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Statement

of the

American Hospital Association

before the

Committee on Health, Education, Labor and Pensions

of the

U.S. Senate

"Obamacare Emergency: Stabilizing the Individual Health Insurance Market"

February 1, 2017

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations (approximately 100 of which sponsor health plans), and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit for the record our comments on the importance of stabilizing the public Health Insurance Marketplaces for 2017.

More than 11.5 million Americans signed up for 2017 health coverage through the federal and state marketplaces by late December, and the final number is expected to increase when accounting for January enrollments. Should the marketplaces collapse, these individuals risk unexpectedly losing health care coverage mid-year. **The marketplaces must be stabilized to prevent millions of consumers from losing coverage.**

The marketplaces face both ongoing and more recent challenges. Lower enrollment and sicker risk pools have resulted in higher than anticipated costs for insurers during the first three years of marketplace operations. The potential loss to insurers of federal payment for the cost-sharing reductions (CSRs) included in the Affordable Care Act (ACA) in 2017 could have immediate catastrophic consequences. Insurers would face a multi-billion dollar unfunded mandate and may be forced to exit the marketplaces mid-year, leaving millions unexpectedly without coverage options.

RECOMMENDED APPROACHES TO STABILIZING THE MARKETPLACES

In order to stabilize the marketplaces, accurate plan pricing and balancing of the risk pools are key. While the states play a significant role in approving rates, we urge Congress to work with the Administration to advance policies that will improve the risk pools and ensure fair and adequate reimbursement to insurers. Specifically, the AHA recommends that Congress and the Administration:

- **Continue payment of the CSRs.** Insurers are required to reduce cost-sharing for certain low-income individuals. The federal government reimburses insurers for the value of the CSRs, estimated at $7 billion for 2016. The House of Representatives challenged the Administration's implementation of this provision, and the case is currently under appeal. However, the Court recently halted proceedings until Feb. 21, 2017 to allow both parties the opportunity to resolve the case before proceeding further. We urge Congress and the Administration to work together to enable these payments to continue in 2017.

  Failure to do so could result in immediate and far-reaching disruption to marketplace coverage. Specifically, the law will continue to require that insurers make the CSRs without reimbursement. As a result, insurers may need to raise their premium rates mid-year to make up for these unanticipated financial losses. If states or the federal government decline to allow the insurers to make such mid-year rate adjustments, they may need to cancel their policies, leaving consumers without a coverage option for the remainder of the year.

- **Maintain and 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. 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 additional oversight of the use of all SEPs. CMS recently announced it will launch an SEP "pre-enrollment verification process" pilot program in June 2017. Under the pilot, half of all SEP applicants will be required to provide proof of eligibility prior to plan enrollment with certain consumer protections in place. We support implementation of this pilot as planned to help manage insurer risk while maintaining access to coverage for individuals eligible for SEPs.

- **Maintain and build on recent changes to the risk-adjustment program.** In 2016, CMS finalized a number of changes to the ACA risk-adjustment program, including, but not limited to, modifying the model to better account for partial-year enrollments and using some prescription drug information to impute missing diagnoses and better reflect patient severity. We support these changes and recommend that Congress and the Administration continue to further evaluate the accuracy of the risk-adjustment program

for potential additional refinements. We are particularly concerned that smaller, newer entrants may still be unintentionally harmed by the model and believe further analysis of the model is required.

- **Increase access to coverage through third-party payment of premiums.** Despite the premium and cost-sharing subsidies, some low-income Americans without access to other coverage options still cannot afford marketplace coverage. As part of their charitable missions, some AHA members assist individuals by paying the consumer's portion of the premium and cost sharing. We support regulatory changes 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 otherwise eligible for Medicare or Medicaid.

- **Support the development of state-level solutions**. Marketplace performance varies significantly by state, and may be enhanced through state-specific programs and policies. We encourage assistance for the states in developing state-level marketplace 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 decreased its rate increase for 2017. Regulatory agencies could work with states to develop such solutions by providing technical expertise, such as legal analyses of what is permissible under federal law.

CONCLUSION

We appreciate the opportunity to provide these comments and support the Committee's efforts and attention to examining the issues concerning the stability of the marketplaces. Millions of U.S. residents rely on the public marketplaces as their source of 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 2017.