



American Hospital  
Association®

**Richard J. Pollack**  
President and Chief Executive Officer

800 10th Street, NW - Suite 400  
Two CityCenter  
Washington, DC 20001-4956  
(202) 638-1100  
[www.aha.org](http://www.aha.org)

August 24, 2016

Sylvia M. Burwell  
Secretary  
U.S. Department of Health & Human Services  
200 Independence Avenue, S.W.  
Washington, DC 20201

***RE: Health Insurance Marketplace Stability***

Dear Secretary Burwell:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations (more than 100 of which sponsor health plans), and our 43,000 individual members, the American Hospital Association (AHA) urges you to take swift action to stabilize the Health Insurance Marketplaces authorized under the Affordable Care Act (ACA). Stable health insurance markets are critical to ensuring reliable consumer access to care, and recent decisions by a number of insurers to exit the marketplaces places this access at risk. **We urge you to make several changes to marketplace policies and operations to stabilize the insurance markets and encourage robust consumer and insurer participation.**

The vision of the AHA and our members is a society of healthy communities, where all individuals reach their highest potential for health. Access to care – facilitated by affordable health care coverage – is foundational to healthy communities. The AHA and our members work daily to connect patients to coverage, with many hospitals and health systems providing enrollment assistance in their facilities and communities. The AHA has supported the work of Enroll America and is developing a toolkit for our members to use to target younger, uninsured adults during the 2017 open enrollment period this fall. We are committed to continuing these efforts, but are increasingly concerned about the stability of the marketplaces.

Today, more than 11 million Americans purchase their health coverage through the federal and state Health Insurance Marketplaces. However, recent decisions by a number of insurers to stop selling plans on these marketplaces will require millions of consumers to find new coverage in 2017. For some consumers, such as those in Pinal County, Ariz., there may no longer be any marketplace options available in their area. In these instances, lower-income consumers will lose access to the advance premium tax credits and cost-sharing reductions that make coverage affordable. Pinal County is the first area identified at such risk; as insurers make their final decisions about where to sell marketplace policies in 2017, there may be many others.



A number of factors influence whether an insurer will sell a plan in a particular market. First and foremost, they must receive adequate reimbursement. To date, many insurers have experienced significant losses on their marketplace business. These losses are largely the result of inaccurate assumptions about the needs of the newly enrolled in the first years of the marketplaces. However, despite evidence demonstrating the sicker risk pool, state regulators have been reluctant to allow insurers to increase rates.

**In order to stabilize the marketplaces, we must focus on getting plan pricing right and balancing the risk pool by enrolling healthier individuals.** While the states play a significant role in approving rates, the administration should use its levers to improve the risk pools and better adjust reimbursement based on enrollee risk. Specifically, the AHA urges the administration to:

- **Strengthen the special enrollment periods (SEPs).** A core component of a functioning insurance market is robust consumer enrollment. To date, the SEPs have served as an important pathway to coverage for many individuals, particularly in the early years of the marketplaces when consumers were still learning about coverage requirements and the options available. However, some consumers have delayed enrollment until they need care. As a result, some insurers have suffered financial losses that put their participation in the marketplaces at risk. For example, one of our members with a health plan recently reported that the average medical loss ratio (MLR) for its marketplace plan enrollees who purchased coverage during open enrollment is 77 percent. In contrast, the average MLR for enrollees who purchased coverage during an SEP is 114 percent. The primary SEPs used by this plan's enrollees are "permanent move" and "loss of other coverage." The Centers for Medicare & Medicaid Services (CMS) already has taken a number of steps to strengthen the SEPs, including tightening the eligibility criteria for the "permanent move" SEP and conducting oversight of the use of all SEPs. We applaud CMS for these efforts and ask that the agency go even further by implementing pre-approval for use of an SEP prior to enrollment via this pathway. However, for those consumers who are determined SEP-eligible, we urge the agency to implement important consumer protections by making enrollment effective on the date of application, recognizing that the consumers would be responsible for payment of premiums beginning at that date.
- **Further refine the risk-adjustment program.** CMS's analysis of the risk-adjustment program suggests that, while the model generally works well, some adjustments are needed to more consistently align payments with actual costs. We have reviewed and agree with many of the changes discussed in the agency's March 2016 Risk Adjustment Methodology White Paper, including use of prescription drug data to help identify diagnoses and accounting for partial year enrollments. We urge CMS to move swiftly in proposing and finalizing these changes.
- **Increase access to coverage through third-party payment of premiums.** While the ACA made significant strides in making insurance less expensive for consumers, some low-income Americans still cannot afford the premiums and cost sharing for these plans.

As part of their charitable missions, some AHA members would like to assist these individuals by paying the consumer's portion of the premium and cost sharing, consistent with two of the "guardrails" CMS outlined in a February 7, 2014 FAQ: 1) subsidies would be awarded based on financial need; and 2) the premium or cost-sharing payments would cover the entire policy year (which should be clarified to include the balance of a premium year in the event the need for financial support arises during a policy year). We therefore urge the agency to explicitly require qualified health plans (QHPs) to accept third-party premium and cost-sharing payments from hospitals, hospital-affiliated foundations and other charitable organizations for individuals not eligible for Medicare or Medicaid.

- **Enhance outreach and enrollment strategies.** As previously discussed, the AHA and our member hospitals and health systems have undertaken a number of efforts to connect individuals to coverage. However, we know more work must be done, particularly with younger, Hispanic adults. We urge the agency to dedicate greater federal resources toward both general and targeted outreach campaigns to increase the number of insured and improve the risk pool.
- **Support the development of state-level solutions.** Given statutory limitations on federal action, we encourage CMS to assist states in developing state-level solutions. For example, states may consider wrap-around risk-adjustment, reinsurance and risk corridor programs. One state, Alaska, already has authorized a state-level reinsurance program to improve the stability of its Health Insurance Marketplace. As a result, an additional insurer has opted to participate in the state's marketplace and the existing insurer has decreased its proposed rate increase for 2017. We encourage CMS to work with states to develop such solutions and to provide technical expertise, such as legal analyses of what is permissible under federal law.

Finally, we encourage CMS to work with state regulators to promote fair and sustainable plan pricing. While recent announcements of double-digit premium increases are alarming, we have reason to believe that such increases may be a one-time correction and necessary to stem insurer losses moving forward. It is well established that insurers mispriced plans in 2014 and 2015. Resistance by state regulators to increase rates perpetuates this underpricing. However, we also understand that states' evaluation of rate proposals may be challenged by lack of consistency in how plans report financial information. **We urge CMS to work with state regulators to ensure plans receive fair rate adjustments. However, as part of this, we also encourage CMS to work with states on improving oversight of and consistency in plans' financial reporting, which will help states to evaluate proposed rates.** CMS also should caution states from approving excessively low rates by plans intent on attracting market share, which inappropriately depress rates across all plans and destabilize markets.

Secretary Sylvia M. Burwell

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We recognize that there may be other ways to bolster enrollment and improve the accuracy of plan payment and we welcome the opportunity to work with you on the development of a comprehensive strategy to ensure the long-term sustainability of the marketplaces. If you have any questions, please contact Molly Smith at (202) 626-4639 or [mollysmith@aha.org](mailto:mollysmith@aha.org).

Sincerely,

/s/

Richard J. Pollack  
President and CEO

CC:

Andrew M. Slavitt  
Kevin Counihan