drugs. In fact, health insurance providers are mandated by the federal government to spend at least 80 percent of premiums on health services. The remaining 20 percent must cover the cost of important health insurance provider services like customer service, patient care coordination, collaboration with doctors and hospitals, and fraud prevention.

To set premium costs for consumers, health insurance providers calculate the cost of providing care to all their members in a geographic area. This is why the increasing cost of doctors, hospitals, and prescription drugs is so important. These rising costs play the biggest role in consumers' premium costs.

**Premiums aren't affordable for an increasing number of middle-class Americans:**

**5 million**

People bought exchange plans without federal subsidies in 2018.

**20%**

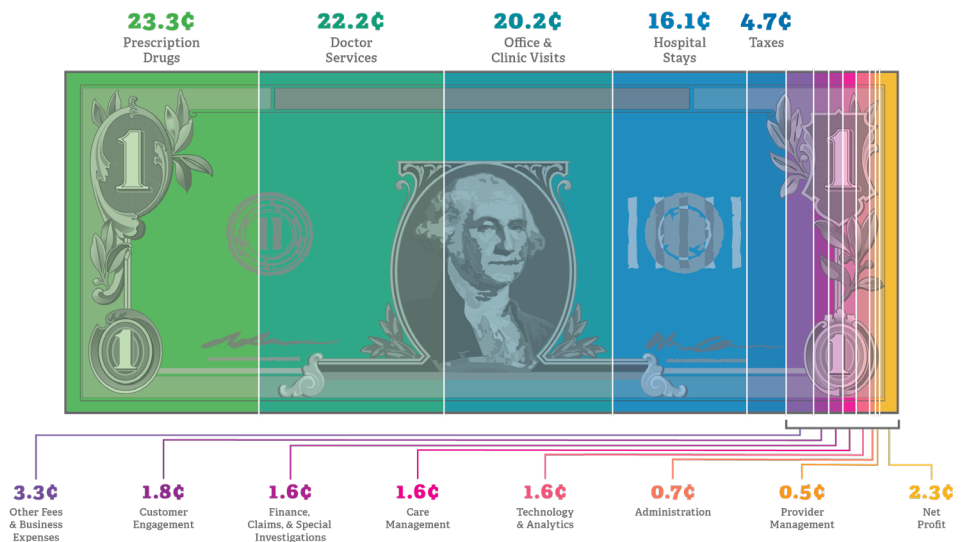
Fewer people covered without subsidies through the exchange from 2016 to 2017.

**\$126**

Average increase in monthly premium for an exchange plan from 2017-2018.

## Where Does the Premium Dollar Go?

Example of a Typical Plan<sup>6</sup>



# Three Levers to Lower Premiums

There are three tested and proven methods for driving down the costs of premiums for consumers:



## Key to Recommendation Categories

- FR** **FED REG** – Could be achieved through Executive action by proposing new or modifying existing regulation.
- SR** **STATE REG** – Proposal could be enacted at the state level through new regulations in some states.
- FL** **FED LEG** – Proposal requires new Federal Legislation.
- SL** **STATE LEG** – Proposal would require the enactment of state legislation in most states.

## LEVER 1: REDUCE THE COST OF HEALTH CARE

Evidence over the last decade indicates by nearly every measure, the United States spends more on health care than any other nation in the developed world. In 2017, the United States spent 17.2 percent of its gross domestic product (GDP) on health care. That is the highest of any nation participating in the Organization for Economic Cooperation and Development (OECD)<sup>7</sup> and almost double the OECD average of 9 percent.<sup>8</sup> In 2017, the nation spent almost \$10,000 per person on health care – or 250 percent more than the OECD median of \$4,000 per person.<sup>9</sup> For Americans who pay the full cost of their insurance premiums, these inflated costs are reflected directly in their premiums.

Some approaches aim to move the “cost-of-care” lever and bring premium costs down by simply eliminating coverage for things like prescription drugs, preventive care, or care for pre-existing conditions. While this approach will result in reduced premiums for some people in the short-term, it can expose families to finding themselves underinsured when they need their coverage most.

*To provide the kinds of affordable insurance options Americans really want, options that cover preventive care and protect them from financial devastation if they get sick, it is imperative we tackle the real problem - misaligned incentives and sky-high unit prices.*

## Reduce Surprise Billing

Health insurance providers develop networks that offer consumers access to safe, affordable, high-quality care. Most private insurance providers - and many public programs - offer a variety of network options. When providers choose to participate in networks, coverage is more affordable. When providers choose not to participate in networks - or if they do not meet the requirements for inclusion in a network - these providers may charge whatever they like, sometimes billing amounts far above average rates in the same area. Most out-of-network providers bill patients for any amounts not paid by their health insurance provider. From the provider's perspective this is "balance billing." From the consumer's perspective this is "surprise billing."



Health plans that limit out-of-network coverage are more affordable, because in-network doctors agree to provide care at a set price. To help navigate the options, health insurance providers and exchanges have developed tools for consumers to check if their providers are in-network before purchasing a plan. For routine or non-urgent care, consumers should check if a provider is in-network before seeking services. The issue of "surprise billing" most often arises in two scenarios, despite the best efforts of a consumer to use in-network providers: (1) when individual providers practice at an in-network hospital but don't participate in the network; and (2) when people receive emergency care at an out-of-network facility.

If insurance providers are required to reimburse out-of-network providers at whatever rates they bill, this creates a disincentive for providers to join networks. Unreasonable out-of-network reimbursement rates and balance billing of patients undermines affordability and imposes a "blank check" approach to payment. Laws or regulations establishing specific levels or guidelines for out-of-network reimbursement can protect patients from surprise bills and keep premiums down.

