



Advancing Health in America

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The Honorable Frank Pallone Jr.
Chairman
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Diana DeGette
Chairwoman, Oversight and
Investigation Subcommittee
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Anna Eshoo
Chairwoman, Health Subcommittee
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Pallone, Chairwoman Eshoo and Chairwoman DeGette:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinical 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) thanks the U.S. House of Representatives Committee on Energy and Commerce for its oversight of certain health insurer practices during the COVID-19 public health crisis. We applaud your recent request to nine health and dental insurance companies for information on their business performance during the COVID-19 pandemic and look forward to your analysis of their responses.

In support of your efforts, we would like to share information regarding the challenges hospitals and health systems have encountered with insurance plans during this unprecedented health crisis. In addition, we offer feedback on the Department of Health and Human Services' COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program.

OVERVIEW

The COVID-19 pandemic has placed considerable stress on communities and the health care providers who care for them. While not every region has experienced the same level of infection, all communities have prepared to respond to the virus. For hospitals, this has meant increasing the capacity to care for patients with COVID-19, as well as supporting federal, state and local public health efforts to track and prevent its spread. All hospitals, whether in communities hard hit by the virus or not, have suffered significant reductions in revenue during this time as both emergent and non-emergent

care has drastically declined and the cost for preparing for the pandemic has been substantial.

For health plans, the impact has been far different. When insurers priced their 2020 premiums, they had no way of knowing that a global pandemic would occur. As COVID-19 began to spread across the country, so did concerns among insurers about a flood of emergency care and high-cost intensive care unit visits. However, as businesses shuttered and governments called on people to stay at home and ordered health care providers to halt most non-emergent care, spending on health care claims declined dramatically.

In fact, many health insurers are not spending nearly as much on care as they anticipated when they set their 2020 premiums. Some of their anticipated expenses have been forgone altogether, in part due to a decrease in more typical health hazards, such as [car accidents](#) and [pollution-related illnesses](#). Other expenses may be postponed to a future date, such as preventive services like mammography and colonoscopy screenings. As a result, actuarial firm Milliman [estimates](#) that there could be a net reduction of health care costs of \$75 billion to \$575 billion nationally in 2020. While the costs to test and treat COVID-19 may be significant, Milliman found that “the deferral and elimination of care is a far more impactful driver of costs.”

Many analysts and health plans alike believe the pandemic will be financially positive for the health insurance industry. An AHA analysis of various filings by the Securities and Exchange Commission found that the top seven health insurers (in terms of covered lives) reported nearly \$12 billion in income before taxes for the first quarter of 2020, representing an 8.3% increase over the previous year. In the second quarter, operating income before taxes jumped to \$22.2 billion, which was more than these companies made in the entire second half of 2019. Unsurprisingly, Moody’s Investor Services, a credit rating agency, projects that even under the most severe scenarios, health insurers generally have significant capital and liquidity. In contrast, recent AHA reports found that the immense financial strain facing hospitals and health systems due to COVID-19 will continue through at least the end of 2020 with patient volume expected to remain well below baseline levels. Total losses for the nation’s hospitals and health systems are projected to be at least \$323.1 billion in 2020.

Despite the health care system’s financial struggles, some health insurers are treating this excess revenue like they would under normal circumstances: using it to engage in stock buyback; paying down debt; and stockpiling excess premium dollars into their reserves. However, these times are anything but “business as usual,” and these dollars are needed to keep our health care system solvent.

