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Statement

of the

American Hospital Association

for the

Committee on Health, Education, Labor and Pensions

of the

U.S. Senate

"Stabilizing Premiums and Helping Individuals in the Individual Insurance Market for 2018: Health Care Stakeholders"

September 14, 2017

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations (approximately 90 of which sponsor health plans), as well as our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit for the record our comments on the importance of stabilizing the Health Insurance Marketplaces for 2018 and beyond.

More than 10 million Americans rely on the Health Insurance Marketplaces for health coverage. While all marketplaces will have at least one insurer selling plans in 2018, some markets are not yet stable, as there is volatility in insurer participation and double-digit premium increases. We appreciate the committee's focus on this issue, as stabilizing the marketplaces would prevent millions of consumers from losing coverage in 2018 and beyond.

A number of factors have contributed to marketplace instability. In some cases, demographic factors, such as a small population base and disproportionately unhealthy population, can make a market unattractive to insurers and expensive for consumers. The federal and state regulatory structure also plays a critical role. Most recently, uncertainty regarding federal payments for the cost-sharing reduction (CSR) subsidies has led to both insurer exits and higher premiums for the

plans that will be sold. Other policy challenges include issues related to appropriate reimbursement, particularly as they relate to the reinsurance and risk-adjustment programs.

The AHA is committed to protecting this vital source of coverage, and we urge Congress to advance policies that will address two major issues contributing to marketplace volatility: accurate plan reimbursement and balancing of the risk pools. Specifically, the AHA recommends that Congress and the Administration, working collaboratively with states, consider pursuing the following policy changes:

- **Fund the CSR Subsidies.** Without a congressional appropriation for the CSRs, health plans are at risk of shouldering approximately $7 billion to $9 billion annually in unreimbursed costs should the Administration stop these payments. Without this funding, plans likely would either exit the marketplaces – reducing consumer coverage options – or significantly increase premium rates to cover these costs – potentially making coverage unaffordable for consumers who do not receive subsidies. The Congressional Budget Office (CBO) estimates that failure to fund the CSRs would result in the cost of silver plan premiums increasing an average of 20 percent for 2018, and increasing the federal deficit by $194 billion from 2017-2026 to account for the impact on the advanced premium tax credits.

- **Enforce the Individual Mandate.** Without the individual mandate or another mechanism to incentivize enrollment, millions of individuals may opt not to enroll in coverage. The most likely consumers to forgo coverage are the healthiest individuals who expect to have minimal health care needs. Without these healthier individuals in the market, rates will rise as the risk pools worsen as there are fewer individuals to share in health care costs. Indeed, insurers already are proposing higher rates because of uncertainty about whether the individual mandate will be enforced. Covered California, California's marketplace, estimated that failure to enforce the mandate could result in premium increases of more than 28 percent and a loss of coverage for 350,000 Californians.

- **Create a Federal Reinsurance Program.** Reinsurance is a proven way to protect plans from high-cost claims. The temporary reinsurance program that was in place for the initial three years of the marketplaces and the recent Alaska reinsurance program approved by the Administration demonstrate that such a program helps attract health plan participation and achieve affordable rates by spreading the costs of expensive claims. We urge Congress to reinstitute this program or a similar one, as was contemplated as a potential use of the stability funds included in the American Health Care Act (AHCA) and Better Care Reconciliation Act (BCRA). In addition, we encourage the Centers for Medicare & Medicaid Services (CMS) to continue working with states to develop and finance state-level reinsurance programs.

- **Continue Evaluation and Refinement of the Risk-adjustment Program.** The risk-adjustment program is an important tool to ensure appropriate reimbursement for health plans. We are concerned, however, that the program may unintentionally harm smaller and newer insurers. Volatility in risk-adjustment payments disincentivizes these insurers from entering and staying in the individual and small group markets, therefore reducing consumer

choice and competition. We encourage CMS to continue analysis of the risk-adjustment model to determine if modifications are necessary to ensure fair treatment of insurers.

- **Expand Federal Outreach and Enrollment Efforts.** Enrollment in coverage is a multi-step process that includes awareness that coverage options exist, determination of eligibility for coverage and subsidies, and plan selection/enrollment. Currently, many consumers rely on navigators, agents and brokers, and other assisters to assess their coverage options and apply for coverage. We are deeply concerned that CMS is reducing its investment in outreach and education efforts for the upcoming open enrollment period, including reducing federal spending on advertising by 90 percent (from $100 million to $10 million) and navigator support by more than 40 percent (from $63 million to $36 million). Given the amount of uncertainty this year around the future of the marketplaces and the shortened open enrollment period, we urge CMS to devote more resources to federal outreach efforts and enrollment support.