Air ambulances generate some of the most egregious surprise bills related to medical emergencies. The Airline Deregulation Act of 1978 prevents states from exercising the same oversight over air ambulances that they exercise for other emergency medical providers. This allows air ambulance providers—who deliver essential emergency medical services to patients who have no choice—to uncompetitively price gouge health care consumers and insurance providers alike. Anticompetitive behavior increases the cost of such life-saving services and premiums for everyone. Far from unleashing the competitive forces that Congress contemplated would result from deregulation, extending the Airline Deregulation Act to the unique market for these highly-specialized emergency medical service providers prevents states from helping to level the playing field, and fosters unfair business practices and consumer harm.

For individual market plans, federal regulation already addresses reimbursement rates for emergency care received out-of-network<sup>10</sup> and notification requirements for out-of-network services provided at in-network hospitals.<sup>11</sup> The current federal requirement specifying reimbursement rates for out-of-network emergency services provides a workable payment benchmark but does not prevent providers from balance billing patients. However, the requirement that health plans notify consumers in advance when they may receive out-of-network services is impractical, because health plans seldom know a member is receiving care until after the care has been provided.

The federal government and states, through legislation and regulation, can take additional steps to: (1) establish regulatory guardrails around health insurance payments to out-of-network providers that provide care at an in-network facility; and (2) protect consumers from surprise bills in emergencies and when care is received at an in-network facility. Any statutory or regulatory approach to the rate of payment to out-of-network providers should be set at a level that does not destabilize provider contracts, but instead continues to encourage health plans and providers to enter into mutually beneficial contracts. We recommend actions below to take patients out of the middle of disputes and provide predictable, fair and reasonable reimbursement rates.





**Protect patients from surprise bills and prevent unnecessary premium increases related to out-of-network care.** For instances when the consumer did not have the opportunity to select an in-network provider, such as emergencies, and the consumer does not have out-of-network benefits defined in their policy, prohibit providers from balance billing patients and set a payment benchmark that clearly defines what the plan is expected to pay the provider for the services rendered. The benchmark should be designed to ensure a reasonable reimbursement rate for providers, while preventing price gouging and excessive consumer bills. Billed rates should never be used as benchmark for out-of-network reimbursement. Providers should be prohibited from billing patients for amounts that exceed the benchmark-based payment.



**Update federal statute to allow states to regulate air ambulance providers to prevent egregious bills.** Many states have attempted to take action to protect consumers from excessive air ambulance bills, which cost \$50,199 on average in 2016<sup>12</sup>, only to find their efforts stymied in the court due to barriers imposed by federal statute. Congress should update the Airline Deregulation Act of 1978 to allow states to regulate their markets.



**In the interim, while policies protecting patients from surprise doctor bills are being implemented, require in-network hospitals and other facilities, rather than health plans, to disclose that a patient may be treated by an out-of-network provider in that facility.** If out-of-network providers may treat the patient while the patient is receiving care at that facility, require the facility to disclose to the patient that out-of-network provider fees may apply. This requirement, which may not be practical for emergency scenarios, should apply to all procedures and services where treatment is scheduled in advance.

## Curb Inappropriate Third-Party Premium Payments

Third-party payments for drugs or services typically are made for consumers by outside entities, such as health care providers, pharmaceutical companies, foundations, or other entities. Concerns about third-party payments, specifically related to conflicts of interest between a provider's financial interest and a patient's best interests, have generally resulted in the prohibition of these payments in public programs like Medicare and Medicaid. However, there has been less clarity regarding the use of these payments in the individual market.

Health insurance providers have seen a rise in third-party payments from entities steering Medicare and Medicaid-eligible individuals to the individual market. The third-party organizations steering consumers to the individual market, stand to benefit financially through greater reimbursement rates from private health insurance providers.

Steering older and less healthy consumers to the individual market also skews the risk pool to higher-cost individuals, resulting in higher premiums for everyone. This is especially challenging for hardworking Americans who pay for their coverage without any support. Ensuring consumers are enrolled in appropriate coverage designed to best meet their needs, instead of steering them to coverage that results in financial gain for a third-party providing health care services, will help keep costs lower and contribute to a more stable market.

Another type of third-party payment is the growing use of drug coupons and copay cards. Consumers are given discounts on brand-name drugs, encouraging use of those drugs instead of less expensive generics or therapeutic substitutes. Drug makers pass along the whole cost of the drug to insurers, increasing overall costs and driving up premiums. *Health Affairs* has reported drug coupons lead to unnecessary spending by health insurance providers that is then passed on to consumers through higher premiums and more limited coverage options.<sup>13</sup> Similar to third-party payments, drug coupons are not allowed in Medicare and Medicaid.

### Additional Resources:

[How Third-Party Premium Payments Can Harm Consumers and Destabilize Markets](#), May 2018

[AHIP Statement on Third Party Payments](#), December 2016

**FR** **Reissue rulemaking, under 42 CFR Part 494, to address conditions for coverage for end-stage renal disease third-party payment.** In December 2016, HHS published an interim final rule that outlined a narrow set of circumstances in which third-party payments by dialysis facilities would be allowed. Due to ongoing litigation, the effective date for this rule has been delayed indefinitely. Revised rulemaking should retain requirements for dialysis facilities to meet certain conditions in order to receive reimbursement and clarify health insurance providers would not be required to accept third-party payments if those conditions are not met. Specifically, third-party organizations that make premium and cost-sharing payments on behalf of individual market enrollees should be required to report information on funding sources, governance, relationships with provider and pharmaceutical organizations, etc., and attest they meet the requirements set out in such revised rulemaking.