As Sean Nicholson and David Asch [argue](#) in the Harvard Business Review, insurers “potentially face a windfall because the high clinical costs of caring for infected patients is almost certainly more than offset by the reduced costs from other care foregone. Those extra funds shouldn’t be theirs; they were there for our health care, and our

health care system needs them now.” **To be clear – taxpayer, employer and individual consumer revenue that health insurers took under the promise of paying for health care services has in many instances been diverted to increase the health insurers’ profits.**

The only thing that appears to be reining in insurers’ profit opportunity are the medical loss ratio (MLR) rules that require that certain types of health plans spend 80% or 85% (depending on the product) of the premium dollar on health care services. As a result of the MLR rules, some health plan products have begun to issue consumer rebates. However, a significant portion of health plans are not subject to the MLR rules, and it is unclear that these rebates, which are diluted across millions of consumers, will have as much impact as if they were invested in the health care system. As researchers at Georgetown University’s Health Policy Institute recently noted: “We are in the midst of the largest global pandemic of our lifetimes. A few hundred dollars in premium relief or rebate checks that won’t arrive until the Fall of 2021 will not help us meet the needs of the moment. Instead, policymakers should consider taking advantage of insurers’ excess cash to support our underfunded public health infrastructure so that we can effectively bring this virus to heel.”¹

Meanwhile, HHS’ COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program is falling short. The Health Resources and Services Administration (HRSA), which oversees the program, adopted rules that make a high percentage of COVID-19 claims ineligible for reimbursement. In fact, these rules specifically exclude some of the most costly cases of COVID-19, leaving the uninsured vulnerable and providers without adequate resources to care for these patients.

Below, we explore each of these challenges and provide specific recommendations to ensure more comprehensive coverage of COVID-19 testing and treatment.

INSURER ACTIONS DURING THE PANDEMIC

While health insurers have benefited from an overall reduction in health care utilization, they continue to pursue other strategies to boost their earnings during this public health crisis. Indeed, a number of health insurer tactics put in place before COVID-19 have financially aided the plans during this time, and several health insurers have even taken steps to expand such policies during the pandemic. These include denials for emergency services, denials for early sepsis interventions, questionable reporting requirements, and abuse of utilization management tools to delay and deny payment.

Emergency Services Denials

Several insurers, such as Anthem, have been denying coverage of emergency services if the health insurer unilaterally determines that the condition did not warrant

¹ <http://chirblog.org/insurers-sit-extra-cash-premium-relief-mlr-rebates-best-use-funds/>.

emergency-level care. The plan makes its determination after the care is delivered, not based on what the clinician knew at the time the patient presented to the emergency department (ED). This policy was purportedly implemented to discourage inappropriate use of the ED, a goal hospitals and health systems share. However, it has instead been used as a blunt tool that has generated fear among patients of accessing emergency services and resulted in financial losses for providers. Meanwhile, it is unclear these health plans have undertaken even minimal efforts to address barriers to care that could lead to someone seeking non-emergent care in an ED, such as working with primary and urgent care providers to extend hours or ensuring greater access to same-day appointments. These plans also completely ignore hospitals' responsibilities under the Emergency Medical Treatment and Labor Act (EMTALA) to assess and stabilize anyone who presents to the ED, as well as federal law that established prudent layperson standards, which require that the need for emergency services be evaluated based on what an average "prudent" person deems an emergency.

It is unacceptable to discourage anyone from seeking care they believe they need, but it is absolutely unconscionable to do so during a public health crisis. Anthem, for example, has lobbied to expand policies that would discourage some of the most vulnerable residents from obtaining emergency medical care in public programs, and, even in the midst of COVID-19, it has not changed course. This plan continues to support efforts by the Commonwealth of Virginia to permit them to apply this policy for the state's Medicaid managed care plan.

Sepsis Denials

Several insurers, led by UnitedHealthcare, have unilaterally stopped reimbursing providers for the care necessary to treat certain cases of sepsis occurring in inpatients. Specifically, these insurers are choosing to no longer follow the "Sepsis 2" guidelines, which had until now been nearly universally adopted, including by the Centers for Medicare & Medicaid Services for Medicare purposes. Instead, they have unilaterally decided to apply a different standard for identifying sepsis for purposes of reimbursement only. They have begun using newer guidelines, referred to as "Sepsis 3," which were developed specifically for research purposes and focus on identifying only the most severe forms of sepsis. To be clear, the insurers do not intend for providers to change how they clinically treat patients. If a provider determines that a patient has sepsis, they should treat the patient accordingly. The insurers, however, will not necessarily account for that care when reimbursing the provider. Instead, providers are expected to absorb those costs even though the insurer has an obligation to cover this medically necessary care.