- **Support State-level Approaches to Marketplace Stabilization.** A number of states are exploring ways to stabilize their marketplaces, including through implementing state-level reinsurance programs (Alaska, Minnesota, Oklahoma, Oregon and Iowa), requiring or incentivizing insurers participating in the state's Medicaid managed care program to sell a minimum number of products on the marketplace (Nevada and New York), and enrolling Medicaid expansion populations in the marketplace to increase enrollment (Arkansas and New Hampshire). We are encouraged that CMS, in a March 2017 letter to governors, reiterated its support of states exploring innovative approaches. We urge the agency to prioritize review of state applications for innovative solutions and encourage it to develop templates for common approaches that will help reduce states' burden associated with the application process.

  Some in Congress are considering modifications to the 1332 waiver authority that makes many of these state-level solutions possible. Potential statutory changes under consideration include removing the requirement that state legislatures pass authorizing state legislation, extending the duration of waiver approval, streamlining the federal approval process, and loosening requirements regarding comprehensiveness of coverage and consumer affordability. While we appreciate that there are several ways to improve the waiver process, we question the need for significant changes to this authority given that section 1332 already gives states broad latitude to tailor their programs. Therefore, while we offer several recommendations on how to improve the application process, we urge Congress to proceed cautiously with other changes under consideration.

  The AHA supports a streamlined waiver process that could facilitate more rapid implementation of state-level solutions, but we urge Congress to preserve the public's ability to contribute meaningful input during the process and to ensure that a thorough review is conducted by the federal government prior to approval. We would not be opposed to replacing the requirement for authorizing state legislation, which can take considerable time to achieve. Instead, Congress could require an alternative process, such as a requirement for letters of support from state legislative leadership. We also encourage, as stated earlier, the development of tools and templates to assist states with the application process. However, we

discourage Congress from making any changes that may reduce opportunities for stakeholder engagement and input or that bypass important components of the federal review process. States may use 1332 waivers to make significant changes in how health coverage is financed and delivered, and the public must have sufficient opportunity to understand, evaluate and comment on these proposals. Similarly, the federal government has a duty to both taxpayers and those who would be impacted by the waivers to ensure that they comply with federal law and regulation, including by meeting important consumer protections. We strongly urge Congress to not dilute the federal review process, especially by allowing waivers to be deemed approved if CMS does not make a decision within a defined period of time.

Any changes to the process also must leave important consumer protections intact. Specifically, we urge Congress to retain the statutory requirements related to the comprehensiveness and affordability of coverage, as well as the provision that requires a comparable number of people to remain covered. 1332 waivers already provide states with broad latitude to modify how the marketplaces work, as well as to direct the federal financial assistance available to eligible consumers toward alternative sources of coverage. Altering the benefit and cost-sharing requirements could have significant negative consequences on consumers and the marketplaces. For example, if a state were to decrease the essential health benefit (EHB) requirements, the value of the federal tax credit would be reduced consistent with the benefit package. Marketplace consumers eligible for premium tax credits would receive less financial help, potentially making less generous coverage the only affordable option. Individuals with greater health care needs could be priced out of coverage. This is because the cost-sharing limits would apply only to services that are designated as EHBs. Not only would patients need to pay more for more comprehensive coverage, but they could face limitless cost sharing for services that were no longer designated as EHBs. These approaches could further destabilize the marketplace by disrupting coverage for millions of consumers, including driving many of them out of the marketplaces due to cost.

We encourage Congress, the Administration and states to continue working together on ways to make coverage more affordable for everyone, and particularly for those individuals who earn too much to qualify for federal subsidies. However, assisting these consumers should not come at the expense of lower-income individuals.

CONCLUSION

Millions of U.S. residents rely on the public marketplaces as their source of health care coverage. Without action to address challenges related to unanticipated costs and potential loss of reimbursement for the CSRs, these consumers could lose their health care coverage. We urge Congress to work with the Administration to ensure that the marketplaces can continue to provide valuable coverage to consumers in 2018 and beyond.