**FR** **Prohibit direct and indirect premium payments to entities in which the provider has a financial interest.** Under its conditions of participation requirements, HHS can prohibit direct or indirect payments by providers as a conflict of interest. Similarly, providers could be considered out of compliance with the conditions of coverage if they do not provide consumers with information on their full coverage options.

**FR** **Clarify existing guidance under 45 CFR § 156.125 related to insurer acceptance of third-party payments.** HHS' long-standing policy is that health insurers may deny any third-party payments that are outside of federal requirements; however, current regulations should be formally amended to include this language.

**FR** **FL** **Do not expand the list of third-party entities from which health insurance providers must accept premium and cost-sharing payments.** HHS has identified a limited roster of entities from which health insurance providers must accept third-party payments, including Ryan White and HIV/AIDS programs, Indian tribes, and state and local programs. Expanding this list to include other entities would result in higher premiums and decreased affordability for consumers.

**SR** **SL**

**FR** **SL** **Prohibit the use of copay coupons for brand-name drugs if there is a less expensive, equally effective alternative.** HHS and states should take steps to address the increased use of prescription drug coupons and co-pay assistance cards, by prohibiting their use in the private marketplace just as they are prohibited in federal programs. If coupons are allowed for drugs with no less expensive alternatives, the coupons or copay cards should be available to all patients for the entire length of time they need the medication.

## Increase Drug Competition

Prescription drug prices are out-of-control and are contributing to unsustainable health care cost growth across the country. In addition to placing strains on the health care system, rising drug prices also place financial burdens on patients who rely on prescription medicines to treat and manage their chronic conditions.

For employer-sponsored coverage, spending on prescription drugs outpaces spending for inpatient hospital care and drug spending continues at a faster rate than overall health care spending and makes up a greater share of total medical expenses.

Bold steps are needed—at both the legislative and regulatory levels—to ensure people have access to affordable medications.

**FR** **Create a robust biosimilars market.** Biosimilars offer great promise in generating cost savings for consumers. Some of the costliest and most widely used biologics have been on the market for decades without biosimilar competition. To achieve this promise, the FDA should finalize regulations that promote a robust competitive market and ensure patients and providers have unbiased information about the benefits of biosimilars. For example, the FDA should provide clarity for all stakeholders and complete the biosimilar approval pathway by finalizing interchangeability policies.

**FR** **FL** **Reduce federal rules, regulation and red tape to generic entry.** The FDA should provide the necessary resources to clear the backlog of generic drug applications, particularly for classes of drugs with no or limited drug competition. “Pay-for-delay” settlements and “product hopping” should be challenged by the FTC to address patent abuses and anti-competitive tactics. Further, the Inter Partes Review (IPR) process through the U.S. Patent and Trademark Office should be preserved. Additional legislation, via passage of the CREATES Act, is needed to address abuse of patient safety protocols and ensure widespread availability of generic and biosimilar drugs to promote affordability and lower consumers’ out-of-pocket costs.

**FL** **Revisit and revise orphan drug incentives.** The Orphan Drug Act incentives are being misapplied. The law’s incentives should only be used by those developing medicines to treat rare diseases, not as a gateway to premium pricing and blockbuster sales beyond orphan indications. In cases of rare diseases for which no effective therapy exists, policymakers should ensure that newly approved drugs are priced in accordance with their value and efficacy.

**FR** **FL** **Publish true R&D costs and explain price setting and price increases.** As part of the FDA approval process, drug manufacturers should be required to disclose information regarding the intended launch price, the use of the drug, and direct and indirect research and development costs. After approval, manufacturers should provide transparency into list price increases. States can also enact state level drug pricing transparency laws. California and Oregon have already done so.

**FR** **FL** **Strictly enforce existing regulations on DTC advertising and evaluate DTC advertising impact to develop additional limits.** Direct-to-Consumer (DTC) drug advertising increases premiums by driving consumers to expensive brand name drugs when more clinically appropriate, higher-value treatments may be available. The FTC should enforce existing regulations to ensure drug ads are not misleading. Further assessment is needed of the impacts of the growth in DTC advertising, particularly broadcast advertising, followed by an evaluation of the best approaches for conveying such information to consumers. As part of this assessment, FTC should examine the impact of DTC advertising and point-of-prescribing drug price disclosures on physician prescribing behavior and/or its effects on generic drug availability and utilization. New requirements for DTC advertising should include provisions to promote transparency and accuracy, including requiring that the drug list price be disclosed in any DTC drug advertising in a meaningful manner, as proposed by the Administration and in bipartisan legislation earlier this year.

**FR** **FL** **Inform patients and physicians on effectiveness and value.** The first step in promoting high-value drugs is to establish a common definition of value. This requires agreed upon standards that account for quality, outcomes, and price. An independent third-party entity, such as the Institute for Clinical and Economic Review (ICER), should take the lead in establishing this definition. To disseminate information on value, increased funding is needed for private and public efforts to provide information to physicians and their patients on the comparative clinical and cost-effectiveness of different treatments, procedures and drugs. These tools can help facilitate appropriate assessments about the value and effectiveness of different treatment approaches, particularly for those with high costs. Findings from independent entities conducting comparative effectiveness reviews, such as ICER, can and should be used to inform decisions around coverage, payment and reimbursement for therapies and drugs.