This policy risks reducing the quality of care, negatively affects quality improvement efforts and underpays providers. The benefit accrues only to the insurer; it is purely financial, not clinical. This policy is egregious in normal times. However, it is a particular affront to patients and their providers in the midst of a global pandemic for which sepsis is a common corollary condition. These insurers' failure to adequately compensate providers for necessary care jeopardizes providers' ability to care for their patients, and

the fact that insurers have adopted these policies without consultation from providers and outside of standard negotiations is additional evidence of the power insurers wield in negotiations with providers.

Lab Code Reporting

UnitedHealthcare, the largest commercial insurer in the country, has launched new reporting requirements on many of its network laboratories during the pandemic, including certain hospital-based laboratories that are already stressed by the significant demand for COVID-19 testing. These new requirements are questionable in value, in violation of HIPAA transaction standards, and extremely burdensome for hospitals. Specifically, the insurer is requiring as a condition of payment that these laboratories report their unique, organization-specific lab codes, as well as a number of other data points that may or may not exist, such as identifying a lab director for each test and including lab test availability dates. The insurer has failed to provide an adequate rationale for this requirement; however, it appears that it intends to use this data to try to isolate tests that generally are included in panels (e.g., a lipid panel that consists of multiple tests) so that it can do line-item denials of tests within a panel. This policy has no clinical objectives, and will not improve the quality of care. Instead, it appears to be another attempt by an insurer to reduce its spend on covered medical services by questioning physicians' orders.

This is not a trivial ask and ignores the longstanding national standard for coding tests for purposes of reimbursement. The vast majority of lab tests (we estimate between 90% - 95%) have their own Current Procedural Terminology (CPT) code, leaving very few tests that are parts of panels where the panel – and not the individual test – is assigned the CPT code. Requesting these unique codes for each of the thousands of lab services therefore gets no new information for the health plan. Yet, the burden on labs will be immense. The information that is being requested is not usually housed in a single database and cannot simply be downloaded into a spreadsheet, as the insurer has suggested. In fact, the data system vendors that hospitals contract with to manage this information will need to rework their systems to accommodate this requirement, and, if not automated, hospital billing departments will be forced to manually insert information into claims. The financial and time resources to comply will be considerable. One member estimated that it will require at least one half of a full time employee's time to accommodate this requirement and the mandatory future updates.

Testing remains one of the core strategies to fight the COVID-19 pandemic. Laboratories across the country have had to scale up operations and are working around the clock to do their part. To have a health insurer force a laboratory to divert resources to submit unnecessary data at this (or any) time is unacceptable. It is particularly egregious that the insurer would threaten reimbursement if a lab is unable to comply when many providers are struggling financially as a result of the pandemic and health insurer profits are at an all-time high.

Administrative Tactics to Delay and Deny Payment

Many commercial health insurers are eroding coverage by restricting access to health care services through the abuse of utilization management programs and changes in health plan rules mid-year. Tactics include unjustified use of prior authorization, mid-year implementation of “site of service” policies that restrict patient access to in-network providers, failure to pay on outstanding claims resulting in large accounts receivable, and adjudicating medical necessity after a service has been provided and not by relying on the information available to the ordering clinician at the time a patient was seen.

Prior authorization, for example, was designed to help patients obtain the right care in the right care setting. Prior authorization can help ensure that providers order care that is consistent with clinical guidelines and protocols, as well as to confirm that such care is covered by the patient’s plan. This tool was designed primarily to help guide (and monitor) providers’ decision-making regarding treatments that are new, particularly high cost, or that have a history of questionable use. However, some health insurers are now applying prior authorization to a wide range of services, including those for which the treatment protocol has remained the same for decades and there is no evidence of abuse.