**FR** **FL** **Reduce regulatory barriers to value-based pricing.** Policymakers should address existing statutory and regulatory requirements that may inhibit the development of pay-for-indication and other value-based strategies in public and private health insurance programs.

**SR** **SL**

## Expand the Use of Telehealth

More consumers of all ages are using new technologies like smartphones and expect the convenience these technologies offer. Health insurance providers are responding by offering telehealth services for their members. Telehealth is the use of telecommunications, like video chatting, to support health care evaluation, treatment, and education for a variety of patients. Telehealth has the potential to improve engagement between patients and providers; improve health care maintenance, especially for those with chronic conditions; and avoid unnecessary and costly acute care settings. While particularly useful for those in rural areas, seniors, and others with mobility concerns, telehealth services can make it easier for all patients to access care and connect with specialists from a computer or mobile device.

However, challenges to expansion of telehealth services do exist. Numerous states have enacted laws and regulations governing telehealth for plans operating in the commercial market. The disparities among state requirements related to provider licensure, site- and technology-specific use, and reimbursement and/or payment parity, create many barriers to continued use and expansion of telehealth services.

While telehealth alone will not solve the problem of affordability and access to care, estimates show that it can save more than \$6 billion annually.<sup>14</sup> This will help meaningfully lower overall costs in the health care system.

### Additional Resource:

[Telehealth Connects Patients and Doctors in Real Time](#), November 2017

## Recommendations

KEY: ● FED REG ● FED LEG ● STATE REG ● STATE LEG

- 
- SR** **SL** **Support establishment of multi-state licensure compacts.** In many cases, providers can only offer services in a state where they are licensed. If a patient can only use an in-state doctor, this closes off doctors that would otherwise be available through national provider networks. Allowing multi-state licensure compacts can promote expedited licensure for physicians and/or reciprocity for certain providers applying in multiple states, will increase the number of accessible services, and expand provider networks available to consumers.
- 
- SR** **SL** **Enhance flexibility by not establishing state mandates related to reimbursement and/or payment parity, site-specific use, prior visit requirements, or specific technology use.** Inconsistent state laws and mandates can make providing access to telehealth services difficult for health insurance providers, particularly those that operate in multiple states. State mandates to cover telehealth in specific ways and under specific requirements hinder flexibility to design benefits that meet the needs of consumers.
- 
- FR** **SR** **SL** **Designate telehealth as a means of satisfying network adequacy requirements.** Under 45 CFR 156.230, HHS should establish telemedicine as an option to meet federal requirements for network adequacy standards. In a 2016 revised model law, the National Association of Insurance Commissioners included the use of telemedicine as an option to meet network adequacy standards. And, several states have passed laws or updated regulation to incorporate telehealth in their network adequacy requirements. As part of updating standards to allow greater use of telemedicine, states can identify guardrails to ensure telemedicine use is expanded for scenarios for which it is clinically appropriate.
- 
- FL** **Permit first-dollar coverage of telehealth services in HSA-eligible health plans.** Existing law restricts what care or services a plan may cover pre-deductible in a high-deductible health plan while retaining HSA-eligibility. Telehealth is not only increasingly popular, it is a means of accessing care that is highly affordable for both the plan and the consumer. Permitting plans to cover telehealth services with first-dollar coverage reduces overall costs to the system and allows greater flexibility and affordability for consumers. The approach to expanding HSAs described in the recommendation “Expand HSA Options” is a more comprehensive approach to HSA modernization that would allow for first-dollar coverage of telehealth. As a fallback, Congress should consider a more limited bill to allow first-dollar coverage of telehealth.

## Increase Flexibility for Reference Pricing

Reference pricing entails a health insurance provider setting a specific amount they will pay for a covered service. If a person decides to go to a provider that sets a price higher than the reference price, they are responsible for the difference. High-cost procedures that vary widely for reasons unrelated to quality, like joint replacements, provide opportunities for real savings. Many employer-sponsored plans are using or exploring reference pricing, but Department of Labor (DOL) guidance issued in 2014 and 2016 limits the ability of individual market coverage to use this promising tool to reduce costs.<sup>15</sup>

Significant savings are possible using reference pricing. A 2013 study found that the California Public Employees' Retirement System saved \$2.8 million dollars in 2011 due to their reference pricing program for knee and hip replacements.<sup>16</sup>

California Public Employees' Retirement System saved **\$2.8 million dollars** in 2011 due to their reference pricing program for knee and hip replacements.

### Reference Pricing in Practice, Impact on Savings and Behavior<sup>17</sup>

	Procedure(s)	Reference Price (Percentile)	Savings	% of Consumers Switching from Higher to Lower Cost Providers	Reduction in Prices Chared Among High-Priced Providers
CalPERS	Cataract Surgery	66 <sup>th</sup>	17.9%	8.6%	n.a.
CalPERS	Colonoscopy	66 <sup>th</sup>	21.0%	17.6%	n.a.
CalPERS	Hip and Knee Replacement	66 <sup>th</sup>	20.2%	28.5%	34.3%
CalPERS	Arthroscopy: Knee	66 <sup>th</sup>	17.6%	14.3%	n.a.
CalPERS	Arthroscopy: Shoulder	66 <sup>th</sup>	17.0%	9.9%	n.a.
Safeway	492 CPT Codes, Lab Services	50 <sup>th</sup>	20.8%	12.0%	n.a.
Safeway	Diagnostic Lab Testing	60 <sup>th</sup>	31.9%	25.2%	n.a.
Safeway	Imaging: CT	60 <sup>th</sup>	12.5%	9.0%	n.a.
Safeway	Imaging: MRI	60 <sup>th</sup>	10.5%	16.6%	n.a.