Unjustified use of utilization management tools, such as prior authorization, has a number of negative implications for patients and the health care system. Patients are often blindsided by denials and can face unexpected medical bills as a result of insurers’ actions. The extensive approval process that physicians and nurses must navigate adds billions of dollars to the health care system and contributes to clinician burnout.²

Evidence of the negative impact of these practices is mounting. The Department of Health and Human Services Office of Inspector General (OIG) warned in a September 2018 report that high rates of Medicare Advantage health plan payment denials and prior authorization delays could negatively affect patients’ access to care.³ In 2019, a federal court found that the largest U.S. commercial insurer was abrogating the *entire point* of health insurance by systematically denying medically necessary, covered behavioral health services for financial reasons.⁴

In response to COVID-19, some health insurers at the urging of government scaled back the use of many of these tactics. State governments, as the primary regulators of insurance, also have taken action. For example, New York State passed a number of insurer accountability measures at the beginning of the COVID-19 to help ensure patient access to care and to remove unnecessary burdens on providers on the front

² Shrank, W. et al., “Waste in the US Health Care System: Estimated Costs and Potential for Savings,” JAMA: The Journal of the American Medical Association. October 7, 2019.

³ U.S. Department of Health and Human Services Office of Inspector General. “Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials,” OEI-09-16-00410. September 2018.

⁴ https://drive.google.com/file/d/1XuzFQV4Z6vCIFnYpTaoS4vBT_RPhQsN/view

lines.⁵ However, not all insurers have scaled back the use of these tools, and many insurers that initially reduced these programs have subsequently reinstated them. In fact, through a recent member survey we learned that some payers have started denying claims for COVID-19 testing citing a lack of prior authorization, despite clear guidelines for when testing is appropriate.

Since early in the crisis, hospitals and health systems have requested assistance from their health insurance partners. The AHA also directly asked the nation's five largest insurers – representing approximately 50% of covered lives – to work with their contract providers to ensure they had the resources necessary to continue to care for patients in their communities. In our April [letter](#), we wrote:

Insurers could make a significant difference in whether a hospital or health system keeps their doors open during this critical time. The federal government has already taken a number of steps to provide critical resources, such as by providing a bump in reimbursement through the Medicare program for COVID-19 cases and enabling Medicare providers to opt for accelerated payments. However, these actions alone are not enough. We urge you to work with your member organizations to commit to similar actions.

Specifically, we ask that insurers support stable cash flow by allowing providers to opt into periodic interim payments and/or accelerated payments for the duration of the public health emergency, much like what is available through the Medicare program. We also ask that insurers eliminate administrative processes that cause delays in payment, such as prior authorization and certain payment edits, and provide adequate coverage and reimbursement of services in hospitals and alternative sites of care, including by covering cost-sharing for COVID-19 treatment. In addition, we urge insurers to expedite processing of outstanding claims that have resulted in billions of dollars in accounts receivables.

This crisis is challenging for all of us, and everyone has a role to play. The courage and dedication of our front-line health care workers who show up every day to care for their communities are an inspiration to us all. We owe them the same kind of dedication by showing up for them. Our patients, our communities and our health care workers deserve nothing less than our best.

This call to action was largely ignored with one primary exception. Most insurers have waived cost-sharing for COVID-19 care. However, even this promise has not been fully met. Despite the fact that widespread testing is crucial to containing the virus, insurers are increasingly denying payment for tests they deem to be not “medically necessary.”

⁵ https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2020_s01_cl2020_08.

Some hospitals have reported losing in the hundreds of thousands to millions of dollars as a result of denied testing claims. One health system has lost close to \$10 million. Treatment denials are even more costly. Hospitals have reported millions of dollars' worth of claims denials for treatment.

In addition, many insurers still have not updated their systems to account for the cost-sharing waivers, and providers have had to override inaccurate information provided by plans to prevent patients from receiving bills for their care. Specifically, when providers run insurance cards for patients, some health insurer systems respond with a positive cost-sharing obligation, not zero, as promised by these health insurers to their enrollees. This inaccurate information is resulting in significant additional administrative burden for hospitals and health systems as they need to reconcile these claims with the insurers. One health system noted that "the variations in the payer interim policies [is] challenging to apply in a standard way" and it is taking a "great deal of resources from the organization to monitor and change" processes regularly. Another commented that "payers have not been consistent with coding and modifier usage and in some cases have changed their stance a number of times which has caused a lot of confusion around billing and also a lot of rework." A number of hospitals and health systems have noted that sorting out these claims not only takes financial and personnel resources, but can delay payments at a time when hospitals are facing immediate cash flow needs. In addition, despite still being deep in the public health crisis, some health insurance cost-sharing waivers are expiring.⁶

HEALTH INSURER ACCOUNTABILITY: ADDITIONAL QUESTIONS FOR CONSIDERATION

We applaud the Committee's focus on the important topic of health insurer practices. In addition to the questions shared with select health insurers on Aug. 13, we believe the following questions will further help the Committee explore this issue.

1. In most markets, health care utilization has declined dramatically. Therefore, providers have fewer resources with which to both maintain capacity to deliver standard services but also stand up capabilities to respond to COVID-19. What actions has your organization taken to ensure that premium dollars paid to your company that were intended for the health care system were shared with providers to help them meet these two objectives?
2. Currently, many health insurance products are undergoing rate review. Please share information on your premium requests for 2021, including the range of changes in premium sought (e.g., -2% in one market to +6% in another), as well as the median and mean requested premium changes. What factors contribute to those requests?

⁶ Kaiser Family Foundation, "Cost-Sharing Waivers and Premium Relief by Private Plans in Response to COVID-19," August 20, 2020. Accessed at: <https://www.healthsystemtracker.org/brief/cost-sharing-waivers-and-premium-relief-by-private-plans-in-response-to-covid-19>.

3. What percentage of contracted premium revenue have you been unable to collect since Jan. 1? How does this compare with the same period in 2019?
4. Is your company reducing premiums for any of its enrollees? Please provide information on the number of enrollees who are receiving some form of premium reduction, the range of reductions and the total dollar value of premium foregone.
5. Has your company dis-enrolled anyone for non-payment of premiums since Jan. 1? If so, how many total people have you dis-enrolled (count all dis-enrollments even if the individual or employer was subsequently reenrolled)? How does this compare to the same period for 2019?

RECOMMENDED STEPS TO ENSURE INSURANCE PREMIUMS SUPPORT ACCESS TO CARE

Health insurers can take a number of steps to help ensure that hospitals are able to continue serving their communities. While a handful of insurers assisted providers with immediate cash flow problems through accelerated and periodic interim payments, a systematic approach to ensuring premium dollars are spent on health care services would provide more meaningful financial help. First, all insurers should settle existing accounts receivables, which amount to billions of dollars in reimbursements for care that has already been delivered but for which providers still await payment. Second, insurers can help alleviate hospital burden and allow clinicians to focus on the patients who need them. This includes halting certain utilization management practices such as prior authorization, concurrent medical necessity reviews, retrospective reviews and site-of-service denials, all of which direct providers away from patients and contribute to reimbursement denials.

Specifically, we urge the Committee to address the following insurer administrative and payment issues that impose significant burden on hospitals and further strain limited financial resources and apply them to all types of health coverage, including self-funded plans:

- **Expedite accounts receivable:** Require immediate processing of payment for all outstanding claims. Claims under dispute may be paid based on the hospital's or health system's average settlement rate for claims in prior years with a reconciliation process after the end of the public health emergency.
- **Require periodic interim and accelerated payments:** Require health plans, including Medicare Advantage and Medicaid managed care plans, to ensure adequate cash flow for providers by transitioning to biweekly and/or accelerated payments similar to what is available through the Medicare program at a provider's request.
- **Suspend prior authorization, medical necessity, and current and retrospective review:** Suspend these utilization management tools during the public health emergency to remove barriers to care and alleviate burden on providers.