Notes: n.a. Not available—study did not explicitly estimate the reduction in prices charged

### Recommendation

KEY: ● FED REG ● FED LEG ● STATE REG ● STATE LEG

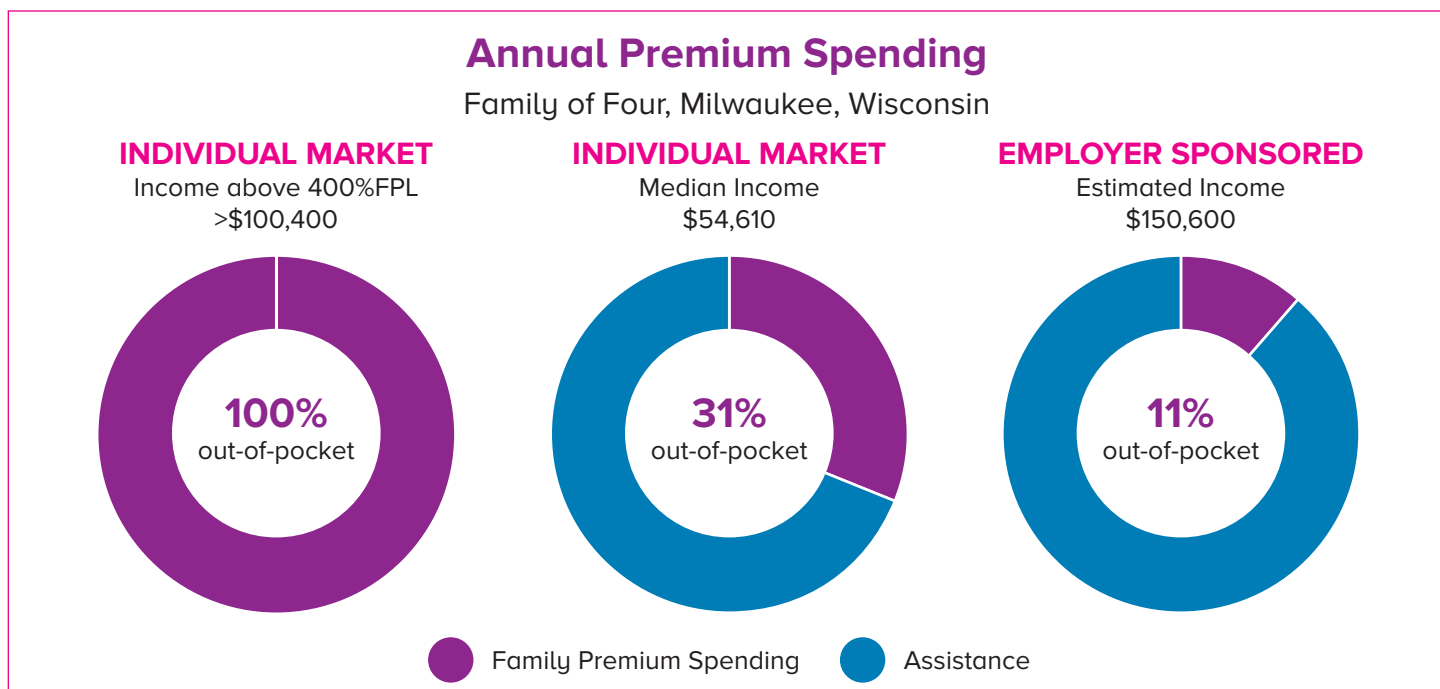
FR

**Withdraw “ACA FAQs Part XXI” published October 10, 2014 and “ACA FAQs Part XXXI, Q&A-7” published April 20, 2016.** These FAQs can be interpreted to limit reference pricing in individual market plans. Withdrawing the FAQs will provide more flexibility to provide individual market consumers with premium savings similar to those seen in employer-based plans that have implemented reference pricing.

## LEVER 2: BRINGING FINANCIAL PARITY TO THE INDIVIDUAL MARKET

Americans who buy their own health coverage with a household income level above 400 percent of the federal poverty level are the only segment of the population that doesn't receive some help with their insurance premiums. Those who are provided coverage at work see thousands of dollars of savings each year in employer contributions to premiums and tax savings. Those who earn under 400 percent of FPL receive premium subsidies that average out to \$550 per month per recipient for 2018.<sup>18</sup>

How Much Premium Assistance do Americans Get for Commercial Coverage? <i>Example: Family Coverage in Wisconsin</i>		
Coverage Type	Monthly Premium Spending	Typical Monthly Assistance
<b>Individual Market – Family of 4<sup>19</sup></b> Income > 400%FPL	Low: \$848 High: \$1,431	\$0
<b>Individual Market - Family of 4</b> Median Income: \$54,610 <sup>20</sup>	Low: \$848 High: \$1,431	APTC <sup>21</sup> : \$786
<b>Employer Sponsored</b>	Average: \$1,634 <sup>22</sup>	Employer Contribution: \$1,172 <sup>23</sup> Federal Tax Savings: \$214 <sup>24</sup> State Tax Savings: \$97 <sup>25</sup>







The most immediate and direct way to help middle-class Americans afford their own coverage is to ensure they have appropriate financial support to do so. Ensuring more equitable treatment of these hardworking Americans can attract healthier people to enroll, improving the risk pool and bringing premiums down for everyone. Below, we recommend approaches to subsidizing premiums.

## Provide Tax Parity for Americans who Buy Individual Market Coverage

Section 106 of the Internal Revenue Code excludes health insurance premiums paid through an employer plan from taxable income. This results in substantial tax savings for individuals with employer-provided coverage. In contrast, consumers purchasing individual health insurance coverage must use taxable income to pay their premiums. For consumers earning a household income in excess of 400 percent of the federal poverty level, and who are therefore ineligible for premium tax credits, there are no tax incentives for purchasing health insurance. This is the only segment of the American population that doesn't receive some help with their insurance premiums.

Allowing the cost of health insurance premiums to be deducted from taxable income would create parity between the individual and group markets. If the Code is excluding health insurance coverage from income, that should apply in all markets. Doing so would substantially increase the affordability of coverage for those purchasing insurance on their own.

### Recommendation

KEY:  FED REG  FED LEG  STATE REG  STATE LEG

FL

#### **Amend the Internal Revenue Code to allow individual market health insurance premium costs to be deductible for federal income tax purposes for those who do not qualify for premium tax credits.**





Individuals and families with gross household incomes over 400 percent of FPL are ineligible for any federal tax assistance. Permitting the cost of health insurance premiums to be deductible from gross income for federal income tax purposes would help millions afford coverage. This would be an “above-the-line” deduction that excludes the premium amount from a taxpayer's gross income but could be subject to the Pease Limitations that existed in the Internal Revenue Code prior to 2018 that phase out deductions based on income.

## Expand HSA Options

Millions of Americans currently use Health Savings Accounts (HSA) to save pre-tax dollars for future health care expenses. As deductibles continue to rise, millions of consumers purchasing coverage through the individual market face challenges in paying for expenses before reaching their deductible, as well as meeting cost-sharing requirements throughout the plan year. As HSA funds are not subject to income taxation, using these funds to pay for expenses allows for consumer dollars to go farther, increasing affordability.

Currently, there are strict limits on what health policies can be paired with an HSA, including a minimum deductible amount and a prohibition on plan coverage of services before an enrollee has met their deductible, except for services or visits that are solely preventive. Allowing more individual market plans to be eligible for pairing with an HSA will give more Americans the ability to save for near-term and long-term health expenses without paying taxes on those savings. Additionally, giving health insurance providers the flexibility to offer coverage of certain services, treatments, or medications necessary to treat chronic health conditions before an enrollee has met their deductible will allow millions of Americans in HSA-eligible plans to better afford essential services.

### Recommendation

KEY:  FED REG  FED LEG  STATE REG  STATE LEG

FL

#### **Expand the criteria for health plans to be HSA-eligible, to include all catastrophic and bronze plans.**

Both catastrophic and bronze plans typically include high deductibles that allow for more affordable premiums but limit overall affordability when it comes to accessing medical care. One way to give consumers a tax-advantaged means of preparing for future medical costs and having funds to access care is to permit those consumers to save in an HSA. Section 223 of the Internal Revenue Code places strict limits on which plans may be HSA-eligible. A federal bill that would accomplish this (HR 6311) recently passed the House.



## Create Reinsurance Programs

A reinsurance program provides payments to health insurance providers enrolling higher risk populations. The program can be funded in a myriad of ways. States have paid for reinsurance programs through: state general funds, utilizing savings within other health care programs, pass through savings, and assessments on carriers, hospitals and provider groups. Ultimately, a federally funded reinsurance program would be ideal to provide premium relief for Americans nationwide.

Reinsurance programs have been implemented in Alaska, Minnesota, and Oregon under 1332 waivers. Applications for reinsurance programs have been approved for Maine, Maryland, New Jersey and Wisconsin. Reinsurance programs have proven to protect against premium increases and can be directed solely to the individual market. This year, within the states enforcing or creating reinsurance programs, premium increases have been up lower due to the reinsurance program.

### State 1332 Reinsurance Program Premium Savings as Estimated in Waiver Applications Submitted to CMS

State	Reinsurance Year 1	Reinsurance Premium Impact <sup>26</sup>
<a href="#">Alaska</a>	2017	-35%
<a href="#">Minnesota</a>	2018	-20%
<a href="#">Oregon</a>	2018	-7%
<a href="#">Maine</a>	2019	-9%
<a href="#">Maryland</a>	2019	-30%
<a href="#">New Jersey</a>	2019	-15%
<a href="#">Wisconsin</a>	2019	-11%

#### Additional Resource:

[Kaiser Family Foundation 1332 Tracking](#), August 2018

### Recommendations

KEY: ● FED REG ● FED LEG ● STATE REG ● STATE LEG

SL

**Create/reinitiate state reinsurance programs that are not solely funded by carrier assessments.**

Reinsurance programs have received bipartisan support in many states. However, funding sources can be controversial. General state funds remain the best option but are scarce. If assessments are necessary, they must be shared by a variety of stakeholders that benefit from reinsurance.

FR

**Continue expediting review and approval of state 1332 applications seeking to create a reinsurance program.** In 2017 CMS issued guidance to simplify the application process for states seeking 1332 waivers to establish reinsurance programs and approved three new waivers that include reinsurance. By October of 2018, CMS had approved four additional waivers including reinsurance programs.

FL

**Create a permanent federal reinsurance program.** Establishing a permanent federal reinsurance program will offset some of the costs that come with caring for individuals with complex health conditions who have significant health care needs.