- **Suspend paper processing and edits; extend appeals timeframes:** Suspend other administrative processes, such as audits, any administrative activities requiring paper processing, and certain payment edits that cannot be met while the majority of the workforce is working remotely and consumed with other more immediate COVID-19 related tasks. In addition, extend the timeframe for a hospital to submit an internal or external appeal following a notice of adverse determination given the same workforce limitations.
- **Prohibit emergency care denials based on retrospective review:** Require that health plans adjudicate medical necessity based on information available at the time of ordering and prohibit denials of emergency and related inpatient hospital services as not medically necessary on retrospective review. This requirement should not be limited to the public health emergency period.

COVERAGE FOR THE UNINSURED

Health care coverage plays an essential role in our public health emergency response. Stopping the spread of communicable disease requires every individual in a community have access to public health information, preventive care, testing and treatment. Health care coverage is a key facilitator of access to these services. And it is not just about keeping an individual healthy, it also is about stopping transmission from one individual to another. In other words, in the face of communicable disease, we are all only as safe as our weakest link.

A major weak link in our public health response to COVID-19 is the high rate of uninsured individuals. Even before the pandemic, approximately 10% of individuals nationally were uninsured and that figure reached nearly 20% in some states. Individuals without health care coverage are less likely to have a routine source of care and are more likely to face financial barriers to care. That means uninsured individuals may avoid testing or treatment because they do not know where to go or out of fear of what the care may cost them, remaining in the community without appropriate safeguards to prevent transmission.

Gaps in coverage also deprive public health experts of an important communication and surveillance vehicle. Health insurers and other coverage programs have mechanisms for getting in touch with their enrollees in ways the government does not: they have their phone numbers, emails and addresses, as well as an established relationship that is based on the sharing of health-related information. Instead of relying on general public service announcements, health insurers and other coverage programs can directly reach enrollees with targeted communications. They also can monitor claims data to assess whether individuals are getting the care they need. For example, health insurers can monitor which enrollees have already received a vaccine and target communications to those who have not.

Health care coverage also is critical for ensuring that the health care system is adequately financed. The growing rate of uninsured, as well as the shift from commercial coverage to Medicaid, is further exacerbating the financial struggles of many providers.

The Administration has established a program to provide coverage for certain COVID-19-related services for uninsured individuals. While we appreciate these efforts, we believe they are inadequate. Limited coverage programs such as the one operated by HRSA do not allow for the full scope of services and communication mechanisms available through comprehensive coverage, and they provide no real certainty of coverage for patients or providers. Case in point: the HRSA program for the uninsured fails to cover a significant portion of COVID-19-related care, including some of the most costly cases.

The HRSA program has several significant limitations. First, it fails to cover cases of COVID-19 treatment where official coding rules require that the COVID-19 diagnosis be placed secondary on the claim. The most common example of this is when the patient has sepsis. Coding rules require that sepsis be listed as the primary diagnosis even when the sepsis is corollary to COVID-19. This also means that care for patients who experience after effects of having COVID-19 may not be covered, such as when a patient experiences COVID-19-related pneumothorax, lung clots, stroke or myocarditis, but the patient is no longer testing as active infection.. Second, HRSA has applied an overly broad definition of coverage to determine who is uninsured. For example, individuals in very limited coverage programs, such as state programs that only cover family planning services, have been deemed to be insured and therefore ineligible despite not having comprehensive coverage and certainly no coverage for COVID-related testing and treatment.