## Create State Premium Discount Programs

States can also implement discount programs for state residents who don't qualify for federal premium subsidies. For the 2017 plan year, the state of Minnesota created and funded a premium discount program for Minnesotans who did not qualify for APTC. The program was funded by the state and provided a 25 percent premium discount for unsubsidized individual market enrollees.<sup>27</sup>

### Recommendation

KEY: ● FED REG ● FED LEG ● STATE REG ● STATE LEG

SL

**Create a state premium discount program for individuals and families earning more than 400 percent of FPL.** For the 2017 plan year, the state of Minnesota created and funded a premium discount program for Minnesotans who did not qualify for APTC. The program was funded by the state and provided a 25 percent premium discount for unsubsidized individual market enrollees. States should consider programs if the approach can be funded without imposing fees or assessments that increase the overall cost of coverage.

## Repeal the Health Insurance Tax

Allowing the health insurance tax to resume in 2020 will result in higher premiums for consumers. If the tax is not suspended or repealed, individual market health insurance providers will have to factor in the cost of the health insurance tax for 2020 and the tax will contribute \$196 per person annually to the cost of coverage in the individual market. Because the tax is calculated as a percent of premium, the consumers paying the highest premiums already bear the biggest burden.

### Additional Resource:

[Legislation to Suspend the Health Insurance Tax Will Help Make Premiums More Affordable](#), August 2018

2019 Savings from HIT Suspension	
Individual Coverage	\$230
Small Group, Individual	\$300
Large Group, Individual	\$280
Medicaid	\$160
Medicare Advantage	\$380
Part D	\$17

Source: "Estimated Impact of Suspending the Health Insurance Tax from 2017-2020." Oliver Wyman, December 2015.

2020 Premium Increases due to HIT	
Individual Coverage	\$196
Small Group, Individual	\$154
Large Group, Individual	\$158
Medicaid	\$157
Medicare Advantage	\$241
Part D	\$16

Source: "Analysis of the Impacts of the ACA's Tax on Health Insurance in Year 2020 and Later." Oliver Wyman, August 2018.

### Recommendation

KEY: ● FED REG ● FED LEG ● STATE REG ● STATE LEG

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**Enact legislation to permanently repeal the Health Insurance Tax.** Enactment of this legislation would help deliver more affordable coverage and care as well as lower premiums for millions of Americans—whether they purchase their own coverage on the individual market, obtain coverage through their jobs, or enroll in Medicare Advantage or Medicaid managed care.

## LEVER 3: INCREASE ENROLLMENT/IMPROVE THE RISK POOL

The individual health insurance market must operate as a single risk pool under federal law. That means everyone who purchases health insurance in the individual market is grouped together and the cost of their collective health care drives the cost of premiums in each state. A well-balanced risk pool includes both people who do and do not need costly (or complex) health services.





The health of those in the risk pool has a major impact on premium costs. When there are a disproportionate number of unhealthy people covered in a risk pool, health care costs go up because there are fewer healthy people to offset those costs. A well-balanced risk pool keeps premium costs down for everyone and ensures people who need care can get it and people who may need it in the future are protected.

### Provide Savings to Consumers who Engage in Wellness Programs

Over the past four decades, wellness programs have become commonplace in many American companies, with most large employers offering some version of a workplace wellness program. For those enrolled, wellness programs help improve overall health and offer opportunities for premium discounts. Thus far, these programs have been limited to the group markets. Increasing the role of wellness programs in the individual market would increase the value of insurance for those who perceive themselves as healthy, attracting more healthy people into the risk pool.

Section 2705 of the Patient Protection and Affordable Care Act (ACA) required the Secretary of Health and Human Services to establish a ten-state demonstration project where health insurance providers would be permitted and funded to develop wellness programs for individual market plans offered on the Marketplace. This was to be established by July 1, 2014, with an option to expand the demonstration to additional states in 2017. No appropriation was made under that section. When wellness programs are included in the individual market as part of the state demonstration project, exchanges in those states may offer health coverage that includes reward/penalty programs that vary people's health insurance costs. The ACA includes a protection that requires these individual market wellness demonstration projects to not result in a decrease of coverage.

#### Recommendations

KEY:  FED REG  FED LEG  STATE REG  STATE LEG



**Implement the 10-state demonstration program for wellness.** Congress should fund an appropriation to enable the program. Federal guidance could be issued to provide general implementation parameters.



**Preserve flexibility for plans to promote safe, effective, high-value care.** Allow individual market health insurance providers to use medical management tools and benefit designs that promote safe, effective, and affordable care. Examples of these tools include but aren't limited to: formulary and provider network designs that tier prescription drugs or providers based on quality and value, and prior authorization that ensures evidence-based care.







### Marketing and Outreach

A stable individual market requires broad participation of people who are healthy and sick, young and old. It also requires consumers to enroll for a full plan year and continually maintain 12 months of coverage, as opposed to enrolling only when they need care. Open enrollment provides an annual opportunity for new consumers to enroll in marketplace coverage and allows existing enrollees to reenroll in coverage or choose a different plan that best meets their needs.

Unlike other health insurance markets that have more static populations such as employer-provided coverage or Medicare, the individual market is subject to frequent changes as consumers move in and out of coverage for various reasons, for example due to a permanent move or gaining or losing coverage from another source. Thus, marketing, outreach, and education are critical to ensure all consumers are aware of the open enrollment timelines.

Health insurance providers who participate on the federal exchange are required to pay a user fee of 3.5 percent of premiums. While CMS has not provided transparency into allocation of these funds, the user fee is intended to be used to support marketing and outreach activities, amongst other Federal exchange functions. For the 2018 plan year, CMS announced a reduction in the Federal exchange’s marketing and outreach budget (from \$100 million in 2017, or \$11 per enrollee, and \$51 million in 2016, or \$5 per enrollee).