In response to our concerns regarding the placement of the diagnosis, HRSA has stated that it is not providing coding guidance and that standard coding rules do not apply to this program. This ambiguous guidance suggests that providers *may* get reimbursed through the program *if* they alter the coding on their claims (however, we do not read HRSA's guidance as explicitly confirming this). This is problematic. First, providers that follow HRSA's approach for coding COVID-19 claims are at risk of HIPAA violations, or worse yet, a charge of fraud and abuse as federal policy does not generally permit providers to deviate from coding rules for purposes of changing their reimbursement. Second, providers must consistently code claims in order to track them for state and federal reporting and quality improvement purposes. Changing the order of the codes changes the diagnostic-related group to which the claim is assigned, making it far harder to track similar cases. Finally, the lack of clarity regarding the rules will almost undoubtedly result in variation in how providers interpret them, resulting in spotty reimbursement for uninsured patients. **We continue to urge HRSA to align its policy with the nationally recognized coding standards.**

However, as discussed above, making these changes to the HRSA program is inadequate for ensuring coverage for the uninsured. **We urge Congress and the Administration to close remaining gaps in comprehensive coverage.** The following steps could make great strides in expanding enrollment in health care coverage and, by extension, routine access to care:

- **Expand employer subsidies to preserve enrollment.** Many employers experiencing loss of revenue as a result of the economic downturn may choose to reduce benefits as one way to manage expenses. Congress could further help employers maintain benefits by expanding eligibility for employer subsidies for the purposes of preserving enrollment in health coverage during the public health emergency.
- **Provide federal subsidies for COBRA.** The COVID-19 public health emergency has already triggered significant job loss. Many individuals may have the option to maintain their job-based health coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA) but find the costs to be prohibitive, especially if they are facing a significant reduction in income, as they are expected to cover the entire cost of the monthly premium. Congress could offset the cost of coverage through COBRA to former employees with a direct subsidy or refundable individual tax credits.
- **Provide full federal match for newly expanding states.** Several million uninsured individuals would likely be eligible for Medicaid if the state in which they lived opted to expand Medicaid. Many of these individuals do not have access to employer-sponsored coverage and are not eligible for subsidies on the Health Insurance Marketplaces because they make too little (less than 100% of the federal poverty limit). Congress should create incentives for the remaining 14 states to expand Medicaid by providing full federal match for the first three years of expansion, regardless of when a state expands.
- **Increase eligibility for federal Marketplace subsidies.** Many lower income individuals neither have access to affordable employer-sponsored coverage nor are eligible for Medicaid or the Marketplaces. Congress could assist these individuals by increasing the eligibility threshold for federal subsidies for coverage through the Health Insurance Marketplaces.
- **Establish a Special Enrollment Period (SEP) for Marketplace coverage.** While individuals who have recently lost employer-based coverage are eligible for an existing SEP, the already uninsured do not have that option. We urge the Administration or Congress to establish a new SEP specifically for those individuals who were already uninsured and not otherwise eligible for an existing SEP.
- **Prohibit cancelation of coverage for non-payment of premiums.** Insurers may disenroll plan participants from Marketplace coverage if the enrollee is unable to pay their portion of the premium for three months. Given the economic downturn, we

encourage Congress to prohibit insurers from disenrolling anyone from coverage for non-payment of premiums if their inability to pay their premiums is due to COVID-19-related job loss or furlough. Insurers also should be required to continue reimbursing providers for the services delivered to those individuals during this time. This prohibition should extend beyond the Marketplaces and apply to all forms of commercial coverage, including self-insured plans with the insurer bearing the cost of coverage for enrollees in self-funded plans.

CONCLUSION

Thank you again for bringing attention to this important topic. The AHA looks forward to working with the Committee as it continues its review process. We believe it is vitally important for our health care system to be supported in this evolving health care crisis, and we stand ready to assist you.

Please contact me if you have questions, or feel free to have a member of your team contact Robyn Bash, vice president of government relations and public policy operations, at rbash@aha.org.

Sincerely,

Thomas P. Nickels
Executive Vice President
Government Relations and Public Policy