## Recommendations

KEY:  FED REG  FED LEG  STATE REG  STATE LEG

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**Support state-based exchange investments in robust advertising and marketing campaigns, so long as these approaches do not increase premiums.** Investments in advertising and marketing should be made without increasing exchange user fees, which would lead to premium increases.

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**At the option of a state participating in the FFM, transfer a portion of the FFM user fee to the state to conduct outreach, education, and marketing.** As CMS evaluates the user fee as the exchange evolves (e.g., with issuers taking on a wider breadth of activities through enhanced direct enrollment) CMS should identify user fees that can be allocated to support state marketing and outreach activities. States that opt to receive these funds may use them to carry out a defined list of marketing and outreach activities, such as support for navigators or other in-person assistance, collaborating with other outreach groups experienced in helping consumers enroll in coverage through the individual market, TV/radio/print advertising, consumer education and enrollment events, or resources for non-English speaking consumers. States that elect to receive user fee funds would be required to provide a plan for how they anticipate using these funds to support open enrollment activities. A commitment by states to promote robust enrollment during the annual open enrollment period could place downward pressure on premiums, increase uptake, and encourage a more balanced risk pool.

## Conclusion

State and federal policymakers and regulators can, and should, act now to improve health care coverage affordability for hardworking Americans. Many of the recommendations above can be implemented through the states or federal regulation and could have impacts on premiums as soon as 2020. We look forward to working with policymakers and other stakeholders to make premiums more affordable.

*Additional resources on these recommendations and other AHIP approaches to improve health care for Americans can be found at [www.ahip.org](http://www.ahip.org).*

# Endnotes

- 1 For 2018. From [Kaiser Family Foundation](#).
- 2 [Trends in Subsidized and Unsubsidized Individual Health Insurance Market Enrollment](#), CMS, July 2 2018
- 3 Ibid, Note that a significant portion of the change in the average monthly premium from 2017 to 2018 is attributable to silver loading to account for the suspension of federal payments to insurers to cover the cost of cost sharing reductions. In most states consumers that chose metal level plans other than silver would have seen a smaller increase.
- 4 CCIIO, Health Insurance Exchange Public Use Files found at <https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.html>
- 5 <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/08/16/health-insurance-premiums-are-stabilizing-despite-gap-attacks>
- 6 A full description of methodology and more information on this infographic can be found at <https://www.ahip.org/health-care-dollar/>
- 7 OECD was founded by 18 European nations, the United States and Canada and now consists of 36 countries that span the globe. A list of OECD member countries can be found here. <http://www.oecd.org/about/membersandpartners/#d.en.194378>
- 8 OECD (2017), *Health at a Glance 2017: OECD Indicators*, OECD Publishing, Paris, [https://doi.org/10.1787/health\\_glance-2017-en](https://doi.org/10.1787/health_glance-2017-en).
- 9 Ibid
- 10 45 CFR 147.138
- 11 45 CFR 156.230
- 12 [Up in the Air: Inadequate Regulation for Emergency Air Ambulance Transportation](#), Consumers Union, March 2017
- 13 Lara Maggs and Aaron Kesselheim, The Short-Term And Long-Term Outlook Of Drug Coupons, November 12, 2014 <http://healthaffairs.org/blog/2014/11/12/the-short-term-and-long-term-outlook-of-drug-coupons/>
- 14 <https://www.towerswatson.com/en-US/Press/2014/08/current-telemedicine-technology-could-mean-big-savings>
- 15 [ACA FAQs Part XXI \(October 10, 2014\)](#) and [ACA FAQs Part XXXI, Q&A-7 \(April 20, 2016\)](#)
- 16 [Increases In Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery](#), James C. Robinson and Timothy T. Brown, Health Affairs, August 3013
- 17 [http://www.actuary.org/files/publications/ReferencePricing\\_11.2018.pdf](http://www.actuary.org/files/publications/ReferencePricing_11.2018.pdf)
- 18 Average 2018 APTC nationwide, from [Marketplace Average Premiums and Average Advanced Premium Tax Credit](#), Kaiser Family Foundation
- 19 2018 premiums found on healthcare.gov for zip code 53207. Based on family members with ages: 40, 35, 13, 8
- 20 Median household income in 2016 based on census data that can be found at <https://www.census.gov/quickfacts/wi>
- 21 APTC is: available for exchange plans only; varies by income level and cost of plans in the area; is not available to those offered affordable employer coverage.
- 22 For 2018 family coverage, from [2018 Health Benefits Survey](#), Kaiser Family Foundation
- 23 Ibid
- 24 Estimate for a family of four with a combined annual income of \$150,600 paying an effective tax rate of 13.1 percent.
- 25 Estimate for a family of four in Wisconsin with a combined annual income of \$150,600 subject to 5.97 percent in state income tax.
- 26 Reinsurance premium impact represents the difference between expected rate increases or decreases with a reinsurance program versus without. It does not represent the total premium change for the year. For example, if premiums would have increased 10 percent without reinsurance and the reinsurance impact is negative 30 percent, premiums would decrease by 20 percent with the reinsurance program. Reinsurance premiums impacts can be found in the state 1332 waiver applications on CCIIO's 1332 Waiver page. [https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section\\_1332\\_State\\_Innovation\\_Waivers.html](https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers.html)
- 27 [Health Insurance Relief FAQ](#), Minnesota Office of Management and Budget